



Medical Record No.
Patient Name
Birthdate
Physician
Please align patient label to the right

To be completed by/for children aged 8-17 yrs

Directions: Please fill in marks like this:	Not like this:	\odot	\otimes	

Physical Function - Mobility	With No	With a little	With some	With a lot of	Not able to				
In the past 7 days	Trouble	trouble	trouble	trouble	do so				
I could do sports and exercise that other kids my age could do	0	Ο	0	0	0				
2. I could get up from the floor	0	0	0	0	0				
3. I could walk upstairs without holding on to anything	0	0	0	Ο	0				
4. I have been physically able to do the activities I enjoy most	Ο	Ο	Ο	Ο	0				
Anxiety									
In the past 7 days	Never	Almost Never	Some times	Often	Almost Always				
1. I felt like something awful might happen	0	0	0	0	0				
2. I felt nervous	Ο	0	Ο	0	0				
3. I felt worried	0	0	0	0	0				
4. I was afraid that I would make mistakes	Ο	0	Ο	Ο	Ο				
Depressive Symptoms									
In the past 7 days	Never	Almost Never	Some times	Often	Almost Always				
1. I felt everything in my life went wrong	0	0	0	Ο	0				
2. I felt lonely	0	0	0	0	0				
3. I felt sad	Ο	0	Ο	Ο	Ο				
4. I thought that my life was bad	0	0	0	0	0				





Medical Record No.
Patient Name
Birthdate
Physician
Please align patient label to the right

Fa	atigue											
In	the past 7 days			Never	Almost Never		ome mes	Often	Almost Always			
1.	Being tired made it hard to keep	o up with	my scho	oolwork			0	Ο	(0	0	0
2.	I got tired easily						0	Ο	0 0		0	0
3.	I was too tired to do sports or ex	xercise					0	Ο	(0	0	0
4.	4. I was too tired to enjoy the things I like to do						0		(0	Ο	0
Pe	eer Relationships											
	the past 7 days					١	Never			me nes	Often	Almost Always
1.	. I felt accepted by other kids my age						0	0 0)	0	Ο
2.	2. I was able to count on my friends						0	0	0		0	Ο
3.	My friends and I helped each other out						0	0 0)	0	Ο
4.	4. Other kids wanted to be my friend						Ο	0 0)	Ο	0
Pa	ain Interference											
In the past 7 days					Never		Almost Never	Some times		Often	Almost Always	
1.	I had trouble sleeping when I had pain						Ο		Ο		Ο	0
2.	2. It was hard for me to pay attention when I had pain						0 0		(0		0
3.	3. It was hard for me to run when I had pain						Ο		Ο		Ο	0
4.	. It was hard for me to walk one block when I had pain						Ο		0		Ο	0
Pa	ain Intensity											
	the past 7 days	No Pain										Worst pain you can imagine
	How bad was your pain on average?	0	1	2	3	4	5	6	7	8	9	10
Si	gnature:											
Re	elationship to patient:											
Date/Time: Interpreter (as applicable):												

Investigator Format@2008-2012 PROMIS Health Organization and PROMIS Cooperative Group