

Finding cures. Saving children.



# SJLIFE

## Behavior Survey 11-17 Years of Age Parent Report

Control

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

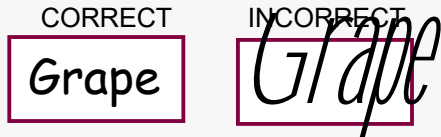
**e-mail:**  
SJLIFE@stjude.org

Please! Do not mark below this line

## 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:



### 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			
	Yes	No	No	If yes, age at first use
	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

#### Example 2

2. Has your child ever taken. . .

- a. PILL(S) 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*

#### Example 3

3. When was this condition diagnosed?

04

Month (mm)

2000

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?**

- 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
- Other

*If Other, please describe.*

**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.*

Please! Do not mark below this line

**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 . . .**

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
- 7th
- 8th
- 9th
- 10th
- 11th
- 12th

**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"/>

**Continue on next page.**

**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.
- 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

## EMPLOYMENT

**B1. Has your child ever had a job?**

- No → Go to Question C1, next page.
- Yes ↵

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

- Not currently working → Go to Question C1.
- Working full-time (30 or more hours per week)
- Working part-time (less than 30 hours per week)
- Caring for home or family (not seeking paid work)
- Unemployed and looking for work
- Unable to work due to illness or disability
- Student
- Other

*If Other, please describe.*

**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:

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

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?**

- No **→ Go to C2.**  
 Yes

**C1a. What previous health history made it difficult?**

*If yes, specify.*

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

- Non U. S. resident **→ Go to D1, next page.**  
 No **→ Go to D1, next page.**  
 Yes ↓

**C3. 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.***

**C3a. 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.***

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

- Don't know  
 No  
 Yes

***Continue on next page.***

## LIVING ARRANGEMENT

D1. What is your child's current living arrangement?

*(Mark all that apply)*

- Lives with parent(s)
- Lives with spouse/partner
- Lives with roommate(s)
- Lives with brother(s) and/or sister(s)
- Lives with other relative(s) (not including minor children)
- Lives alone
- Other

*Specify.*

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

- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 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?

- 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

# PHYSICAL FUNCTIONING

## E1. Would you rate your child as being:

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

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

- Excellent
- Very good
- Good
- Fair
- Poor

## E3. 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

## E4. 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
<b>In the <u>past 7 days</u>. . . .</b>					
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.**



# SOCIAL FUNCTIONING

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

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

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

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

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

- |   |                          | Worse                    | About Same               | Better                   |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| a. Get along with his/her brothers and sisters? ..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Get along with other children? .....               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Behave with his/her parents? .....                 | <input type="checkbox"/> | <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"/> | <input type="checkbox"/> |

## F4. 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"/> | <input type="checkbox"/> |
| b. Feels or complains that no one loves him/her .....                | <input type="checkbox"/> | <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"/> | <input type="checkbox"/> |
| d. Cheats or tells lies .....  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Is too fearful or anxious .....                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Argues too much .....   | <input type="checkbox"/> | <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"/> | <input type="checkbox"/> |
| h. Is easily confused, seems to be in a fog ...                      | <input type="checkbox"/> | <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"/> | <input type="checkbox"/> |
| j. Is disobedient at home .....                                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Is disobedient at school .....                                    | <input type="checkbox"/> | <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"/> | <input type="checkbox"/> |

## F4. (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"/> | <input type="checkbox"/> |
| n. Has trouble getting along with teachers .....   | <input type="checkbox"/> | <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"/> | <input type="checkbox"/> |
| p. Feels worthless or inferior .....   | <input type="checkbox"/> | <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"/> | <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"/> | <input type="checkbox"/> |
| s. Is restless or overly active, cannot sit still ...                                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| t. Is stubborn, sullen, or irritable .....   | <input type="checkbox"/> | <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"/> | <input type="checkbox"/> |
| v. Is unhappy, sad or depressed .....  | <input type="checkbox"/> | <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"/> | <input type="checkbox"/> |

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

**F5. FOR CHILDREN UNDER 12 YEARS OF AGE**

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

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

- |   | 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"/> |

**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 . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G2. He/she was satisfied with his/her sleep . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G3. His/her sleep was refreshing. . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G4. He/she had difficulty falling asleep.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Always				
	Often				
	Sometimes				
	Rarely				
	Never				
G5. He/she had trouble staying asleep . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G6. He/she had trouble sleeping . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G7. He/she got enough sleep. . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Very good				
	Good				
	Fair				
	Poor				
	Very poor				
G8. His/her sleep quality was . . . . .	<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

# PAIN

H1. 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.*

H2. How much bodily pain has your child had during the past 4 weeks?

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

H3. 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.*

## MOOD

11. 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 . . .	<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"/>

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

- No
- Yes

13. 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
14. My child felt nervous . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. My child felt scared . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. My child felt worried . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. My child felt like something awful might happen . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. My child thought about scary things . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. 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"/>
110. 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"/>
111. 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
J1. It is hard for my child to pay attention to details . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J2. My child can't pay attention for long . .	<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 . . . . .	<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 . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J5. My child has trouble finishing things . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J6. My child has trouble concentrating . . .	<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 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 work, 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

**We are always interested in your input in the St. Jude Life study.  
Use this space for any additional comments you may have:**

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Please! Do not mark below this line