

Date:
(Day Month Year)

ID-Number:



Questionnaire for parents of children with arthritis

Dear Parent,

Thank you very much for taking the time to complete this questionnaire about your child's well-being and health-related quality of life.

We would like you to complete this questionnaire on behalf of your child, but please complete the questionnaire without asking your child for any help with the answers. All the answers you give will be treated with the strictest confidentiality.

When answering the questions, unless instructed otherwise, please think about how your child has been feeling **over the past 4 weeks**.

For example:

never seldom quite often very often always

Does your child spend time with his/her friends?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
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About your child's arthritis

Think about the last four weeks!

	never	seldom	quite often	very often	always
1. Did your child feel stiff in the mornings (like an old grandma/granddad)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Did your child get exhausted easily?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Does arthritis make your child feel too exhausted to be with his/her friends?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Does your child hate being in pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Does it annoy your child that the pain sometimes comes on so suddenly?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Does pain stop your child from doing what he/she wants?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Does it bother your child that they can't do all sports/hobbies because of their arthritis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Does your child hate being restricted in movement?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Does it bother your child that he/she has trouble writing/ drawing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



About your child's arthritis

Think about the last four weeks!

	never	seldom	quite often	very often	always
10. Does your child feel that others understand that their symptoms may change suddenly?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Does your child feel that their friends understand that they may feel poorly quite suddenly?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Does your child feel that their teachers understand that sometimes they can't join in?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The last three questions are about how much trouble your child has had with his/her arthritis **in the last year**.



About your child's symptoms

Think about the last year

never few times every month every week daily

a. How often did your child have problems with his/her arthritis during the last year?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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not at all a little bit moderately quite a bit extremely

b. How severe was your child's arthritis during the last year?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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never seldom quite often very often always

c. How often did your child have pain in his/her joints or muscles during the last year?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Thank you for your assistance!

