

Date \_\_\_\_\_

**DePaul Pediatric Health Questionnaire (Child Version)**

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

1. How old are you? ..... \_\_\_\_\_

2. Are you male or female?

Male..... 1

Female ..... 2

3. Are you of Latino or Hispanic origin?

Yes ..... 1

No..... 2

4. To which of the following race(s) do you 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 are you in or what was the last grade that you completed? \_\_\_\_\_

6. Do you attend school or do you have home-schooling/homebound instruction?

Attend School.....1








**OR**








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








When did you start home-schooling/Homebound Instruction? \_\_\_\_\_

7. How many days of school do you usually miss in one month? \_\_\_\_\_

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

Question #8...  Have you 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 you had this symptom?		Frequency: How often do you have this symptom? <b>Please choose a number from 1-7:</b>	Severity: How much does this symptom bother you? <b>Please choose a number from 1-7:</b>
		Month or Season	Year	1 .....Hardly 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	<b>Y</b> <b>N</b>				
2) Feeling worse after doing activities that require physical or mental effort	<b>Y</b> <b>N</b>				
3) Feeling tired after you wake up in the morning	<b>Y</b> <b>N</b>				
4) Need to nap every day	<b>Y</b> <b>N</b>				
5) Problems falling asleep	<b>Y</b> <b>N</b>				
6) Problems staying asleep	<b>Y</b> <b>N</b>				
7) Waking up early in the morning (like 3am)	<b>Y</b> <b>N</b>				
8) Problems remembering things	<b>Y</b> <b>N</b>				
9) Difficulty paying attention for a long period of time	<b>Y</b> <b>N</b>				
10) Difficulty finding the right word to say	<b>Y</b> <b>N</b>				
11) Difficulty understanding things	<b>Y</b> <b>N</b>				
12) Only able to focus on one thing at a time	<b>Y</b> <b>N</b>				
13) Frequently losing your train of thought	<b>Y</b> <b>N</b>				
14) Slowness of thought	<b>Y</b> <b>N</b>				
15) Absent-mindedness or forgetfulness	<b>Y</b> <b>N</b>				

<p>#8 continued...</p> <p>Have you 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 you had this symptom?</p>		<p><i>Frequency:</i> How often do you have this symptom? <b>Please choose a number from 1-7:</b></p>	<p><i>Severity:</i> How much does this symptom bother you? <b>Please choose a number from 1-7:</b></p>
		<p>Month or Season</p>	<p>Year</p>	<p>1 .....Hardly 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	<p><b>Y</b>      <b>N</b></p>				
17) Feel unsteady on your feet, like you might fall	<p><b>Y</b>      <b>N</b></p>				
18) Shortness of breath or trouble catching your breath	<p><b>Y</b>      <b>N</b></p>				
19) Dizziness	<p><b>Y</b>      <b>N</b></p>				
20) Irregular heart beats	<p><b>Y</b>      <b>N</b></p>				
21) Losing or gaining weight	<p><b>Y</b>      <b>N</b></p>				
22) Not wanting to eat	<p><b>Y</b>      <b>N</b></p>				
23) Sweating hands	<p><b>Y</b>      <b>N</b></p>				
24) Night sweats	<p><b>Y</b>      <b>N</b></p>				
25) Feel chills or shivers	<p><b>Y</b>      <b>N</b></p>				
26) Feeling hot or cold	<p><b>Y</b>      <b>N</b></p>				
27) Feeling like you have a high temperature	<p><b>Y</b>      <b>N</b></p>				
28) Feeling that your temperature is low	<p><b>Y</b>      <b>N</b></p>				
29) Sore throat	<p><b>Y</b>      <b>N</b></p>				
30) Tender/sore lymph nodes	<p><b>Y</b>      <b>N</b></p>				
31) Fever and sweats	<p><b>Y</b>      <b>N</b></p>				
32) Some smells, foods, or chemicals make you feel sick	<p><b>Y</b>      <b>N</b></p>				
33) Rash(es)	<p><b>Y</b>      <b>N</b></p>				

#8 continued...	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 you had this symptom?		Frequency: How often do you have this symptom? <b>Please choose a number from 1-7:</b>	Severity: How much does this symptom bother you? <b>Please choose a number from 1-7:</b>
		Month or Season	Year	1 .....Hardly 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	<b>Y</b> <b>N</b>				
35) Mood changes	<b>Y</b> <b>N</b>				
36) Anxiety	<b>Y</b> <b>N</b>				
37) Pain or aching in your muscles	<b>Y</b> <b>N</b>				
38) Muscle twitches	<b>Y</b> <b>N</b>				
39) Pain/stiffness/ tenderness in more than one joint without swelling or redness	<b>Y</b> <b>N</b>				
40) Eye pain	<b>Y</b> <b>N</b>				
41) Vomiting/ throwing up	<b>Y</b> <b>N</b>				
42) Nausea/ feeling like you might throw up	<b>Y</b> <b>N</b>				
43) Chest pain or heartburn	<b>Y</b> <b>N</b>				
44) Upset stomach	<b>Y</b> <b>N</b>				
45) Abdomen/stomach pain	<b>Y</b> <b>N</b>				
46) Ringing in Ears	<b>Y</b> <b>N</b>				
47) Headaches**	<b>Y</b> <b>N</b>				

\*\*IF you have headaches now, do you 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. Do you have any medical illness that might be causing your symptoms?

No ..... 1

Yes (***What medical illnesses do you have?***) .. 2

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10. Do you seem to catch illnesses more easily than other people your age?

No..... 1


Yes ..... 2


11. Does it seem to take longer for you to get better after you are sick than other people your age?

No..... 1


Yes ..... 2

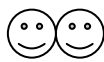
12. How does being physically active (such as using stairs, walking, playing sports, doing chores, getting dressed) make you feel for the rest of the day?

 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. Do you participate in any hobbies or activities outside of school?

Yes..... 1

No..... 2

13b. Are you currently able to carry out your activities or hobbies?

Yes..... 1

No..... 2

IF NO, when and why did you quit your hobbies/activities: \_\_\_\_\_

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14. Have you 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 the cause of your fatigue or tiredness is?

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

Yes ..... 1

No..... 2

17. Did your fatigue illness start after you 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

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18. How long did it take for your 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

I have always experienced fatigue..... 8

19. When you first became sick what were your worst 3 symptoms?

a. \_\_\_\_\_

b. \_\_\_\_\_

c. \_\_\_\_\_

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

a. \_\_\_\_\_

b. \_\_\_\_\_

c. \_\_\_\_\_

21. Do your symptoms change over time?
- No..... 1  
Yes ..... 2
22. Do you limit or cut back your activity levels to avoid feeling even more tired?
- No..... 1  
Yes ..... 2
23. If you rest, does all of your 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 do you have to rest before your fatigue gets better?
- 
- 24b. Will your fatigue come back if you stop resting and start doing something?
- No..... 1  
Yes ..... 2
25. How would you describe the way your fatigue illness is changing over time?
- My fatigue is getting worse ..... 1  
I have good and bad periods ..... 2  
There is no change..... 3  
My fatigue is getting better..... 4



Thank you for filling out the DePaul Health Questionnaire.