

IMACS FORM 05b: CHILDHOOD HEALTH ASSESSMENT QUESTIONNAIRE

Subject's IMACS number _____

Person Completing: Mother Father Patient Other _____

Date of assessment (mm/dd/yy) _____

Assessment number _____

In this section we are interested in learning how your child's illness affects his/her ability to function in daily life. Please feel free to add any comments on the back of this page. In the following questions, please check the one response which best describes your child's usual activities (average over an entire day) **OVER THE PAST WEEK. ONLY NOTE THOSE DIFFICULTIES OR LIMITATIONS WHICH ARE DUE TO ILLNESS.** If most children at your child's age are not expected to do a certain activity, please mark "Not Applicable". For example, if your child has difficulty in doing a certain activity or is unable to do it because he/she is too young but **NOT** because he/she is **RESTRICTED BY ILLNESS**, please mark "Not Applicable".

	<u>Without ANY Difficulty</u>	<u>With SOME Difficulty</u>	<u>With MUCH Difficulty</u>	<u>UNABLE To do</u>	<u>NOT Applicable</u>
DRESSING & GROOMING					
Is your child able to:					
-Dress, including tying shoelaces and doing buttons?	_____	_____	_____	_____	_____
-Shampoo his/her hair?	_____	_____	_____	_____	_____
-Remove socks?	_____	_____	_____	_____	_____
-Cut fingernails?	_____	_____	_____	_____	_____
ARISING					
Is your child able to:					
-Stand up from a low chair or floor?	_____	_____	_____	_____	_____
-Get in and out of bed or stand up in crib?	_____	_____	_____	_____	_____
EATING					
Is your child able to:					
-Cut his /her own meat?	_____	_____	_____	_____	_____
-Lift a cup or glass to mouth?	_____	_____	_____	_____	_____
-Open a new cereal box?	_____	_____	_____	_____	_____
WALKING					
Is your child able to:					
-Walk outdoors on flat ground?	_____	_____	_____	_____	_____
-Climb up five steps?	_____	_____	_____	_____	_____

*** Please check any AIDS or DEVICES that your child usually uses for any of the above activities:**

- | | |
|------------------|---|
| _____ Cane | _____ Devices used for dressing (button hook, zipper pull, long-handled shoe horn, etc) |
| _____ Walker | _____ Built up pencil or special utensils |
| _____ Crutches | _____ Special or built up chair |
| _____ Wheelchair | _____ Other (Specify: _____) |

*** Please check any category for which your child usually needs help from another person BECAUSE OF ILLNESS:**

- | | |
|-----------------------------|---------------|
| _____ Dressing and Grooming | _____ Eating |
| _____ Arising | _____ Walking |

	<u>Without ANY Difficulty</u>	<u>With SOME Difficulty</u>	<u>With MUCH Difficulty</u>	<u>UNABLE To do</u>	<u>Not Applicable</u>
HYGIENE					
Is your child able to:					
-Wash and dry entire body?	_____	_____	_____	_____	_____
-Take a tub bath (get in & out of tub)?	_____	_____	_____	_____	_____
-Get on and off the toilet or potty chair?	_____	_____	_____	_____	_____
-Brush teeth?	_____	_____	_____	_____	_____
-Comb/brush hair?	_____	_____	_____	_____	_____
REACH					
Is your child able to:					
-Reach and get down a heavy object such as a large game or books from just above his/her head?	_____	_____	_____	_____	_____
-Bend down to pick up clothing or a piece of paper from the floor?	_____	_____	_____	_____	_____
-Pull on a sweater over his/her head? head?	_____	_____	_____	_____	_____
-Turn neck to look back over shoulder?	_____	_____	_____	_____	_____
GRIP					
Is your child able to:					
-Write or scribble with pen or pencil?	_____	_____	_____	_____	_____
-Open car doors?	_____	_____	_____	_____	_____
-Open jars which have been previously opened?	_____	_____	_____	_____	_____
-Turn faucets on and off?	_____	_____	_____	_____	_____
-Push open a door when he/she to turn a door knob?	_____	_____	_____	_____	_____
ACTIVITIES					
Is your child able to:					
-Run errands and shop?	_____	_____	_____	_____	_____
-Get in and out of car or toy car or school?	_____	_____	_____	_____	_____
-Ride bike or tricycle?	_____	_____	_____	_____	_____
-Do household chores (eg, wash dishes, take out trash, vacuuming, yard work, make bed, clean room)?	_____	_____	_____	_____	_____
-Run and play?	_____	_____	_____	_____	_____

Please check any AIDS or DEVICES that your child usually uses for any of the above activities:

- | | |
|--|--|
| <input type="checkbox"/> Raised toilet seat | <input type="checkbox"/> Bathtub bar |
| <input type="checkbox"/> Bathtub seat | <input type="checkbox"/> Long-handled appliances for Reach |
| <input type="checkbox"/> Jar opener (for jars previously opened) | <input type="checkbox"/> Long-handled appliances in bathroom |

Please check any categories for which your child usually needs help from another person BECAUSE OF ILLNESS?

- | | |
|----------------------------------|--|
| <input type="checkbox"/> Hygiene | <input type="checkbox"/> Gripping and opening things |
| <input type="checkbox"/> Reach | <input type="checkbox"/> Errands and chores |

We are also interested in learning whether or not your child has been affected by pain because of his or her illness.

How much pain do you think your child has had because of his or her illness **IN THE PAST WEEK?**

Place a mark on the line below to indicate the severity of pain.

No Pain Very Severe Pain

0 100

Considering all the ways that myositis affects your child, rate how your child is doing on the following scale by placing a mark on the line.

0 100

Very well Very poor
