ACT Annual Questionnaire

5-17 Years of Age Parent Report

The questions in this booklet relate to:

Person completing this questionnaire is:

Your relationship:

☐ Parent ☐ Other: _____

Today's date: ☐☐ / ☐☐ / ☐☐☐☐
m m d d y y y y

MRN: ☐☐☐☐☐

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Survey #233

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03/13/2018 10:09:02 AM

INSTRUCTIONS FOR COMPLETING THE QUESTIONNAIRE

Please follow these rules in completing this questionnaire. If you have any questions about completing this questionnaire, please call 1-800-775-2167.

1. Use a black ballpoint pen or a number 2 black pencil. Do not use a felt-tip or roller-ball pen. These may cause smudging. If you must erase answers, erase them completely.
2. When marking boxes, make an x inside the box (see examples below).
3. Make no stray marks of any kind. Please keep the form as clean as possible.
4. Written responses must stay within the boxes provided:

CORRECT

Grape

INCORRECT

MARKING EXAMPLES

Below are some examples of how to fill out this questionnaire. Please look these over before you begin.

Example 1

1. During the past month, did your child participate in any physical activities or exercises such as running, aerobics, golf, gardening, bicycling, swimming, wheelchair basketball, or walking for exercise?

☐ No ☒ Yes

Example 2

2. Has your child ever taken. . .

	No	Yes	Not sure	If yes, age at first use
a. PILLS OR INSULIN FOR DIABETES such as Glucophage (metformin), Glucotrol (glipizide), Glynase (glyburide), Prandin, Amaryl, Avandia, Actos, or insulin injections (such as Humulin, Novolin, Lantus)	X	☐	☐	
If yes, specify the name of the drug(s) or indicate you do not know the specific name				
b. MEDICATIONS FOR ATTENTION OR MEMORY PROBLEMS such as Ritalin, Adderall, Concerta, Strattera, Aricept (donepezil), or Provigil (modafinil)		☒	☐	10
If yes, specify the name of the drug(s) or indicate you do not know the specific name		ritalin		

Example 3

3. When was this condition diagnosed?

Month (mm)	Year (yyyy)
04	2000

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Current Health Problems (Review of Systems)

Is your child **currently having problems** with any of the conditions below:

	No	Yes
Frequent headaches	☐	☐
Problems seeing	☐	☐
Problems hearing	☐	☐
Dizziness or unsteadiness	☐	☐
Problems walking	☐	☐
Frequently tired	☐	☐
Changes in appetite or eating habits	☐	☐
Sensitivity to heat or cold	☐	☐
Chest pain	☐	☐
Rapid or irregular heartbeat	☐	☐
Frequent or severe belly pain	☐	☐
Frequent constipation	☐	☐
Frequent diarrhea	☐	☐
Frequent need to urinate	☐	☐
Burning or pain with urination	☐	☐
Back pain	☐	☐
Any other chronic pain	☐	☐
Problems with menstrual periods	☐	☐
Heavy periods with excessive bleeding	☐	☐
Irregular or frequently missed periods	☐	☐
Severe cramping	☐	☐
Problems with sexual functioning	☐	☐
Problems with memory, thinking, forgetting which affect school or work performance	☐	☐
Problems controlling temper or anger	☐	☐
Difficulty getting along with others	☐	☐
Increased worries or upsetting thoughts	☐	☐
Problems with anxiety/panic attacks	☐	☐
Frequently feeling sad, blue or depressed	☐	☐
Problems sleeping or frequent use of sleep medicines	☐	☐
Increased use of tobacco, alcohol or other drugs	☐	☐
Use of over the counter weight loss medicine	☐	☐

→ *Please continue on next page.*

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Medical Information

Please provide the name, address, and telephone number of the patient's physician and specialty physician.

