

Finding cures. Saving children.



SJLIFE

Behavior Survey
5-10 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

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

Please! Do not mark below this line

SCHOOL HISTORY

A1. Is your child currently in school?

Yes *If yes, what grade is he/she in?*

--	--

No *If no, please explain.*

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

- 1 - 8 years (grade school)
- 9 - 12 years (high school), but did not graduate
- Completed high school/GED
- Training after high school, other than college
- Some college
- College graduate
- Post-graduate level
- Not Applicable
- Unknown
- Other *Specify.*

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

- 1 - 8 years (grade school)
- 9 - 12 years (high school), but did not graduate
- Completed high school/GED
- Training after high school, other than college
- Some college
- College graduate
- Post-graduate level
- Not Applicable
- Unknown
- Other *Specify.*

Continue on next page.

A4. In school was your child ever in any of the following programs?

(Mark all that apply)

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

If no, skip to A6.

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

	No	Yes	Not sure
a. Missed school.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Low scores on tests.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Problems learning or concentrating.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. In Reading?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ii. In Math?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iii. In Writing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Emotional or behavioral problems	<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)*

- Pre-K
- K
- 1st
- 2nd
- 3rd
- 4th
- 5th
- 6th

A6. Has your child ever . . .

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

A7. Is your child currently receiving . . .

	No	Yes	Not sure
a. Physical therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Occupational therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Speech therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Counseling?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Services via 504 plan?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Services via IEP?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Services for sensory impairment (vision/hearing)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

- No → **Go to Question B1 on next page.**
- Not sure
- Yes ↴

A8a. Where did he/she get tested?

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


INSURANCE

Health Insurance

B1. Have you ever had difficulty obtaining health insurance for your child because of his/her health history?

- No
- Yes

B2. Does your child currently have health insurance coverage?

- Non U. S. resident **→ Go to C1.**
- No **→ Go to C1.**
- Yes 

B3. 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.***

B3a. Does this health insurance plan have any exclusions or restrictions because of your child's health history?

- Don't know
- No
- Yes ***If yes, please specify.***

B3b. Is there an extra premium charge on your health insurance policy because of your child's health history?

- Don't know
- No
- Yes

LIVING ARRANGEMENT

C1. 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.

INCOME

C2. Over the last year, what was the total income of the household your child lived in?

- Less than \$20,000
- \$20,000 - \$39,999
- \$40,000 - \$59,999
- \$60,000 - \$79,999
- \$80,000 - \$99,999
- Over \$100,000
- Don't know

C3. During the past year, how many people in this household were supported on this income?

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

Please! Do not mark below this line

PHYSICAL FUNCTIONING

D1. Would you rate your child as being:

- Completely disabled
- Severely disabled
- Moderately disabled
- Mildly disabled
- Not at all disabled

D2. In general, would you say your child's health is:

- Excellent
- Very good
- Good
- Fair
- Poor

D3. Compared to one year ago, how would you rate your child's health in general now?

- Much better now than one year ago
- Somewhat better now than one year ago
- About the same as one year ago
- Somewhat worse now than one year ago
- Much worse now than one year ago

D4. Please respond to each item by marking one box per row.

	With no trouble	With a little trouble	With some trouble	With a lot of trouble	Not able to do
In the <u>past 7 days</u> . . .					
a. My child could do sports and exercise that other kids his/her age could do	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. My child could get up from the floor.	<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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. My child could move his/her legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. My child could stand up without help	<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	<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	<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	<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

E1. About how many close friends does your child have?

- 0 → Go to Question E3.
- 1
- 2 or 3
- 4 or more

E2. About how many times a week does your child do things with close friends?

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

E3. Compared to other children of his/her age, how well does your child ...

	Better	About Same	Worse
a. Get along with his/her brothers and sisters?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Get along with other children?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Behave with his/her parents?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Play and work by himself/herself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

E4. How well do the following statements describe your child's behavior?

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

E4. (Cont.) How well do the following statements describe your child's behavior?

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

Continue on next page.

E5. 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	<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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. My child was good at making friends.	<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	<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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Other kids wanted to be with my child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Other kids wanted to talk to my child.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F2. He/she was satisfied with his/her sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F3. His/her sleep was refreshing.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F4. He/she had difficulty falling asleep.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Never	Rarely	Sometimes	Often	Always
F5. He/she had trouble staying asleep .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F6. He/she had trouble sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F7. He/she got enough sleep.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Very poor	Poor	Fair	Good	Very good
F8. His/her sleep quality was	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please! Do not mark below this line

PAIN

G1. Does your child currently have pain as a result of his/her cancer or similar illness, or its treatment?

- No pain
- Small amount of pain
- Medium amount of pain
- A lot of pain
- Very bad, excruciating pain

G2. For pain that your child has had during the past 4 weeks, where has this pain been located? (Mark all that apply)

- My child did not have pain in the past 4 weeks.
- Head
- Neck
- Chest
- Hands/Arms
- Abdomen
- Back
- Pelvis
- Legs/Feet
- Other

If other, please specify.

