

# Adolescent (parent reported)

---

## Outcomes Questionnaire

*Developed by:*

American Academy of Orthopaedic Surgeons®  
Pediatric Orthopaedic Society of North America  
American Academy of Pediatrics  
Shriner's Hospitals

To be completed by the parent for adolescents 11 – 18 years old.

Based on the Version 2.0 Pediatrics–Parent/ Adolescent Outcomes Instrument  
Also commonly referred to as the PODCI ("Pediatric Outcomes Data Collection Instrument")  
Revised, renumbered, reformatted August 2005

FOR OFFICE USE ONLY

Clinic ID

First six letters of patient's last name

Physician ID

Office Chart #

**Primary DX**

Diagnosis & ICD-9 Code

CPT Date

Procedure & CPT Code

Side of body procedure was performed on:

Right     Both     Left     N/A

**Secondary DX**

Diagnosis & ICD-9 Code

CPT Date

Procedure & CPT Code

Side of body procedure was performed on:

Right     Both     Left     N/A

**Secondary DX**

Diagnosis & ICD-9 Code

CPT Date

Procedure & CPT Code

Side of body procedure was performed on:

Right     Both     Left     N/A

**Secondary DX**

Diagnosis & ICD-9 Code

CPT Date

Procedure & CPT Code

Side of body procedure was performed on:

Right     Both     Left     N/A

**Secondary DX**

Diagnosis & ICD-9 Code

CPT Date

Procedure & CPT Code

Side of body procedure was performed on:

Right     Both     Left     N/A

Today's Date:

**Thank you for completing this questionnaire!**

**This questionnaire will help us to better understand your general health and any problems related to bone and muscle conditions. Your completion of this questionnaire is completely voluntary and your responses will be held in the strictest confidence.**

**Please answer every question. Some questions may look like others, but each one is different. There are no right or wrong answers. If you are not sure how to answer a question, just give the best answer you can.**

Your Child's Birth Date:

Your Child's Social Security Number:

Your Social Security Number:

**Adolescent Health Assessment (parent-reported)**

Some kind of problems can make it hard to do many activities, such as eating, bathing, school work, and playing with friends. We would like to find out how your child is doing. (Choose one response per line.)

During the **last week**, was it easy or hard for your child to:

	1 - Easy	2 - A little hard	3 - Very hard	4 - Can't do at all	5 - Too young for this activity
1. Lift heavy books?	<input type="radio"/>				
2. Pour a half gallon of milk?	<input type="radio"/>				
3. Open a jar that has been opened before?	<input type="radio"/>				
4. Use a fork and spoon?	<input type="radio"/>				
5. Comb his/her hair?	<input type="radio"/>				
6. Button buttons?	<input type="radio"/>				
7. Put on his/her coat?	<input type="radio"/>				
8. Write with a pencil?	<input type="radio"/>				

9. On average, **over the last 12 months**, how often did your child miss school (camp, etc.) because of his/her health?

- Rarely
- Once a month
- Two or three times a month
- Once a week
- More than once a week
- Do not attend school, etc.

During the **last week**, how happy has your child been with: (Choose one response per line.)

	1 - Very happy	2 - Somewhat happy	3 - Not sure	4 - Somewhat unhappy	5 - Very unhappy	6 - Child is too young
10. How he/she looks?	<input type="radio"/>					
11. His/her body?	<input type="radio"/>					
12. What clothes or shoes he/she can wear?	<input type="radio"/>					
13. His/her ability to do the same things his/her friends do?	<input type="radio"/>					
14. His/her health in general?	<input type="radio"/>					

## Adolescent Health Assessment (parent-reported)

During the **last week**, how much of the time: (Choose one response per line.)

	1 - Most of the time	2 - Some of the time	3 - A little of the time	4 - None of the time
15. Did your child feel sick and tired?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. Were your child full of pep and energy?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. Did pain or discomfort interfere with your child's activities?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

During the **last week**, has it been easy or hard for your child to: (Choose one response per line.)

	1 - Easy	2 - A little hard	3 - Very hard	4 - Can't do at all	5 - Too young for this activity
18. Run short distances?	<input type="radio"/>				
19. Bicycle or tricycle?	<input type="radio"/>				
20. Climb three flights of stairs?	<input type="radio"/>				
21. Climb one flight of stairs?	<input type="radio"/>				
22. Walk more than a mile?	<input type="radio"/>				
23. Walk three blocks?	<input type="radio"/>				
24. Walk one block?	<input type="radio"/>				
25. Get on and off a bus?	<input type="radio"/>				

26. How often does your child need help from another person for walking and climbing? (Choose one response.)

- 1 - Never     
  2 - Sometimes     
  3 - About half the time     
  4 - Often     
  5 - All the time

27. How often does your child use assistive devices (such as braces, crutches, or wheelchair) for walking and climbing? (Choose one response.)

- 1 - Never     
  2 - Sometimes     
  3 - About half the time     
  4 - Often     
  5 - All the time

During the **last week**, has it been easy or hard for your child to: (Choose one response per line.)

