A1. Site/Study ID #:___ ___ / **G**___ ___ ___ ___ A2. Assessment Date: ___ ___ / ___ ___ / ___ ___ ___ ___ (Month / Day / Year) A3. Staff Initials: ___ ___ ___

A5. 1. ☐ Age 5 Years 2. ☐ Age 6 Years 3. ☐ Age 7 Years 4. ☐ LT/ABD To DCC ☐

PedsQL™

Pediatric Quality of Life Inventory

Version 4.0

YOUNG CHILD REPORT (ages **5-7**)

INSTRUCTIONS FOR INTERVIEWER

I am going to ask you some questions about things that might be a problem for some children. I want to know how much of a problem any of these things might be for you.

Show the child the template and point to the responses as you read.

If it is <u>not at all</u> a problem for you, point to the smiling face.

If it is <u>sometimes</u> a problem for you, point to the middle face.

If it is a problem for you <u>a lot</u>, point to the frowning face.

I will read each question. Point to the pictures to show me how much of a problem it is for you. Let's try a practice one first.

	Not at all	Sometimes	A lot
Is it hard for you to snap your fingers	☺	😐	☹

Ask the child to demonstrate snapping his or her fingers to determine whether or not the question was answered correctly. Repeat the question if the child demonstrates a response that is different from his or her action.

A1. Site/Study ID #:___ ___ / **G**___ ___ ___ ___ A2. Assessment Date: ___ ___ / ___ ___ / ___ ___ ___ ___
Month Day Year

A5. 1. ☐ Age 5 Years 2. ☐ Age 6 Years 3. ☐ Age 7 Years 4. ☐ LT/ABD

Think about how you have been doing for the last few weeks. Please listen carefully to each sentence and tell me how much of a problem this is for you.

After reading the item, gesture to the template. If the child hesitates or does not seem to understand how to answer, read the response options while pointing at the faces.

PHYSICAL FUNCTIONING (*problems with…*)	**Not at all**	**Some-times**	**A lot**
1. Is it hard for you to walk	0	2	4
2. Is it hard for you to run	0	2	4
3. Is it hard for you to play sports or exercise	0	2	4
4. Is it hard for you to pick up big things	0	2	4
5. Is it hard for you to take a bath or shower	0	2	4
6. Is it hard for you to do chores (like pick up your toys)	0	2	4
7. Do you have hurts or aches? ***(Where?*** _____***)***	0	2	4
8. Do you ever feel too tired to play?	0	2	4

Remember, tell me how much of a problem this has been for you for the last few weeks.

EMOTIONAL FUNCTIONING (*problems with…*)	**Not at all**	**Some-times**	**A lot**
1. Do you feel scared	0	2	4
2. Do you feel sad	0	2	4
3. Do you feel mad	0	2	4
4. Do you have trouble sleeping	0	2	4
5. Do you worry about what will happen to you	0	2	4

SOCIAL FUNCTIONING *(problems with…)*	**Not at all**	**Some-times**	**A lot**
1. Is it hard for you to get along with other kids	0	2	4
2. Do other kids say they do not want to play with you	0	2	4
3. Do other kids tease you	0	2	4
4. Can other kids do things that you cannot do	0	2	4
5. Is it hard for you to keep up when you play with other kids	0	2	4

SCHOOL FUNCTIONING (*problems with…*)	**Not at all**	**Some-times**	**A lot**
1. Is it hard for you to pay attention in school	0	2	4
2. Do you forget things	0	2	4
3. Is it hard to keep up with schoolwork	0	2	4
4. Do you miss school because of not feeling good	0	2	4
5. Do you miss school because you have to go to the doctor's or hospital	0	2	4

How much of a problem is this for you?

Not at all	Sometimes	A lot