Primary Care Physician:

Doctor's name
Street
City, State, Zip
Phone

Specialty Physician (Example: Endocrinologist):

Doctor's name
Street
City, State, Zip
Phone
Specialty

Specialty Physician (Example: Endocrinologist):

Doctor's name
Street
City, State, Zip
Phone
Specialty

Specialty Physician (Example: Endocrinologist):

Doctor's name
Street
City, State, Zip
Phone
Specialty

Interval History

Medical Check-Ups:

A1. Has your child seen a doctor since his/her last St. Jude visit?

☐ No ➞ *Go to Question A3.*

☐ Yes

A2. Reason for doctor visit:

☐ Routine check-up; sports or school physical

☐ Illness; indicate approximate date and condition treated

Date
Doctor's name
Medical problem

Date
Doctor's name
Medical problem

A3. Has your child seen a dentist since his/her last St. Jude visit?

☐ No ➞ *Go to Question A5, next page.*

☐ Yes

A4. Reason for dental visit:

☐ Routine check-up

☐ Dental Problem

If dental problem, please specify:

Please! Do not mark below this line

Hospitalizations

A5. Has your child been hospitalized since his/her last St. Jude visit?

☐ No

☐ Yes

Date	Hospital
Medical problem	

Date	Hospital
Medical problem	

Medications and Health Supplements

Medications: List the medicines your child takes regularly. Remember to include hormones, birth control pills and over the counter medicines.

Name of medicine	Dose of medicine	Reason taken	Prescribing MD

Health Supplements: List herbs, supplements and other natural products your child takes regularly.

Name of product	Reason taken

Please! Do not mark below this line

Living Arrangement

B1. What is your child's current living arrangement? *(Mark all that apply)*

- ☐ Lives with parent(s)
- ☐ Lives with adult brother(s) and/or sister(s)
- ☐ Lives with other adult relative(s)
- ☐ Other

If Other, please specify.

School History

B2. Is your child currently in school?

- ☐ No — ***If no, please explain.***
- ☐ Yes — ***If yes, what grade is he/she in?*** ☐☐

B2a. If yes and your child is in elementary or middle school, what are your child's average grades?

B2b. If yes and in high school, what is your child's grade point average (GPA)?

☐.☐

Driver's License

B3. Does your child currently have a driver's license?

- ☐ No
- ☐ Yes

Health Insurance

B4. Does your child currently have health insurance coverage?

- ☐ Non U. S. resident → *Go to C1, next page.*
- ☐ No → *Go to C1, next page.*
- ☐ Yes

B5. How is this insurance provided? *(Mark all that apply)*

- ☐ Through parent's place of employment
- ☐ Through parent's policy
- ☐ Through a policy you have purchased for your child
- ☐ Affordable Care Act (Obama Care)
- ☐ Medicaid or other public assistance program
- ☐ Medicare
- ☐ Military dependent/Veteran's benefits (CHAMPUS)
- ☐ Other

If Other, please specify.

→ *Please continue on next page.*

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Sun Sensitivity

C1. Has your child ever used artificial tanning devices such as a sunlamp, or gone to a tanning booth?

☐ No

☐ Yes

C2. When your child was outside last summer for more than 15 minutes, how often did he/she protect themself from the sun by . . .

	Never	Rarely	Sometimes	Often	Always
Applying a sunscreen with a sun protection factor (SPF) of 15 or more on all sun exposed skin areas.	☐	☐	☐	☐	☐
Wearing protective clothing such as long-sleeved shirts and long pants.	☐	☐	☐	☐	☐
Wearing a hat.	☐	☐	☐	☐	☐
Limiting exposure to the sun during the mid-day hours.	☐	☐	☐	☐	☐
Staying in the shade.	☐	☐	☐	☐	☐

Physical Activity

D1. Which one of the following describes you best for the last 7 days? Read all five statements before deciding on the one answer that describes you.

