

Subject ID: \_\_\_\_\_

Date (MM/DD/YY): \_\_\_\_/\_\_\_\_/\_\_\_\_

## Selected Questions from the DePaul Pediatric Health Questionnaire (Child Version)

**Please fill out this chart from left to right.**

Symptoms	In this box, write the number of months you had this symptom in your <b>life</b>	Place a check in this box if you had this symptom in the <b>past 3 months</b>	<i>Frequency:</i> In the past 3 months, how often have you had this symptom?  Please <b>circle</b> a number from 1-7							<i>Severity:</i> How much has this symptom bothered you in the past 3 months?  Please <b>circle</b> a number from 1-7						
			Hardly Ever		Half of the time			Always		No		Moderate Problem			Big	
			1	2	3	4	5	6	7	1	2	3	4	5	6	7
1) Upset stomach			1	2	3	4	5	6	7	1	2	3	4	5	6	7
2) Ringing in ears			1	2	3	4	5	6	7	1	2	3	4	5	6	7
3) Problems remembering things			1	2	3	4	5	6	7	1	2	3	4	5	6	7
4) Difficulty paying attention for a long period of time			1	2	3	4	5	6	7	1	2	3	4	5	6	7
5) Difficulty finding the right word to say			1	2	3	4	5	6	7	1	2	3	4	5	6	7
6) Difficulty understanding things			1	2	3	4	5	6	7	1	2	3	4	5	6	7
7) Only able to focus on one thing at a time			1	2	3	4	5	6	7	1	2	3	4	5	6	7
8) Frequently losing your train of thought			1	2	3	4	5	6	7	1	2	3	4	5	6	7
9) Slowness of thought			1	2	3	4	5	6	7	1	2	3	4	5	6	7
10) Absent-mindedness or forgetfulness			1	2	3	4	5	6	7	1	2	3	4	5	6	7
11) Recent trouble with math or numbers			1	2	3	4	5	6	7	1	2	3	4	5	6	7
12) Feel unsteady on your feet, like you might fall			1	2	3	4	5	6	7	1	2	3	4	5	6	7
13) Shortness of breath or trouble catching your breath			1	2	3	4	5	6	7	1	2	3	4	5	6	7
14) Dizziness			1	2	3	4	5	6	7	1	2	3	4	5	6	7
15) Irregular heart beats			1	2	3	4	5	6	7	1	2	3	4	5	6	7
16) Some smells, foods, or chemicals make you feel sick			1	2	3	4	5	6	7	1	2	3	4	5	6	7
17) Mood changes			1	2	3	4	5	6	7	1	2	3	4	5	6	7
18) Anxiety			1	2	3	4	5	6	7	1	2	3	4	5	6	7

19. When you feel stress, are the following symptoms more severe?

- a). Upset Stomach (vomiting, diarrhea).....  Yes  No
- b). Sweating .....  Yes  No
- c). Headaches .....  Yes  No
- d). Anxiety/Depression/Mood.....  Yes  No

e). Please list any other symptoms that become more severe when you feel stress.

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f). Among the symptoms you have specified above, please write down the symptom **worsen most** when you feel stress.

\_\_\_\_\_ (Please only specify **one** symptom.)



**Please proceed to the next questionnaire.**