	1 - Easy	2 - A little hard	3 - Very hard	4 - Can't do at all	5 - Too young for this activity
28. Stand while washing his/her hands and face at a sink?	<input type="radio"/>				
29. Sit in a regular chair without holding on?	<input type="radio"/>				
30. Get on and off a toilet or chair?	<input type="radio"/>				
31. Get in and out of bed?	<input type="radio"/>				
32. Turn door knobs?	<input type="radio"/>				
33. Bend over from a standing position and pick up something off the floor?	<input type="radio"/>				

## Adolescent Health Assessment (parent-reported)

34. How often does your child need help from another person for sitting and standing? (Choose one response.)

- 1 - Never       2 - Sometimes       3 - About half the time       4 - Often       5 - All the time

35. How often does your child use assistive devices (such as braces, crutches, or wheelchair) for sitting and standing? (Choose one response.)

- 1 - Never       2 - Sometimes       3 - About half the time       4 - Often       5 - All the time

36. Can your child participate in **recreational outdoor activities** with other children the same age? (For example: bicycling, skating, hiking, jogging) (Choose one response.)

- 1 - Yes, easily       2 - Yes, but a little hard       3 - Yes, but very hard       4 - No

If you answered "no" to Question 36 above, was your child's activity limited by: (Choose all that apply.)

37. Pain?  
 38. General health?  
 39. Doctor or parent instructions?  
 40. Fear the other kids won't like him/her?  
 41. Dislike of recreational outdoor activities?  
 42. Too young?  
 43. Activity not in season?

44. Can your child participate in **pickup games or sports** with other children the same age? (For example: tag, dodge ball, basketball, softball, soccer, catch, jump rope, touch football, hop scotch) (Choose one response.)

- 1 - Yes, easily       2 - Yes, but a little hard       3 - Yes, but very hard       4 - No

If you answered "no" to Question 44 above, was your child's activity limited by: (Choose all that apply.)

45. Pain?  
 46. General health?  
 47. Doctor or parent instructions?  
 48. Fear the other kids won't like him/her?  
 49. Dislike of pickup games or sports?  
 50. Too young?  
 51. Activity not in season?

52. Can your child participate in **competitive level sports** with other children the same age? (For example: hockey, basketball, soccer, football, baseball, swimming, running [track or cross country], gymnastics, or dance) (Choose one response.)

- 1 - Yes, easily     
  2 - Yes, but a little hard     
  3 - Yes, but very hard     
  4 - No

If you answered "no" to Question 52 above, was your child's activity limited by: (Choose all that apply.)

53. Pain?  
 54. General health?  
 55. Doctor or parent instructions?  
 56. Fear the other kids won't like your child?  
 57. Dislike of competitive level sports?  
 58. Too young?  
 59. Activity not in season?

60. How often in the **last week** did your child get together and do things with friends? (Choose one response.)

- 1 - Often     
  2 - Sometimes     
  3 - Never or rarely

If you answered "sometimes" or "never or rarely" to Question 60 above, was your child's activity limited by: (Choose all that apply.)

61. Pain?  
 62. General health?  
 63. Doctor or parent instructions?  
 64. Fear the other kids won't like him/her?  
 65. Friends not around?

66. How often in the **last week** did your child participate in **gym/recess**? (Choose one response.)

- 1 - Often     
  2 - Sometimes     
  3 - Never or rarely     
  4 - No gym or recess

If your child answered "sometimes" or "never or rarely" to Question 66 above, was your child's activity limited by: (Choose all that apply.)

67. Pain?  
 68. General health?  
 69. Doctor or parent instructions?  
 70. Fear the other kids won't like your child?  
 71. Dislike of gym/recess?  
 72. School not in session?  
 73. Does not attend school?

74. Is it easy or hard for your child to make friends with children his/her own age? (Choose one response.)

- 1 - Usually easy     
  2 - Sometimes easy     
  3 - Sometimes hard     
  4 - Usually hard

**Adolescent Health Assessment (parent-reported)**

75. How much pain has your child had during the **last week**? (Choose one response.)

- 1 - None     2 - Very mild     3 - Mild     4 - Moderate     5 - Severe     6 - Very severe

76. During the **last week**, how much did pain interfere with your child's normal activities (including at home, outside of the home, and at school)? (Choose one response.)

- 1 - Not at all     2 - A little bit     3 - Moderately     4 - Quite a bit     5 - Extremely

**What expectations do you have for your child's treatment?**

As a result of my child's treatment, I expect my child: (Choose one response per line.)

	1 - Definitely yes	2 - Probably yes	3 - Not sure	4 - Probably not	5 - Definitely not
77. To have pain relief.	<input type="radio"/>				
78. To look better.	<input type="radio"/>				
79. To feel better about himself/herself.	<input type="radio"/>				
80. To sleep more comfortably.	<input type="radio"/>				
81. To be able to do activities at home.	<input type="radio"/>				
82. To be able to do more at school.	<input type="radio"/>				
83. To be able to do more play or recreational activities (biking, walking, doing things with friends).	<input type="radio"/>				
84. To be able to do more sports.	<input type="radio"/>				
85. To be free from pain or disability as an adult.	<input type="radio"/>				

86. If your child had to spend the rest of his/her life with his/her bone and muscle condition **as it is right now**, how would you feel about it? (Choose one response.)

- 1 - Very satisfied     2 - Somewhat satisfied     3 - Neutral     4 - Somewhat dissatisfied     5 - Very dissatisfied

**Comments:**