☐ All or most of my free time was spent doing things that involve little physical effort

☐ I sometimes (1-2 times last week) did physical things in my free time (e.g. played sports, went running, swimming, bike riding, did aerobics)

☐ I often (3-4 times last week) did physical things in my free time

☐ I quite often (5-6 times last week) did physical things in my free time

☐ I very often (7 or more times last week) did physical things in my free time

D2. Over the past 30 days, on a typical day how much time altogether did your child spend sitting and watching TV or videos or using a computer outside of work? Would you say ...

☐ Doesn't watch TV or videos or use a computer

☐ <1 hour

☐ 1 hour

☐ 2 hours

☐ 3 hours

☐ 4 hours

☐ 5 hours or more

Social

E1. Please respond to each item by marking one box per row.

In the past 7 days. . . .

	Never	Almost Never	Sometimes	Often	Almost Always
a. My child felt accepted by other kids his/her age	☐	☐	☐	☐	☐
b. My child was able to count on his/her friends	☐	☐	☐	☐	☐
c. My child was good at making friends.	☐	☐	☐	☐	☐
d. My child and his/her friends helped each other out	☐	☐	☐	☐	☐
e. Other kids wanted to be my child's friend	☐	☐	☐	☐	☐
f. Other kids wanted to be with my child	☐	☐	☐	☐	☐
g. Other kids wanted to talk to my child.	☐	☐	☐	☐	☐

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Pain Interference

E2. Please respond to each item by marking one box per row.

In the past 7 days. . . .

	Never	Almost Never	Sometimes	Often	Almost Always
a. My child had trouble sleeping when he/she had pain	☐	☐	☐	☐	☐
b. My child felt angry when he/she had pain	☐	☐	☐	☐	☐
c. My child had trouble doing schoolwork when he/she had pain	☐	☐	☐	☐	☐
d. It was hard for my child to pay attention when he/she had pain	☐	☐	☐	☐	☐
e. It was hard for my child to run when he/she had pain	☐	☐	☐	☐	☐
f. It was hard for my child to walk one block when he/she had pain	☐	☐	☐	☐	☐
g. It was hard for my child to have fun when he/she had pain	☐	☐	☐	☐	☐
h. It was hard for my child to stay standing when he/she had pain	☐	☐	☐	☐	☐

Mood

E3. Please respond to each item by marking one box per row.

In the past 7 days. . . .

	Never	Almost Never	Sometimes	Often	Almost Always
a. My child could not stop feeling sad	☐	☐	☐	☐	☐
b. My child felt everything in his/her life went wrong	☐	☐	☐	☐	☐
c. My child felt like he/she couldn't do anything right	☐	☐	☐	☐	☐
d. My child felt lonely	☐	☐	☐	☐	☐
e. My child felt sad	☐	☐	☐	☐	☐
f. My child thought that his/her life was bad	☐	☐	☐	☐	☐

Anxiety

Please respond to each item by marking one box per row.

In the past 7 days. . . .

	Never	Almost Never	Sometimes	Often	Almost Always
E4. My child felt nervous	☐	☐	☐	☐	☐
E5. My child felt scared	☐	☐	☐	☐	☐
E6. My child felt worried	☐	☐	☐	☐	☐
E7. My child felt like something awful might happen	☐	☐	☐	☐	☐
E8. My child thought about scary things	☐	☐	☐	☐	☐
E9. My child was afraid that he/she would make mistakes	☐	☐	☐	☐	☐
E10. My child worried about what could happen to him/her	☐	☐	☐	☐	☐
E11. My child worried when he/she went to bed at night	☐	☐	☐	☐	☐

→ *Please continue on next page.*

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Sleep

F1 to F8 relate to the past 7 days.

	Not at all	A little bit	Somewhat	Quite a bit	Very much
F1. His/Her sleep was restless	☐	☐	☐	☐	☐
F2. He/She was satisfied with his/her sleep	☐	☐	☐	☐	☐
F3. His/Her sleep was refreshing.	☐	☐	☐	☐	☐
F4. He/She had difficulty falling asleep.	☐	☐	☐	☐	☐

	Never	Rarely	Sometimes	Often	Always
F5. He/She had trouble staying asleep	☐	☐	☐	☐	☐
F6. He/She had trouble sleeping	☐	☐	☐	☐	☐
F7. He/She got enough sleep.	☐	☐	☐	☐	☐

	Very poor	Poor	Fair	Good	Very good
F8. His/Her sleep quality was	☐	☐	☐	☐	☐

Attention/Concentration

Please read each item carefully and tell us how true it is about your child in the past month.

