ID#

Date:

**PedsQL**™

# Pediatric Quality of Life Inventory

Infant Scales

**PARENT REPORT for INFANTS (ages 1-12 months)**

**DIRECTIONS**

On the following page is a list of things that might be a problem for **your child**. Please tell us **how much of a problem** each one has been for **your child** during the **past ONE month** by circling:

1. if it is **never** a problem
2. if it is **almost never** a problem
3. if it is **sometimes** a problem
4. if it is **often** a problem
5. if it is **almost always** a problem

There are no right or wrong answers.

If you do not understand a question, please ask for help.

PedsQL™ Infant Scales 1-12 months Not to be reproduced without permission Copyright© 1998 JW Varni, Ph.D. All rights reserved 1/10

*In the past* ***ONE month,*** *how much of a* ***problem*** *has your child had with …*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **PHYSICAL FUNCTIONING *(problems with…)*** | **Never** | **Almost Never** | **Some- times** | **Often** | **Almost Always** |
| 1. Low energy level | 0 | 1 | 2 | 3 | 4 |
| 2. Difficulty participating in active play | 0 | 1 | 2 | 3 | 4 |
| 3. Having hurts or aches | 0 | 1 | 2 | 3 | 4 |
| 4. Feeling tired | 0 | 1 | 2 | 3 | 4 |
| 5. Being lethargic | 0 | 1 | 2 | 3 | 4 |
| 6. Resting a lot | 0 | 1 | 2 | 3 | 4 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **PHYSICAL SYMPTOMS *(problems with…)*** | **Never** | **Almost Never** | **Some- times** | **Often** | **Almost Always** |
| 1. Having gas | 0 | 1 | 2 | 3 | 4 |
| 2. Spitting up after eating | 0 | 1 | 2 | 3 | 4 |
| 3. Difficulty breathing | 0 | 1 | 2 | 3 | 4 |
| 4. Being sick to his/her stomach | 0 | 1 | 2 | 3 | 4 |
| 5. Difficulty swallowing | 0 | 1 | 2 | 3 | 4 |
| 6. Being constipated | 0 | 1 | 2 | 3 | 4 |
| 7. Having a rash | 0 | 1 | 2 | 3 | 4 |
| 8. Having diarrhea | 0 | 1 | 2 | 3 | 4 |
| 9. Wheezing | 0 | 1 | 2 | 3 | 4 |
| 10. Vomiting | 0 | 1 | 2 | 3 | 4 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **EMOTIONAL FUNCTIONING *(problems with…)*** | **Never** | **Almost Never** | **Some- times** | **Often** | **Almost Always** |
| 1. Feeling afraid or scared | 0 | 1 | 2 | 3 | 4 |
| 2. Feeling angry | 0 | 1 | 2 | 3 | 4 |
| 3. Crying or fussing when left alone | 0 | 1 | 2 | 3 | 4 |
| 4. Difficulty soothing himself/herself when upset | 0 | 1 | 2 | 3 | 4 |
| 5. Difficulty falling asleep | 0 | 1 | 2 | 3 | 4 |
| 6. Crying or fussing while being cuddled | 0 | 1 | 2 | 3 | 4 |
| 7. Feeling sad | 0 | 1 | 2 | 3 | 4 |
| 8. Difficulty being soothed when picked up or held | 0 | 1 | 2 | 3 | 4 |
| 9. Difficulty sleeping mostly through the night | 0 | 1 | 2 | 3 | 4 |
| 10. Crying a lot | 0 | 1 | 2 | 3 | 4 |
| 11. Feeling cranky | 0 | 1 | 2 | 3 | 4 |
| 12. Difficulty taking naps during the day | 0 | 1 | 2 | 3 | 4 |

*In the past* ***ONE month,*** *how much of a* ***problem*** *has your child had with …*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **SOCIAL FUNCTIONING *(problems with…)*** | **Never** | **Almost Never** | **Some- times** | **Often** | **Almost Always** |
| 1. Not smiling at others | 0 | 1 | 2 | 3 | 4 |
| 2. Not laughing when tickled | 0 | 1 | 2 | 3 | 4 |
| 3. Not making eye contact with a caregiver | 0 | 1 | 2 | 3 | 4 |
| 4. Not laughing when cuddled | 0 | 1 | 2 | 3 | 4 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **COGNITIVE FUNCTIONING *(problems with…)*** | **Never** | **Almost Never** | **Some- times** | **Often** | **Almost Always** |
| 1. Not imitating caregivers’ actions | 0 | 1 | 2 | 3 | 4 |
| 2. Not imitating caregivers’ facial expressions | 0 | 1 | 2 | 3 | 4 |
| 3. Not imitating caregivers’ sounds | 0 | 1 | 2 | 3 | 4 |
| 4. Not able to fix his/her attention on objects | 0 | 1 | 2 | 3 | 4 |