

Date _____

DePaul Pediatric Health Questionnaire (Adult Version)

For all of the following questions, please provide or circle only one answer unless otherwise asked.

1. What is your child's age (in years)? _____

2. Is your child male or female?

Male..... 1

Female 2

3. Is your child of Latino or Hispanic origin?

Yes 1

No..... 2

4. To which of the following race(s) does your child belong?

Black, African-American 1

White 2

American Indian or Alaska Native 3

Asian or Pacific Islander 4

Some other race (***Please write-in below***) 5

5. What grade is your child in or what was the last grade that he/she completed? _____

6. Does your child attend school or does he/she have home-schooling/homebound instruction?

Attend School 1








OR








Home-school/Homebound Instruction (***Please write-in below***) 2








When did he/she start home-schooling/Homebound Instruction? _____

7. How many days of school does your child usually miss in one month? _____

8. Please fill out this chart (go from left to right)

Question #8... Has your child been experiencing any of the following symptoms / problems <u>within the last month</u> ? ↓	CIRCLE ONE: Y=YES...N=NO If YES, then answer the rest of the questions in the chart → If NO, then go to the next symptom on the list. ↓	Duration: When was the first time that your child had this symptom?		Frequency: How often does your child have this symptom? Please choose a number from 1-7:	Severity: How much does this symptom bother your child? Please choose a number from 1-7:
		Month or Season	Year	1Hardly ever 2 3 4.....Half of the time 5 6 7.....Always	1 (no problem)...  2.....  3.....  4 (moderate problem).....  5.....  6.....  7 (big problem).. 
1) Fatigue/ Extreme tiredness	Y N				
2) Feeling worse after doing activities that require physical or mental effort	Y N				
3) Feeling tired after he/she wakes up in the morning	Y N				
4) Need to nap daily	Y N				
5) Problems falling asleep	Y N				
6) Problems staying asleep	Y N				
7) Waking up early in the morning (like 3am)	Y N				
8) Problems remembering things	Y N				
9) Difficulty paying attention for a long period of time	Y N				
10) Difficulty finding the right word to say	Y N				
11) Difficulty understanding things	Y N				
12) Only able to focus on one thing at a time	Y N				
13) Frequently losing his/her train of thought	Y N				
14) Slowness of thought	Y N				
15) Absent-mindedness or forgetfulness	Y N				

<p>#8 continued...</p> <p>Has your child been experiencing any of the following symptoms / problems <u>within the last month?</u></p> <p style="text-align: center;">↓</p>	<p>CIRCLE ONE: Y=YES...N=NO</p> <p>If YES, then answer the rest of the questions in the chart</p> <p style="text-align: center;">→</p> <p>If NO, then go to the next symptom on the list.</p> <p style="text-align: center;">↓</p>	<p><i>Duration:</i> When was the first time that your child had this symptom?</p>		<p><i>Frequency:</i> How often does your child have this symptom? Please choose a number from 1-7:</p>	<p><i>Severity:</i> How much does this symptom bother your child? Please choose a number from 1-7:</p>
		<p>Month or Season</p>	<p>Year</p>	<p>1Hardly ever 2 3 4.....Half of the time 5 6 7.....Always</p>	<p>1 (no problem)..... 2..... 3..... 4 (moderate problem)..... 5..... 6..... 7 (big problem).....</p>
16) Recent trouble with math or numbers	Y N				
17) Feel unsteady on his/her feet, like he/she might fall	Y N				
18) Shortness of breath or trouble catching his/her breath	Y N				
19) Dizziness	Y N				
20) Irregular heart beats	Y N				
21) Losing or gaining weight	Y N				
22) Not wanting to eat	Y N				
23) Sweating hands	Y N				
24) Night sweats	Y N				
25) Feel chills or shivers	Y N				
26) Feeling hot or cold	Y N				
27) Feeling like he/she has a high temperature	Y N				
28) Feeling like he/she has a low temperature	Y N				
29) Sore throat	Y N				
30) Tender/ sore lymph nodes	Y N				
31) Fever and sweats	Y N				
32) Some smells, foods, or chemicals make your child feel sick	Y N				
33) Rash(es)	Y N				

