



SJLIFE

Behavior Survey 11-17 Years of Age Parent Report

Finding cures. Saving children.

The questions in this booklet relate to:

Name

Person completing this questionnaire is:

percomp **text**

Your relationship:

2 Parent 3 Other: **percode** **coded**
relation

Today's date:

/ /
m m d d y y y y

datecomp

Our mailing address is:

St. Jude Children's Research Hospital
Department of Epidemiology
Mail Stop 735
262 Danny Thomas Place
Memphis, TN 38105-3678

Toll-free phone number:

1-800-775-2167

e-mail:

SJLIFE@stjude.org

SJLIFEID

STUDYNAME

Please! Do not mark below this line

MRN

Survey #312

0935417683

11/12/2021 09:51:51 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. Do not use a felt-tip or roller-ball pen. These may cause smudging.
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

INCORRECT

Grape

Grape

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

	Not sure	
No	Yes	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

If yes,
age at
first use

--	--

Example 2

2. Has your child ever taken. . .

- 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)-----

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)-----

If yes, specify the name of the drug(s) or indicate you do not know the specific name

ritalin

1	0
---	---

Example 3

3. When was this condition diagnosed?

04

2000

Month (mm)

Year (yyyy)

Please! Do not mark below this line

SCHOOL HISTORY

A1. What is the highest grade or level of schooling your child has now completed? **grade**

- 1 1 - 8 years (grade school)
- 2 9 - 12 years (high school) but did not graduate
- 3 Completed high school/GED
- 4 Training after high school, other than college
- 5 Some college
- 6 College graduate
- 7 Post graduate level
- 8 Other

If Other, please describe.

gradespe
text

A2. What is the highest grade or level of schooling that your child's mother has completed? **gradem**

- 1 1 - 8 years (grade school)
- 2 9 - 12 years (high school), but did not graduate
- 3 Completed high school/GED
- 4 Training after high school, other than college
- 5 Some college
- 6 College graduate
- 7 Post-graduate level
- 9 Not Applicable
- 10 Unknown
- 8 Other

Specify.

grdmspe
text

A3. What is the highest grade or level of schooling that your child's father has completed? **gradef**

- 1 1 - 8 years (grade school)
- 2 9 - 12 years (high school), but did not graduate
- 3 Completed high school/GED
- 4 Training after high school, other than college
- 5 Some college
- 6 College graduate
- 7 Post-graduate level
- 9 Not Applicable
- 10 Unknown
- 8 Other

Specify.

grdfspe
text

Continue on next page.

Please! Do not mark below this line

A4. In school was your child ever in any of the following programs? (Mark all that apply)

	2 No	1 Yes	3 Not sure
Advanced placement or talented program? <i>adplc</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Homebound education (instruction at home by a school teacher) for at least one school year? <i>homed</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learning disabled or special education program? <i>speced</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If no, skip to A6.

If yes, was he/she in the program because of . . .

a. Missed school. <i>speced_a</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Low scores on tests. <i>speced_b</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Problems learning or concentrating. <i>speced_c</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>speced_read</i> i. In Reading?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>speced_math</i> ii. In Math?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>speced_write</i> iii. In Writing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Emotional or behavioral problems <i>speced_d</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

A5. If your child was in a learning disabled or special education program, what grades was he/she in at that time? (Mark all that apply) *specprog*

- Pre-K *specprog_prek*
- K *specprog_k*
- 1st *specprog_1*
- 2nd *specprog_2*
- 3rd *specprog_3*
- 4th *specprog_4*
- 5th *specprog_5*
- 6th *specprog_6*
- 7th *specprog_7*
- 8th *specprog_8*
- 9th *specprog_9*
- 10th *specprog_10*
- 11th *specprog_11*
- 12th *specprog_12*

A6. Has your child ever . . .

	2 No	1 Yes	3 Not sure
a. Attended summer school? <i>smrsch</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Repeated a grade? <i>repgrd</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Skipped a grade? <i>skpgrd</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Taken adaptive physical education? <i>adappe</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Been suspended from school? <i>suspend</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Been expelled from school? <i>expelled</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Been physically bullied? <i>phybully</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Been emotionally bullied? <i>emotbully</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Bullied others? <i>bully</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Been socially isolated by classmates? <i>socisol</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Engaged in self harm? <i>selfharm</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Engaged in dangerous or risky internet behavior? <i>riskyint</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Continue on next page.

