ACT/SJLIFE Questionnaire 5-17 Years of Age Parent Report

The questions in this booklet relate to:

name

Person completing this questionnaire is:

percomp text

Your relationship:

2 ☐ Parent 3 ☐ Other: percode coded

relation

Today's date: datecomp

☐☐ / ☐☐ / ☐☐☐☐

m m d d y y y y

MRN: ☐☐☐☐☐

MRN

Core: ☐☐

Core

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SEQNUM

Please! Do not mark below this line

Survey #327

5668067783

01/12/2022 10:20:55 AM

Current Health Problems (Review of Systems)

Is your child **currently having problems** with any of the conditions below:

	2 No	1 Yes
Frequent headaches. roshdache	☐	☐
Problems seeing. rossee	☐	☐
Problems hearing. roshear	☐	☐
Dizziness or unsteadiness. rosdizzy	☐	☐
Problems walking. roswalk	☐	☐
Frequently tired. rostired	☐	☐
Changes in appetite or eating habits. roseat	☐	☐
Sensitivity to heat or cold. rostemp	☐	☐
Chest pain. roschstpn	☐	☐
Rapid or irregular heartbeat. roshrtbt	☐	☐
Frequent or severe belly pain. rosblypn	☐	☐
Frequent constipation. rosconst	☐	☐
Frequent diarrhea. rosdiarh	☐	☐
Frequent need to urinate. rosurine	☐	☐
Burning or pain with urination rosurpn	☐	☐
Back pain. rosbkpn	☐	☐
Any other chronic pain. rosotpn	☐	☐
Problems with menstrual periods. rosmens	☐	☐
Heavy periods with excessive bleeding. roshvyper	☐	☐
Irregular or frequently missed periods. rosmisper	☐	☐
Severe cramping. roscramp	☐	☐
Problems with sexual functioning. rossexf	☐	☐
Problems with memory, thinking, forgetting which affect school or work performance. rosmem	☐	☐
Problems controlling temper or anger. rostemper	☐	☐
Difficulty getting along with others. rossocial	☐	☐
Increased worries or upsetting thoughts. rosworry	☐	☐
Problems with anxiety/panic attacks. rosanx	☐	☐
Frequently feeling sad, blue or depressed. rosdep	☐	☐
Problems sleeping or frequent use of sleep medicines. rosleep	☐	☐
Increased use of tobacco, alcohol or other drugs. rosalch	☐	☐
Use of over the counter weight loss medicine. rosweight	☐	☐

1. In the past 12 months, has your child ever made statements about wanting to hurt or kill him or herself?

2 ☐ No
1 ☐ Yes

shstate

2. In the past 12 months, has your child ever done anything to try to hurt or kill him or herself?

2 ☐ No
1 ☐ Yes

shtry

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Medical Information

Please provide the name, address, and telephone number of the patient's physician and specialty physician.

Primary Care Physician:

Doctor's name PCPName text
Street PCPStreet text
City, State, Zip PCPCity text PCPState text PCPZip text
Phone PCPPhone text

Specialty Physician (Example: Endocrinologist):

Doctor's name Specialist1Name text
Street Specialist1Street text
City, State, Zip Specialist1City text Specialist1State text Specialist1Zip text
Phone Specialist1Phone text
Specialty Specialist1Specialty text

Specialty Physician (Example: Endocrinologist):

Doctor's name Specialist2Name text
Street Specialist2Street text
City, State, Zip Specialist2City text Specialist2State text Specialist2Zip text
Phone Specialist2Phone text
Specialty Specialist2Specialty text

Specialty Physician (Example: Endocrinologist):

Doctor's name Specialist3Name- Specialist7Name text
Street Specialist3Street- Specialist7Street text
City, State, Zip Specialist3City- Specialist7City text Specialist3State- Specialist7State Specialist3Zip- Specialist7Zip
Phone Specialist3Phone- Specialist7Phone text
Specialty Specialist3Specialty- Specialist7Specialty text

Interval History

Medical Check-Ups:

A1. Has your child seen a doctor since the last St. Jude visit? DrVisit

2 ☐ No → *Go to Question A3.*

1 ☐ Yes

A2. Reason for doctor visit: VisitReason

☐ Routine check-up; sports or school physical VisitReasonCheckUp

☐ Illness; indicate approximate date and condition treated VisitReasonIllness

Date Visit1Date text
Doctor's name Visit1DrName text
Medical problem Visit1Problem text

Date Visit2Date text
Doctor's name Visit2DrName text
Medical problem Visit2Problem text

Visit3Date-Visit6Date, Visit3DrName-Visit6DrName, Visit3Problem- Visit6Problem

A3. Has your child seen a dentist since the last St. Jude visit? Dentist

2 ☐ No → *Go to Question A5, next page.*

1 ☐ Yes

A4. Reason for dental visit: DentistReason

☐ Routine check-up DentistReasonCheckUp

☐ Dental Problem DentistReasonProb

If dental problem, please specify:

DentalProblem

text

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Hospitalizations

A5. Has your child been hospitalized since the last St. Jude visit? Hospital

2 ☐ No

1 ☐ Yes

Date	Hospital
Hospital1Date text	Hospital1Name text
Medical problem	
Hospital1Reason text	

Date	Hospital
Hospital2Date text	Hospital2Name text
Medical problem	
Hospital2Reason text	

Medications and Health Supplements

Medications: List the medicines your child take(s) regularly. Remember to include hormones, birth control pills and over the counter medicines.

Name of medicine	Dose of medicine	Reason taken	Prescribing MD
Med1-Med14	Med1Dose-Med14Dose	Med1Reason-Med14Reason	Med1MD-Med14MD
text	text	text	text

Health Supplements: List herbs, supplements and other natural products your child take(s) regularly.

Name of product	Reason taken
Supplement1-Supplement8	Supplement1Reason-Supplement8Reason
text	text

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