G3. How much bodily pain has your child had during the past 4 weeks?

- None
- Very mild
- Mild
- Moderate
- Severe
- Very severe

G4. 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	<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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. My child had trouble doing 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	<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	<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	<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	<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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Continue on next page.

WORRY/CONCERNS

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

- No anxiety/fears
- Small amount of anxiety/fears
- Medium amount of anxiety/fears
- A lot of anxiety/fears
- Very many, extreme anxiety/fears

MOOD

H2. Please respond to each item by marking one box per row.

	Never	Almost Never	Sometimes	Often	Almost Always
a. My child could not stop feeling sad	<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	<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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. My child felt lonely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. My child felt sad	<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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

In the past 7 days. . . .

- 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

H3. In the past 12 months, has your child ever made statements about wanting to hurt or kill him or herself?

- No
- Yes

H4. In the past 12 months, has your child ever done anything to try to hurt or kill him or herself?

- No
- Yes

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

In the past 7 days. . . .

	Never	Almost Never	Sometimes	Often	Almost Always
H5. My child felt nervous	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H6. My child felt scared	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H7. My child felt worried	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H8. My child felt like something awful might happen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H9. My child thought about scary things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H10. My child was afraid that he/she would make mistakes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H11. My child worried about what could happen to him/her	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H12. My child worried when he/she went to bed at night	<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.

	Never or seldom	Occasionally	Often	Very often
I1. It is hard for my child to pay attention to details	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I2. My child can't pay attention for long	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I3. My child loses track of what he/she is supposed to do	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I4. My child gets distracted by things that are going on around him/her	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I5. My child has trouble finishing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I6. My child has trouble concentrating	<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.

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Prefer Not to Answer
J1. Because of the illness, we are not able to travel out of the city	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J2. People in the neighborhood treat us special because of my child's illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J3. We have little desire to go out because of my child's illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J4. It is hard to find a reliable person to take care of my child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J5. Sometimes, we have to change plans about going out at the last minute because of my child's condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J6. We see family and friends less because of the illness.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J7. Sometimes I wonder whether my child should be treated "special" or the same as a normal child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J8. I think about not having more children because of the illness.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J9. I don't have much time left over for other family members after caring for my child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J10. Our family gives up things because of my child's illness.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J11. Fatigue is a problem for me because of my child's illness.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J12. I live from day to day and don't plan for the future	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J13. Nobody understands the burden I carry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J14. Traveling to the hospital is a strain on me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J15. Sometimes I feel like we live on a rollercoaster: in crisis when my child is acutely ill, OK when things are stable	<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.

	Never	Almost Never	Sometimes	Fairly Often	Very Often
K1. How often did your child appear frustrated by being unable to control or do something	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K2. How often did your child appear confident about his or her ability to handle personal problems.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K3. How often did your child seem to feel things were going well	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K4. How often did difficulties pile up so high that your child did not seem able to overcome them	<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:

	Very concerned	Somewhat concerned	Concerned	Not very concerned	Not at all concerned
L1. Your child's future health . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L2. Your child's ability to have children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L3. Your child developing another cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L4. Your ability to get health insurance for your child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L5. Your ability to get life insurance for your child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L6. Your ability to cover expenses for health care for your child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L7. Your ability to cover expenses for prescribed medicine for your child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L8. Any other issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please specify.

Please! Do not mark below this line

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

M1. Depression

Yes No

If yes, did your child ever receive treatment?

Yes, in the past Yes, currently No

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

- Behavior/talk therapy/counseling
- Hospitalization
- Medication

List medications:

M2. Anxiety

Yes No

If yes, did your child ever receive treatment?

Yes, in the past Yes, currently No

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

- Behavior/talk therapy/counseling
- Hospitalization
- Medication

List medications:

**M3. Attention Deficit Disorder
(with or without hyperactivity)**

Yes No

If yes, did your child ever receive treatment?

Yes, in the past Yes, currently No

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

- Behavior/talk therapy/counseling
- Hospitalization
- Medication

List medications:

M4. Bipolar Disorder

Yes No

If yes, did your child ever receive treatment?

Yes, in the past Yes, currently No

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

- Behavior/talk therapy/counseling
- Hospitalization
- Medication

List medications:

M5. Oppositional Defiant/Conduct Disorder

Yes No

If yes, did your child ever receive treatment?

Yes, in the past Yes, currently No

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

- Behavior/talk therapy/counseling
- Hospitalization
- Medication

List medications:

M6. Other psychiatric disorder (e.g. obsessive-compulsive disorder)

Yes No

If yes, please specify the disorder:

If yes, did you ever receive treatment?

Yes, in the past Yes, currently No

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

- Behavior/talk therapy/counseling
- Hospitalization
- Medication

List medications:

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

Yes No

If yes, which condition(s):

Please! Do not mark below this line