A7. Is your child currently receiving . . .

		2 No	1 Yes	3 Not sure
a. Physical therapy?	phythrp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Occupational therapy?	occthrp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Speech therapy?	sphthrp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Counseling?	counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Services via 504 plan?	srvc504	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Services via IEP?	srvciep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Services for sensory impairment (vision/hearing)?	srvcnsry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

A8. Has your child ever received neuropsychological/psychoeducational assessment (also known as "testing")? npsytst

2 No → **Go to Question B1.**

3 Not sure

1 Yes ↴

A8a. Where did he/she get tested?

npsytst_loc text

A8b. How many years has it been since your child's last testing took place? npsytst_yrs years

EMPLOYMENT

B1. Has your child ever had a job? evjob

2 No → **Go to Question C1, next page.**

1 Yes ↴

B2. What is his/her current employment status? Include unpaid work in the family business or farm. empst (Mark all that apply)

Not currently working → **Go to Question C1.**

Working full-time (30 or more hours per week) empst_not

Working part-time (less than 30 hours per week) empst_full

Caring for home or family (not seeking paid work) empst_par

Unemployed and looking for work empst_look

Unable to work due to illness or disability empst_dis

Student empst_std

Other empst_oth

If Other, please describe.

empsp text

B3. The following questions are about your child's present occupation. Please write his/her job title and brief details of what he/she does. If he/she has more than one job, please give the title of your child's main job.

B3a. Main job title:

mainj text

B3b. Please briefly describe the primary tasks in your child's job:

no entry

Please! Do not mark below this line


INSURANCE

Health Insurance

C1. Have you ever had difficulty obtaining health insurance for your child because of his/her health history? *hltins*

- 2 No
- 1 Yes

C2. Does your child currently have health insurance coverage? *hltcov*

- 3 Non U. S. resident → Go to D1, next page.
- 2 No → Go to D1, next page.
- 1 Yes 

C3. How is this insurance provided? *insprv*
(Mark all that apply)

- Through parent's place of employment *insprv_emp*
- Through parent's policy *insprv_par*
- Through a policy you have purchased for your child *insprv_sel*
- Affordable Care Act (Obama Care) *insprv_aca*
- Medicaid or other public assistance program *insprv_pub*
- Medicare *insprv_med*
- Military dependent/Veteran's benefits (CHAMPUS) *insprv_mil*
- Other *insprv_oth* *If other, please specify.* *insspe*
text

C3a. Does this health insurance plan have any exclusions or restrictions because of your child's health history? *insexc*

- 3 Don't know
- 2 No
- 1 Yes

If yes, please specify.

insexcsp text

C3b. Is there an extra premium charge on your health insurance policy because of your child's health history? *insext*

- 3 Don't know
- 2 No
- 1 Yes

Continue on next page.

LIVING ARRANGEMENT

D1. What is your child's current living arrangement? **curliv**
(Mark all that apply)

- Lives with parent(s) **curliv_par**
- Lives with spouse/partner **curliv_spo**
- Lives with roommate(s) **curliv_rm**
- Lives with brother(s) and/or sister(s) **curliv_sib**
- Lives with other relative(s) (not including minor children) **curliv_rel**
- Lives alone **curliv_aln**
- Other **curliv_oth**

Specify.

msspec

text

D3. During the past year, how many people in this primary household were supported on this income? **incsupn**

- 1 1
- 2 2
- 3 3
- 4 4
- 5 5
- 6 6
- 7 7
- 8 8
- 9 9 or more

Continue on next page.

