SJLIFE

Adolescent Health Questionnaire
13-17 Years of Age Self Report

SJLIFE participants are being asked to complete this questionnaire. These questions are sensitive and personal. They are very important in helping us understand how your medical illness and treatment affects you and your body. Be assured that your participation is voluntary and you may choose to answer all, some, or none of the questionnaire items. Your responses will be kept confidential so please do not put *any* identifying information (like name, age, or date of birth) on this questionnaire. Once completed, please seal the questionnaire in the attached envelope and drop it off in the questionnaire box in the SJLIFE clinic. Thank you in advance for your participation.

Today's date: ☐☐ / ☐☐ / ☐☐☐☐
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Please! Do not mark below this line

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INSTRUCTIONS FOR COMPLETING THE QUESTIONNAIRE

Please follow these rules in completing this questionnaire. If you have any questions about completing this questionnaire, please call 1-800-775-2167.

1. Use a black ballpoint pen or a number 2 black pencil. Do not use a felt-tip or roller-ball pen. These may cause smudging. If you must erase answers, erase them completely.
2. When marking boxes, make an x inside the box.
3. Make no stray marks of any kind. Please keep the form as clean as possible.
4. Written responses must stay within the boxes provided.
5. Once you have completed the questionnaire, please place it in the attached envelope and drop it off in the SJLIFE questionnaire box in clinic.

BODY IMAGE SCALE

In this section you will be asked how you feel about your appearance, and about any changes that may have resulted from your disease or treatment. Please read each item carefully, and mark the response which comes closest to the way you have been feeling about yourself during the past week.

During the past week	Not at all	A little	Quite a bit	Very much
A1. Have you felt less physically attractive as a result of your disease or treatment?.	☐	☐	☐	☐
A2. Have you been feeling the treatment has left your body less whole?	☐	☐	☐	☐
A3. Have you been dissatisfied with the appearance of a scar(s)?	☐	☐	☐	☐

Please read each item carefully, and mark the response which comes closest to the way you feel about yourself.

	False. Not like me at all; it isn't like me at all	Mostly false	More false than true	More true than false	Mostly true	True. This statement describes me well; it is very much like me
A4. I am good looking	☐	☐	☐	☐	☐	☐
A5. I hate the way I look	☐	☐	☐	☐	☐	☐
A6. I have a nice looking face . .	☐	☐	☐	☐	☐	☐
A7. I am ugly	☐	☐	☐	☐	☐	☐
A8. Other people think I am good looking	☐	☐	☐	☐	☐	☐
A9. I have a good looking body .	☐	☐	☐	☐	☐	☐
A10. Most of my friends are better looking than I am . . .	☐	☐	☐	☐	☐	☐
A11. Nobody thinks I am good looking	☐	☐	☐	☐	☐	☐

B1. At the present time, do you have any of the following?

	No	Yes
Persistent hair loss	☐	☐
Scarring or disfigurement of the head or neck region (including the face)	☐	☐
Scarring or disfigurement of the chest or abdominal region	☐	☐
Scarring or disfigurement of the arms or legs (including an unequally sized arm or leg)	☐	☐
Walk with a limp	☐	☐
Loss of an arm or a leg	☐	☐
Loss of an eye	☐	☐
Other	☐	☐

If other, specify.

C1. Have you ever had sexual intercourse?

☐ No → *Go to Question C4.*

☐ Yes

The last time you had sexual intercourse . . .

C1a. Did you or your partner use a condom?

☐ No

☐ Yes → *Go to Question C2.*

C1b. If you did not use a condom at last intercourse, what method did you or your partner use to prevent pregnancy? (Select only one response.)

☐ No method was used to prevent pregnancy
☐ Birth control pills
☐ IUD (such as Mirena or ParaGard)
☐ Implant (such as Implanon or Nexplanon)
☐ Shot (such as Depo-Provera)
☐ Birth control patch (such as Ortho Evra)
☐ Birth control ring (such as NuvaRing)
☐ Sponge (such as Today Sponge)
☐ Spermicide
☐ Withdrawal or some other method

C2. Over the course of your lifetime, how many people have you had sexual intercourse with?

☐☐

C3. How old were you when you had sexual intercourse for the first time?

☐☐

C4. Do you have any concerns about your fertility (your ability to have/produce biological children in the future)?

☐ No

☐ Yes

☐ Not sure

Please! Do not mark below this line

We are always interested in your input.
Use this space for any additional comments you may have:

Thank you for your participation.

St. Jude Children's Research Hospital
ALSAC • Danny Thomas, Founder
Finding cures. Saving children.

Please! Do not mark below this line

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