



(affix label here)

Patient ID Number	<input type="text"/>						
	Site	Sub-site	Sequential ID				

# PedsQL<sup>TM</sup>

## Pediatric Quality of Life Inventory

Version 4.0

**NOTE: All variables in the data have suffix "\_parent"**

### PARENT REPORT for YOUNG CHILDREN (ages 5-7)

#### 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.

Public reporting burden of this collection of information is estimated to average 5 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-0904).

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

<b>PHYSICAL FUNCTIONING (problems with...)</b>	Never	Almost Never	Some-times	Often	Almost Always
1. Walking more than one block <b>walk</b>	0	1	2	3	4
2. Running <b>run</b>	0	1	2	3	4
3. Participating in sports activity or exercise <b>sports</b>	0	1	2	3	4
4. Lifting something heavy <b>lift</b>	0	1	2	3	4
5. Taking a bath or shower by him or herself <b>bath</b>	0	1	2	3	4
6. Doing chores, like picking up his or her toys <b>chores</b>	0	1	2	3	4
7. Having hurts or aches <b>aches</b>	0	1	2	3	4
8. Low energy level <b>energy</b>	0	1	2	3	4

<b>EMOTIONAL FUNCTIONING (problems with...)</b>	Never	Almost Never	Some-times	Often	Almost Always
1. Feeling afraid or scared <b>scared</b>	0	1	2	3	4
2. Feeling sad or blue <b>sad</b>	0	1	2	3	4
3. Feeling angry <b>angry</b>	0	1	2	3	4
4. Trouble sleeping <b>sleep</b>	0	1	2	3	4
5. Worrying about what will happen to him or her <b>worry</b>	0	1	2	3	4

<b>SOCIAL FUNCTIONING (problems with...)</b>	Never	Almost Never	Some-times	Often	Almost Always
1. Getting along with other children <b>getalong</b>	0	1	2	3	4
2. Other kids not wanting to be his or her friend <b>friend</b>	0	1	2	3	4
3. Getting teased by other children <b>tease</b>	0	1	2	3	4
4. Not able to do things that other children his or her age can do <b>dothings</b>	0	1	2	3	4
5. Keeping up when playing with other children <b>keepup</b>	0	1	2	3	4

<b>SCHOOL FUNCTIONING (problems with...)</b>	Never	Almost Never	Some-times	Often	Almost Always
1. Paying attention in class <b>class</b>	0	1	2	3	4
2. Forgetting things <b>forget</b>	0	1	2	3	4
3. Keeping up with school activities <b>homework</b>	0	1	2	3	4
4. Missing school because of not feeling well <b>feelwell</b>	0	1	2	3	4
5. Missing school to go to the doctor or hospital <b>godoc</b>	0	1	2	3	4

FOR STUDY USE ONLY						
Date Completed	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Completed by	<input type="text"/>
	Month	Day	Year			
Date Reviewed	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Reviewer Code	<input type="text"/>
	Month	Day	Year			
Date Entered	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Data Entry Code	<input type="text"/>
	Month	Day	Year			