INCOME

D2. Over the last year, what was the total income of the primary household your child lived in? **homeinc**

- 1 Less than \$20,000
- 2 \$20,000 - \$39,999
- 3 \$40,000 - \$59,999
- 4 \$60,000 - \$79,999
- 5 \$80,000 - \$99,999
- 6 Over \$100,000
- 9 Don't know

Please! Do not mark below this line

PHYSICAL FUNCTIONING

E1. Would you rate your child as being: **disable**

- 1 Completely disabled
- 2 Severely disabled
- 3 Moderately disabled
- 4 Mildly disabled
- 5 Not at all disabled

E2. In general, would you say your child's health is:

- 1 Excellent **health**
- 2 Very good
- 3 Good
- 4 Fair
- 5 Poor

E3. Compared to one year ago, how would you rate your child's health in general now? **hlthcomp**

- 1 Much better now than one year ago
- 2 Somewhat better now than one year ago
- 3 About the same as one year ago
- 4 Somewhat worse now than one year ago
- 5 Much worse now than one year ago

E4. Please respond to each item by marking one box per row.

	0	1	2	3	4
	Not able to do	With a lot of trouble	With some trouble	With a little trouble	With no trouble
In the <u>past 7 days</u>. . . .					
a. My child could do sports and exercise that other kids his/her age could do trbsport	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. My child could get up from the floor. trbgetup	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. My child could keep up when he/she played with other kids trbkeepup	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. My child could move his/her legs trbmvlge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. My child could stand up without help trbstand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. My child could stand up on his/her tiptoes trbtiptoe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. My child could walk up stairs without holding on to anything trbstair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. My child has been physically able to do the activities he/she enjoys most trbactv	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Continue on next page.

Please! Do not mark below this line

SOCIAL FUNCTIONING

F1. About how many close friends does your child have?

- 0 0 **→ Go to Question F3.** friendsn
- 1 1
- 2 2 or 3
- 3 4 or more

F2. About how many times a week does your child do things with close friends? friendswk

- 0 Less than 1
- 1 1 or 2
- 2 3 or more

F3. Compared to other children of his/her age, how well does your child ...

- | | | | |
|---|--------|--------------------------|--------------------------|
| | | 3 Better | |
| | | 2 About Same | |
| | | 1 Worse | |
| a. Get along with his/her brothers and sisters? | sfsibs | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Get along with other children? | sfkids | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Behave with his/her parents? | sfprnt | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Play and work by himself/herself? | sfself | <input type="checkbox"/> | <input type="checkbox"/> |

F4. How well do the following statements describe your child's behavior?

- | | | | |
|--|------------|--------------------------|--------------------------|
| | | 3 Not True | |
| | | 2 Sometimes True | |
| | | 1 Often True | |
| a. Has sudden changes in mood or feelings | moody | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Feels or complains that no one loves him/her | unloved | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Is rather high strung, tense, or nervous | highstrung | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Cheats or tells lies | lies | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Is too fearful or anxious | fearful | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Argues too much | argues | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Has difficulty concentrating, cannot pay attention for long | attention | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Is easily confused, seems to be in a fog | fog | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Bullies, or is cruel or mean to others | cruel | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Is disobedient at home | disobhm | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Is disobedient at school | disobsch | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Does not seem to feel sorry after he/she misbehaves | remorse | <input type="checkbox"/> | <input type="checkbox"/> |

F4. (Cont.) How well do the following statements describe your child's behavior?

- | | | | |
|--|----------|--------------------------|--------------------------|
| | | 3 Not True | |
| | | 2 Sometimes True | |
| | | 1 Often True | |
| m. Has trouble getting along with other children | peers | <input type="checkbox"/> | <input type="checkbox"/> |
| n. Has trouble getting along with teachers | teachers | <input type="checkbox"/> | <input type="checkbox"/> |
| o. Is impulsive, or acts without thinking. | impulse | <input type="checkbox"/> | <input type="checkbox"/> |
| p. Feels worthless or inferior | inferior | <input type="checkbox"/> | <input type="checkbox"/> |
| q. Is not liked by other children | disliked | <input type="checkbox"/> | <input type="checkbox"/> |
| r. Has a lot of difficulty getting his/her mind off certain thoughts, has obsessions | obsess | <input type="checkbox"/> | <input type="checkbox"/> |
| s. Is restless or overly active, cannot sit still | active | <input type="checkbox"/> | <input type="checkbox"/> |
| t. Is stubborn, sullen, or irritable | stubborn | <input type="checkbox"/> | <input type="checkbox"/> |
| u. Has a very strong temper and loses it easily | temper | <input type="checkbox"/> | <input type="checkbox"/> |
| v. Is unhappy, sad or depressed | unhappy | <input type="checkbox"/> | <input type="checkbox"/> |
| w. Is withdrawn, does not get involved with others | alone | <input type="checkbox"/> | <input type="checkbox"/> |

If child is 12 years of age or older → Go to Question F6.

