

ID#

Date:

# PedsQL™

## Pediatric Quality of Life Inventory

Version 4.0

### YOUNG CHILD REPORT (ages 5-7)

Instructions for interviewer:

**I am going to ask you some questions about things that might be a problem for some children. I want to know how much of a problem any of these things might be for you.**

Show the child the template and point to the responses as you read.

***If it is not at all a problem for you, point to the smiling face***

***If it is sometimes a problem for you, point to the middle face***

***If it is a problem for you a lot, point to the frowning face***

***I will read each question. Point to the pictures to show me how much of a problem it is for you.***

***Let's try a practice one first.***

|                                         | Not at all                                                                          | Sometimes                                                                             | A lot                                                                                 |
|-----------------------------------------|-------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|
| Is it hard for you to snap your fingers |  |  |  |

Ask the child to demonstrate snapping his or her fingers to determine whether or not the question was answered correctly. Repeat the question if the child demonstrates a response that is different from his or her action.

**Think about how you have been doing for the last few weeks. Please listen carefully to each sentence and tell me how much of a problem this is for you.**

After reading the item, gesture to the template. If the child hesitates or does not seem to understand how to answer, read the response options while pointing at the faces.

| <b>PHYSICAL FUNCTIONING (problems with...)</b>              | <b>Not at all</b> | <b>Some-times</b> | <b>A lot</b> |
|-------------------------------------------------------------|-------------------|-------------------|--------------|
| 1. Is it hard for you to walk                               | 0                 | 2                 | 4            |
| 2. Is it hard for you to run                                | 0                 | 2                 | 4            |
| 3. Is it hard for you to play sports or exercise            | 0                 | 2                 | 4            |
| 4. Is it hard for you to pick up big things                 | 0                 | 2                 | 4            |
| 5. Is it hard for you to take a bath or shower              | 0                 | 2                 | 4            |
| 6. Is it hard for you to do chores (like pick up your toys) | 0                 | 2                 | 4            |
| 7. Do you have hurts or aches ( <b>Where?</b> _____)        | 0                 | 2                 | 4            |
| 8. Do you ever feel too tired to play                       | 0                 | 2                 | 4            |

**Remember, tell me how much of a problem this has been for you for the last few weeks.**

| <b>EMOTIONAL FUNCTIONING (problems with...)</b> | <b>Not at all</b> | <b>Some-times</b> | <b>A lot</b> |
|-------------------------------------------------|-------------------|-------------------|--------------|
| 1. Do you feel scared                           | 0                 | 2                 | 4            |
| 2. Do you feel sad                              | 0                 | 2                 | 4            |
| 3. Do you feel mad                              | 0                 | 2                 | 4            |
| 4. Do you have trouble sleeping                 | 0                 | 2                 | 4            |
| 5. Do you worry about what will happen to you   | 0                 | 2                 | 4            |

| <b>SOCIAL FUNCTIONING (problems with...)</b>                   | <b>Not at all</b> | <b>Some-times</b> | <b>A lot</b> |
|----------------------------------------------------------------|-------------------|-------------------|--------------|
| 1. Is it hard for you to get along with other kids             | 0                 | 2                 | 4            |
| 2. Do other kids say they do not want to play with you         | 0                 | 2                 | 4            |
| 3. Do other kids tease you                                     | 0                 | 2                 | 4            |
| 4. Can other kids do things that you cannot do                 | 0                 | 2                 | 4            |
| 5. Is it hard for you to keep up when you play with other kids | 0                 | 2                 | 4            |

| <b>SCHOOL FUNCTIONING (problems with...)</b>                             | <b>Not at all</b> | <b>Some-times</b> | <b>A lot</b> |
|--------------------------------------------------------------------------|-------------------|-------------------|--------------|
| 1. Is it hard for you to pay attention in school                         | 0                 | 2                 | 4            |
| 2. Do you forget things                                                  | 0                 | 2                 | 4            |
| 3. Is it hard to keep up with schoolwork                                 | 0                 | 2                 | 4            |
| 4. Do you miss school because of not feeling good                        | 0                 | 2                 | 4            |
| 5. Do you miss school because you have to go to the doctor's or hospital | 0                 | 2                 | 4            |

