Form Approved
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Appendix 13

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 **life**	Place a check in this box if you had this symptom in the **past 3 months**	*Frequency:* In the past 3 months, how often have you had this symptom? Please **circle** a number from 1-7 (Hardly Ever 1 2 3 4 5 6 7 Always)	*Severity:* How much has this symptom bothered you in the past 3 months? Please **circle** a number from 1-7 (No Problem 1 2 3 4 5 6 7 Big Problem)
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

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

a). Upset Stomach (vomiting, diarrhea)..... ☐ 1 Yes ☐ 2 No
b). Sweating ..... ☐ 1 Yes ☐ 2 No
c). Headaches ..... ☐ 1 Yes ☐ 2 No
d). Anxiety/Depression/Mood..... ☐ 1 Yes ☐ 2 No

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

_____

_____

_____

_____

_____

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.