Please! Do not mark below this line

F5. FOR CHILDREN UNDER 12 YEARS OF AGE

- | | | | | | |
|----|--|--------------------|--------------------------|--------------------------|--------------------------|
| | | 3 Not True | | | |
| | | 2 Sometimes True | | | |
| | | 1 Often True | | | |
| a. | Breaks things on purpose, deliberately destroys his/her own things | destructive | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. | Clings to adults | clingy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. | Cries too much | cries | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. | Demands a lot of attention | demanding | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. | Is too dependent on others | dependent | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

If child is under 12 years of age → Go to Question F7.

F6. FOR CHILDREN 12 YEARS OF AGE OR OLDER

- | | | | | | |
|----|---|-------------------|--------------------------|--------------------------|--------------------------|
| | | 3 Not True | | | |
| | | 2 Sometimes True | | | |
| | | 1 Often True | | | |
| a. | Feels others are out to get him/her | paranoid | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. | Hangs around with kids who get into trouble. | influenced | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. | Is secretive, keeps things to himself/herself | secretive | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. | Worries too much | worrier | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

F7. Please respond to each item by marking one box per row.

In the past 7 days . . .

- | | | | | | | | |
|----|--|-------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| | | 4 Almost Always | | | | | |
| | | 3 Often | | | | | |
| | | 2 Sometimes | | | | | |
| | | 1 Almost Never | | | | | |
| | | 0 Never | | | | | |
| a. | My child felt accepted by other kids his/her age | peeracct | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. | My child was able to count on his/her friends | peerct | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. | My child was good at making friends. | peermkfrnd | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. | My child and his/her friends helped each other out | peerhlp | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. | Other kids wanted to be my child's friend | peerfrndme | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. | Other kids wanted to be with my child | peerwme | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g. | Other kids wanted to talk to my child. | peertlkme | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Continue on next page.

SLEEP

G1 to G8 relate to the past 7 days.

		Very much				
		Quite a bit				
		Somewhat				
		A little bit				
		Not at all				
G1. His/her sleep was restless	<i>slprstl</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		1	2	3	4	5
G2. He/she was satisfied with his/her sleep	<i>slpsat</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		5	4	3	2	1
G3. His/her sleep was refreshing	<i>slpref</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		5	4	3	2	1
G4. He/she had difficulty falling asleep	<i>slpdif</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		1	2	3	4	5

		Always				
		Often				
		Sometimes				
		Rarely				
		Never				
G5. He/she had trouble staying asleep	<i>slpstay</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		1	2	3	4	5
G6. He/she had trouble sleeping	<i>slptrb</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		1	2	3	4	5
G7. He/she got enough sleep	<i>slpengh</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		5	4	3	2	1

		Very good				
		Good				
		Fair				
		Poor				
		Very poor				
G8. His/her sleep quality was	<i>slpqual</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		5	4	3	2	1

Continue on next page.

Please! Do not mark below this line

PAIN

H1. Does your child currently have pain as a result of his/her cancer or similar illness, or its treatment? **capain**

- 1 No pain
- 2 Small amount of pain
- 3 Medium amount of pain
- 4 A lot of pain
- 5 Very bad, excruciating pain

H2. For pain that your child has had during the past 4 weeks, where has this pain been located? **painloct**
(Mark all that apply)

- My child did not have pain in the past 4 weeks. **painloct_none**
- Head **painloct_head**
- Neck **painloct_neck**
- Chest **painloct_chst**
- Hands/Arms **painloct_arm**
- Abdomen **painloct_abd**
- Back **painloct_back**
- Pelvis **painloct_pel**
- Legs/Feet **painloct_leg**
- Other **painloct_oth**

If other, please specify.
painspe1-5
coded

H3. How much bodily pain has your child had during the past 4 weeks? **painmuch**

- 1 None
- 2 Very mild
- 3 Mild
- 4 Moderate
- 5 Severe
- 6 Very severe

H4. Please respond to each item by marking one box per row.

