**PedsQL™ - Pediatric Quality of Life Inventory**
**Parent Report for Infants (1-12 months)**

Patient ID __ __ - __ __ __ __ - __ __ __
Date of evaluation *(mm/dd/yy):* __ /__ /__
Follow-up time-point: ☐ 6 Month ☐ 12 Month

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Directions: On the following page is a list of things that might be a problem for **your child**. Please tell us **how much of a problem** each one has been for **your child** during the **past ONE month** by circling:

**0** if it is **never** a problem
**1** if it is **almost never** a problem
**2** if it is **sometimes** a problem
**3** if it is **often** a problem
**4** if it is **almost always** a problem

There are no right or wrong answers. If you do not understand a question, please ask for help.

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*In the past **ONE month**, how much of a **problem** has your child had with…*

| Physical Functioning *(problems with…)* | Never | Almost Never | Some-times | Often | Almost Always |
|---|---|---|---|---|---|
| 1. Low energy level | 0 | 1 | 2 | 3 | 4 |
| 2. Difficulty participating in active play | 0 | 1 | 2 | 3 | 4 |
| 3. Having hurts or aches | 0 | 1 | 2 | 3 | 4 |
| 4. Feeling tired | 0 | 1 | 2 | 3 | 4 |
| 5. Being lethargic | 0 | 1 | 2 | 3 | 4 |
| 6. Resting a lot | 0 | 1 | 2 | 3 | 4 |

| Physical Symptoms *(problems with…)* | Never | Almost Never | Some-times | Often | Almost Always |
|---|---|---|---|---|---|
| 1. Having gas | 0 | 1 | 2 | 3 | 4 |
| 2. Spitting up after eating | 0 | 1 | 2 | 3 | 4 |
| 3. Difficulty breathing | 0 | 1 | 2 | 3 | 4 |
| 4. Being sick to his/her stomach | 0 | 1 | 2 | 3 | 4 |
| 5. Difficulty swallowing | 0 | 1 | 2 | 3 | 4 |
| 6. Being constipated | 0 | 1 | 2 | 3 | 4 |
| 7. Having a rash | 0 | 1 | 2 | 3 | 4 |
| 8. Having diarrhea | 0 | 1 | 2 | 3 | 4 |
| 9. Wheezing | 0 | 1 | 2 | 3 | 4 |
| 10. Vomiting | 0 | 1 | 2 | 3 | 4 |

| Emotional Functioning *(problems with…)* | Never | Almost Never | Some-times | Often | Almost Always |
|---|---|---|---|---|---|
| 1. Feeling afraid or scared | 0 | 1 | 2 | 3 | 4 |
| 2. Feeling angry | 0 | 1 | 2 | 3 | 4 |
| 3. Crying or fussing when left alone | 0 | 1 | 2 | 3 | 4 |
| 4. Difficulty soothing himself/herself when upset | 0 | 1 | 2 | 3 | 4 |
| 5. Difficulty falling asleep | 0 | 1 | 2 | 3 | 4 |
| 6. Crying or fussing while being cuddled | 0 | 1 | 2 | 3 | 4 |
| 7. Feeling sad | 0 | 1 | 2 | 3 | 4 |
| 8. Difficulty being soothed when picked up or held | 0 | 1 | 2 | 3 | 4 |
| 9. Difficulty sleeping mostly through the night | 0 | 1 | 2 | 3 | 4 |
| 10. Crying a lot | 0 | 1 | 2 | 3 | 4 |
| 11. Feeling cranky | 0 | 1 | 2 | 3 | 4 |
| 12. Difficulty taking naps during the day | 0 | 1 | 2 | 3 | 4 |

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*In the past **ONE month**, how much of a **problem** has your child had with…*

| Social Functioning *(problems with…)* | Never | Almost Never | Some-times | Often | Almost Always |
|---|---|---|---|---|---|
| 1. Not smiling at others | 0 | 1 | 2 | 3 | 4 |
| 2. Not laughing when tickled | 0 | 1 | 2 | 3 | 4 |
| 3. Not making eye contact with a caregiver | 0 | 1 | 2 | 3 | 4 |
| 4. Not laughing when cuddled | 0 | 1 | 2 | 3 | 4 |

| Cognitive Functioning *(problems with…)* | Never | Almost Never | Some-times | Often | Almost Always |
|---|---|---|---|---|---|
| 1. Not imitating caregivers' actions | 0 | 1 | 2 | 3 | 4 |
| 2. Not imitating caregivers' facial expressions | 0 | 1 | 2 | 3 | 4 |
| 3. Not imitating caregivers' sounds | 0 | 1 | 2 | 3 | 4 |
| 4. Not able to fix his/her attention on objects | 0 | 1 | 2 | 3 | 4 |