	Never or seldom	Occasionally	Often	Very often
G1. It is hard for my child to pay attention to details	☐	☐	☐	☐
G2. My child can't pay attention for long	☐	☐	☐	☐
G3. My child loses track of what he/she is supposed to do	☐	☐	☐	☐
G4. My child gets distracted by things that are going on around him/her	☐	☐	☐	☐
G5. My child has trouble finishing things	☐	☐	☐	☐
G6. My child has trouble concentrating	☐	☐	☐	☐

→ *Please continue on next page.*

H1. How well do the following statements describe your child's behavior?

	Often True	Sometimes True	Not True
a. Has trouble getting along with other children	☐	☐	☐
b. Has trouble getting along with teachers	☐	☐	☐
c. Is impulsive, or acts without thinking.	☐	☐	☐
d. Feels worthless or inferior	☐	☐	☐
e. Is not liked by other children	☐	☐	☐
f. Has a lot of difficulty getting his/her mind off certain thoughts, has obsessions	☐	☐	☐
g. Is restless or overly active, cannot sit still	☐	☐	☐
h. Is stubborn, sullen, or irritable	☐	☐	☐
i. Has a very strong temper and loses it easily	☐	☐	☐
j. Is unhappy, sad or depressed	☐	☐	☐
k. Is withdrawn, does not get involved with others	☐	☐	☐
l. Has sudden changes in mood or feelings	☐	☐	☐
m. Feels or complains that no one loves him/her	☐	☐	☐
n. Is rather high strung, tense, or nervous	☐	☐	☐
o. Cheats or tells lies	☐	☐	☐
p. Is too fearful or anxious	☐	☐	☐
q. Argues too much	☐	☐	☐
r. Has difficulty concentrating, cannot pay attention for long	☐	☐	☐
s. Is easily confused, seems to be in a fog	☐	☐	☐
t. Bullies, or is cruel or mean to others	☐	☐	☐
u. Is disobedient at home	☐	☐	☐
v. Is disobedient at school	☐	☐	☐
w. Does not seem to feel sorry after he/she misbehaves	☐	☐	☐

H2. FOR CHILDREN UNDER 12 YEARS OF AGE

	Often True	Sometimes True	Not True
a. Breaks things on purpose, deliberately destroys his/her own things	☐	☐	☐
b. Clings to adults	☐	☐	☐
c. Cries too much	☐	☐	☐
d. Demands a lot of attention	☐	☐	☐
e. Is too dependent on others	☐	☐	☐

If child is under 12 years of age → *Go to Question I1.*

H3. FOR CHILDREN 12 YEARS OF AGE OR OLDER

	Often True	Sometimes True	Not True
a. Feels others are out to get him/her	☐	☐	☐
b. Hangs around with kids who get into trouble.	☐	☐	☐
c. Is secretive, keeps things to himself/herself	☐	☐	☐
d. Worries too much	☐	☐	☐

I1. In the <u>past 12 months</u>, has your child ever made statements about wanting to hurt or kill him or herself?

☐ No

☐ Yes

I2. In the <u>past 12 months</u>, has your child ever done anything to try to hurt or kill him or herself?

☐ No

☐ Yes

Please! Do not mark below this line

Do you have an email address we could use to contact you?

☐ No ☐ Yes

Your Email Address

Please give us your correct address or location and also cell phone number:

Address		
City	State	
Zip Code	Home Phone Number	Cell Phone Number

→ *Please continue on next page.*

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We are always interested in your input.
Use this space for any additional comments you may have:

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