In the past 7 days. . . .

	0 Never	1 Almost Never	2 Sometimes	3 Often	4 Almost Always
a. My child had trouble sleeping when he/she had pain painslp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. My child felt angry when he/she had pain painang	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. My child had trouble doing painwk schoolwork when he/she had pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. It was hard for my child to pay attention when he/she had pain painatn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. It was hard for my child to run when he/she had pain painrun	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. It was hard for my child to walk one block when he/she had pain painwlk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. It was hard for my child to have fun when he/she had pain painfun	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. It was hard for my child to stay standing when he/she had pain painstnd	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Continue on next page.

Please! Do not mark below this line

WORRY/CONCERNS

11. Does your child currently have anxieties/fears as a result of his/her cancer or similar illness, or its treatment? **caanx**

- 1 No anxiety/fears
- 2 Small amount of anxiety/fears
- 3 Medium amount of anxiety/fears
- 4 A lot of anxiety/fears
- 5 Very many, extreme anxiety/fears

MOOD

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

In the past 7 days. . . .

	0 Never	1 Almost Never	2 Sometimes	3 Often	4 Almost Always
a. My child could not stop feeling sad mdfsad	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. My child felt everything in his/her life went wrong mdwrng	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. My child felt like he/she couldn't do anything right mdrght	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. My child felt lonely mdlonly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. My child felt sad mdsad	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. My child thought that his/her life was bad mdbad	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

In the past 7 days. . . .

	0 Never	1 Almost Never	2 Sometimes	3 Often	4 Almost Always
13. My child felt nervous anxnrv	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. My child felt scared anxscrd	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. My child felt worried anxwor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. My child felt like something awful might happen anxbad	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. My child thought about scary things anxscary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. My child was afraid that he/she would make mistakes anxmis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. My child worried about what could happen to him/her anxhap	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
110. My child worried when he/she went to bed at night anxbed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ATTENTION/CONCENTRATION

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

	1 Never or seldom	2 Occasionally	3 Often	4 Very often
J1. It is hard for my child to pay attention to details atndetail	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J2. My child can't pay attention for long atnlength	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J3. My child loses track of what he/she is supposed to do atntrack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J4. My child gets distracted by things that are going on around him/her atndistr	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J5. My child has trouble finishing things atnfin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J6. My child has trouble concentrating atnconc	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please! Do not mark below this line

IMPACT ON FAMILY

These questions ask about the impact cancer or a similar illness has had on your family. For each item, please indicate whether or not the statement describes your family.

		0 Strongly Agree	1 Agree	2 Disagree	3 Strongly Disagree	4 Don't Know	5 Prefer Not To Answer
K1. Because of the illness, we are not able to travel out of the city	<i>fitravel</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K2. People in the neighborhood treat us special because of my child's illness	<i>fispecial</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K3. We have little desire to go out because of my child's illness	<i>fiisolated</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K4. It is hard to find a reliable person to take care of my child	<i>ficare</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K5. Sometimes, we have to change plans about going out at the last minute because of my child's condition	<i>fiflexible</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K6. We see family and friends less because of the illness.	<i>fisocial</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K7. Sometimes I wonder whether my child should be treated "special" or the same as a normal child	<i>fiwonder</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K8. I think about not having more children because of the illness.	<i>fikids</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K9. I don't have much time left over for other family members after caring for my child	<i>fitime</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K10. Our family gives up things because of my child's illness.	<i>fisacrifice</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K11. Fatigue is a problem for me because of my child's illness.	<i>fifatigue</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K12. I live from day to day and don't plan for the future	<i>fifuture</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K13. Nobody understands the burden I carry	<i>fiburden</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K14. Traveling to the hospital is a strain on me	<i>fistrain</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K15. Sometimes I feel like we live on a rollercoaster: in crisis when my child is acutely ill, OK when things are stable	<i>fistability</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please! Do not mark below this line

DAILY STRESS

These questions ask about your child's feelings and thoughts during the last month. For each item, please indicate with a mark how often your child felt or thought a certain way.