# How much of a problem is this for you?

**Not at all**



**Sometimes**



**A lot**



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## Pediatric Quality of Life Inventory

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

### DIRECTIONS

On the following page is a list of things that might be a problem for **your child**. Please tell us **how much of a problem** each one has been for **your child** during the **past ONE month** by circling:

- 0** if it is **never** a problem
- 1** if it is **almost never** a problem
- 2** if it is **sometimes** a problem
- 3** if it is **often** a problem
- 4** if it is **almost always** a problem

There are no right or wrong answers.

If you do not understand a question, please ask for help.

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

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

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

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

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

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## Pediatric Quality of Life Inventory

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**PARENT REPORT for TODDLERS (ages 2-4)**

### DIRECTIONS

On the following page is a list of things that might be a problem for **your child**. Please tell us **how much of a problem** each one has been for **your child** during the **past ONE month** by circling:

- 0** if it is **never** a problem
- 1** if it is **almost never** a problem
- 2** if it is **sometimes** a problem
- 3** if it is **often** a problem
- 4** if it is **almost always** a problem

There are no right or wrong answers.

If you do not understand a question, please ask for help.

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

| <b>PHYSICAL FUNCTIONING (problems with...)</b> | <b>Never</b> | <b>Almost<br/>Never</b> | <b>Some-<br/>times</b> | <b>Often</b> | <b>Almost<br/>Always</b> |
|------------------------------------------------|--------------|-------------------------|------------------------|--------------|--------------------------|
| 1. Walking                                     | 0            | 1                       | 2                      | 3            | 4                        |
| 2. Running                                     | 0            | 1                       | 2                      | 3            | 4                        |
| 3. Participating in active play or exercise    | 0            | 1                       | 2                      | 3            | 4                        |
| 4. Lifting something heavy                     | 0            | 1                       | 2                      | 3            | 4                        |
| 5. Bathing                                     | 0            | 1                       | 2                      | 3            | 4                        |
| 6. Helping to pick up his or her toys          | 0            | 1                       | 2                      | 3            | 4                        |
| 7. Having hurts or aches                       | 0            | 1                       | 2                      | 3            | 4                        |
| 8. Low energy level                            | 0            | 1                       | 2                      | 3            | 4                        |

| <b>EMOTIONAL FUNCTIONING (problems with...)</b> | <b>Never</b> | <b>Almost<br/>Never</b> | <b>Some-<br/>times</b> | <b>Often</b> | <b>Almost<br/>Always</b> |
|-------------------------------------------------|--------------|-------------------------|------------------------|--------------|--------------------------|
| 1. Feeling afraid or scared                     | 0            | 1                       | 2                      | 3            | 4                        |
| 2. Feeling sad or blue                          | 0            | 1                       | 2                      | 3            | 4                        |
| 3. Feeling angry                                | 0            | 1                       | 2                      | 3            | 4                        |
| 4. Trouble sleeping                             | 0            | 1                       | 2                      | 3            | 4                        |
| 5. Worrying                                     | 0            | 1                       | 2                      | 3            | 4                        |

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

***\*Please complete this section if your child attend school or daycare***

| <b>SCHOOL FUNCTIONING (problems with...)</b>              | <b>Never</b> | <b>Almost<br/>Never</b> | <b>Some-<br/>times</b> | <b>Often</b> | <b>Almost<br/>Always</b> |
|-----------------------------------------------------------|--------------|-------------------------|------------------------|--------------|--------------------------|
| 1. Doing the same school activities as peers              | 0            | 1                       | 2                      | 3            | 4                        |
| 2. Missing school/daycare because of not feeling well     | 0            | 1                       | 2                      | 3            | 4                        |
| 3. Missing school/daycare to go to the doctor or hospital | 0            | 1                       | 2                      | 3            | 4                        |