#8 continued... Has your child been experiencing any of the following symptoms / problems <u>within the last month</u> ? ↓	CIRCLE ONE: Y=YES...N=NO If YES, then answer the rest of the questions in the chart → If NO, then go to the next symptom on the list. ↓	Duration: When was the first time that your child had this symptom?		Frequency: How often does your child have this symptom? Please choose a number from 1-7:	Severity: How much does this symptom bother your child? Please choose a number from 1-7:
		Month or Season	Year	1Hardly ever 2 3 4.....Half of the time 5 6 7.....Always	1 (no problem).....  2.....  3.....  4 (moderate problem).....  5.....  6.....  7 (big problem)..... 
34) Allergies	Y N				
35) Mood changes	Y N				
36) Anxiety	Y N				
37) Pain or aching in his/her muscles	Y N				
38) Muscle twitches	Y N				
39) Pain/stiffness/tenderness in more than one joint without swelling or redness	Y N				
40) Eye pain	Y N				
41) Vomiting	Y N				
42) Nausea	Y N				
43) Chest pain or heartburn	Y N				
44) Upset stomach	Y N				
45) Abdomen/stomach pain	Y N				
46) Ringing in Ears	Y N				
47) Headaches**	Y N				


**IF your child has headaches now, does he/she get them more often, in a different place, or do the headaches feel worse than they did in the past? (You may circle more than one answer.)

Headaches happen more often 1

Headaches feel worse/more severe 2

Headaches are in a different place/spot 3

9. Does your child have any medical illness that might be causing his/her symptoms?
 No 1
 Yes (**What medical illnesses does he/she have?**) 2
-
10. Does your child seem to catch illnesses more easily than other people his/her age?
 No..... 1
 Yes 2
11. Does it seem to take your child longer to get better after he/she is sick than other people his/her age?
 No..... 1
 Yes 2
12. How does being physically active (such as using stairs, walking, playing sports, doing chores, getting dressed) make your child feel for the rest of the day?
- ☹️☹️ Much more tired than usual 1
 ☹️ More tired than usual 2
 😐 Has no effect 3
 😊 More energetic than usual 4
 😊😊 Much more energetic than usual 5
- 13a. Does your child participate in any activities or hobbies outside of school?
 Yes..... 1
 No..... 2
- 13b. Is he/she currently able to carry out his/her activities or hobbies?
 Yes..... 1
 No..... 2
 IF NO, when and why did your child quit his/her activities: _____

14. Has your child been experiencing any problems with fatigue/ extreme tiredness for at least one month?
- No (**Stop here**)  1
 Yes (**Continue to next page**) 2
 IF YES, For about how many months? _____

15. What do you think is the cause is of your child's fatigue or tiredness?

16. Do you think that your child's fatigue is caused by ongoing activity?

Yes 1

No..... 2

17. Did your child's fatigue illness start after he/she experienced_____? (Circle one or more.)

An infectious illness 1

An accident 2

A trip or vacation 3

An immunization (shot at doctor's office)..... 4

Surgery..... 5

Severe stress (bad or unhappy event(s)) 6

Other (***Please write in below***) 7

18. How long did it take for your child's problem with fatigue or tiredness to get started?

Rapidly - within 24 hours..... 1

Over 1 week..... 2

Over 1 month 3

Over 2-6 months..... 4

Over 7-11 months..... 5

Over 1-2 years 6

Longer than 2 years 7

He/she has always experienced fatigue 8

19. When your child first became sick what were his/her worst 3 symptoms?

a. _____

b. _____

c. _____

20. Right now, what are your child's worst 3 symptoms?

a. _____

b. _____

c. _____

21. Do his/her symptoms change over time?
- No..... 1
Yes 2
22. Does your child limit or cut back his/her activity levels to avoid feeling even more tired?
- No..... 1
Yes 2
23. If your child rests, does all of his/her fatigue go away, some of it go away, or none of it go away?
- All of it goes away(**Go to Question 24a**) 1
Some of it goes away (**Go to Question 24a**)..... 2
None of it goes away (**Go to Question 25**)..... 3
- 24a. How long does your child have to rest before his/her fatigue gets better?
-
- 24b. Will your child's fatigue return if he/she stops resting and starts doing something?
- No..... 1
Yes 2
25. How would you describe the way your child's fatigue illness is changing over time?
- His/her fatigue is getting worse..... 1
He/she have good and bad periods..... 2
There is no change..... 3
His/her fatigue is getting better 4



Thank you for filling out the DePaul Pediatric Health Questionnaire (Adult Version).