

Patient ID _____ - ___ - ____ - ____ - ____ Date of evaluation (*mm/dd/yy*): ___ / ___ / ___ Follow-up time-point: D 6 Month D 12 Month

<u>Directions:</u> 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.

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

Physical Functioning (problems with)	Never	Almost	Some-	Often	Almost
		Never	times		Always
1. Walking more than one block	0	1	2	3	4
2. Running	0	1	2	3	4
3. Participating in sports activity or exercise	0	1	2	3	4
4. Lifting something heavy	0	1	2	3	4
5. Taking a bath or shower by him or herself	0	1	2	3	4
6. Doing chores around the house	0	1	2	3	4
7. Having hurts or aches	0	1	2	3	4
8. Low energy level	0	1	2	3	4
Emotional Functioning (problems with)	Never	Almost	Some-	Often	Almost
		Never	times		Always
1. Feeling afraid or scared	0	1	2	3	4
2. Feeling sad or blue	0	1	2	3	4
3. Feeling angry	0	1	2	3	4
4. Trouble sleeping	0	1	2	3	4
5. Worrying about what will happen to him or her	0	1	2	3	4
Social Functioning (problems with)	Never	Almost	Some-	Often	Almost
		Never	times		Always
1. Getting along with other children	0	1	2	3	4
2. Other kids not wanting to be his or her friend	0	1	2	3	4
3. Getting teased by other children	0	1	2	3	4
4. Not able to do things that other children his or her age can do	0	1	2	3	4
5. Keeping up when playing with other children	0	1	2	3	4
School Functioning (problems with)	Never	Almost	Some-	Often	Almost
		Never	times		Always
1. Paying attention in class	0	1	2	3	4
2 Forgetting things	0	1	2	3	4