	1 Never	2 Almost Never	3 Sometimes	4 Fairly Often	5 Very Often
L1. How often did your child appear frustrated by being unable to control or do something? dscntrl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L2. How often did your child appear confident about his or her ability to handle personal problems? dsconf	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L3. How often did your child seem to feel things were going well? dswell	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L4. How often did difficulties pile up so high that your child did not seem able to overcome them? dspile	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

OTHER ISSUES

Please rate how concerned you are about the following:

	1 Very concerned	2 Somewhat concerned	3 Concerned	4 Not very concerned	5 Not at all concerned
M1. Your child's future health confhlth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
M2. Your child's ability to have children conkids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
M3. Your child developing another cancer conca	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
M4. Your ability to get health insurance for your child conhins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
M5. Your ability to get life insurance for your child conlins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
M6. Your ability to cover expenses for health care for your child conhcxp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
M7. Your ability to cover expenses for prescribed medicine for your child conrxexp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
M8. Any other issues conoth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please specify.

conspe

text

Please! Do not mark below this line

Has your child been diagnosed with any of the following medical problems?

N1. Depression **depdx** 1 Yes 2 No

If yes, did your child ever receive treatment? **deprtr**

1 Yes, in the past 2 Yes, currently 3 No

If yes, what type of treatment? (Mark all that apply) **ydeprtr**

Behavior/talk therapy/counseling **ydeprtr_talk**

Hospitalization **ydeprtr_hosp**

Medication **ydeprtr_med**

List medications:

depmed1-4 coded

N2. Anxiety **anxdx** 1 Yes 2 No

If yes, did your child ever receive treatment? **anxtrtr**

1 Yes, in the past 2 Yes, currently 3 No

If yes, what type of treatment? (Mark all that apply) **yanxtrtr**

Behavior/talk therapy/counseling **yanxtrtr_talk**

Hospitalization **yanxtrtr_hosp**

Medication **yanxtrtr_med**

List medications:

anxmed1-4 coded

N3. Attention Deficit Disorder (with or without hyperactivity) 1 Yes 2 No **adddx**

If yes, did your child ever receive treatment? **addtrtr**

1 Yes, in the past 2 Yes, currently 3 No

If yes, what type of treatment? (Mark all that apply) **yaddtrtr**

Behavior/talk therapy/counseling **yaddtrtr_talk**

Hospitalization **yaddtrtr_hosp**

Medication **yaddtrtr_med**

List medications:

addmed1-4 coded

N4. Bipolar Disorder **biplrdx** 1 Yes 2 No

If yes, did your child ever receive treatment? **biplrtrtr**

1 Yes, in the past 2 Yes, currently 3 No

If yes, what type of treatment? (Mark all that apply) **ybiplrtrtr**

Behavior/talk therapy/counseling **ybiplrtrtr_talk**

Hospitalization **ybiplrtrtr_hosp**

Medication **ybiplrtrtr_med**

List medications:

biplrmed1-4 coded

N5. Oppositional Defiant/Conduct Disorder **odddx** 1 Yes 2 No

If yes, did your child ever receive treatment? **oddrtr**

1 Yes, in the past 2 Yes, currently 3 No

If yes, what type of treatment? (Mark all that apply) **yoddrtr**

Behavior/talk therapy/counseling **yoddrtr_talk**

Hospitalization **yoddrtr_hosp**

Medication **yoddrtr_med**

List medications:

oddrmed1-4 coded

N6. Other psychiatric disorder (e.g. obsessive-compulsive disorder) 1 Yes 2 No **opsydx**

If yes, please specify the disorder:

psydxsp coded

If yes, did you ever receive treatment? **opsytrtr**

1 Yes, in the past 2 Yes, currently 3 No

If yes, what type of treatment? (Mark all that apply) **yopsytrtr**

Behavior/talk therapy/counseling **yopsytrtr_talk**

Hospitalization **yopsytrtr_hosp**

Medication **yopsytrtr_med**

List medications:

opsymed1-4 coded

Do any of these medical conditions prevent your child from attending work, school or engaging in extracurricular activities on a regular basis (more days than not)? **psyint**

1 Yes 2 No

If yes, which condition(s):

psyintsp1-4 coded

Please! Do not mark below this line