C.H.A.Q.

CHILDHOOD HEALTH ASSESSMENT QUESTIONNAIRE

PATIENT NAME: …… DOB: …… DATE: ……

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. In the following questions, please tick the one response which best describes your child's usual activities OVER THE PAST WEEK. ONLY NOTE THOSE DIFFICULTIES OR LIMITATIONS WHICH ARE DUE TO ILLNESS.

	Without ANY Difficulty	With SOME Difficulty	With MUCH Difficulty	UNABLE To do	Not Applicable
DRESSING & PERSONAL CARE					
Is your child able to:					
- Dress, including tying shoelaces and doing buttons?	☐	☐	☐	☐	☐
- Shampoo his/her hair?	☐	☐	☐	☐	☐
- Remove socks?	☐	☐	☐	☐	☐
- Cut fingernails?	☐	☐	☐	☐	☐
GETTING UP					
Is your child able to:					
- Stand up from a low chair or floor?	☐	☐	☐	☐	☐
- Get in and out of bed or stand up in a cot?	☐	☐	☐	☐	☐
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 outside on flat ground?	☐	☐	☐	☐	☐
- Climb up five steps?	☐	☐	☐	☐	☐

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

Walking	☐	Devices used for dressing (button hook, zip pull, long-handled shoe horn, etc.)	☐
Walking Frame	☐	Build up pencil or special utensils	☐
Crutches	☐	Special or built up chair	☐
Wheechair	☐	Other (Specify: ……..)	☐

- **Please tick any categories for which your child usually needs help from another person BECAUSE OF PAIN OR ILLNESS:**

Dressing and personal care	☐	Eating	☐
Getting up	☐	Walking	☐

	Without ANY Difficulty	With SOME Difficulty	With MUCH Difficulty	UNABLE To do	Not Applicable
HYGIENE					
Is your child able to:					
- Wash and dry entire body?	☐	☐	☐	☐	☐
- Take a bath (get in and get out)?	☐	☐	☐	☐	☐
- Get on and off the toilet or potty?	☐	☐	☐	☐	☐
- 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 jumper over his/her head?	☐	☐	☐	☐	☐
- Turn neck to look back over shoulder?	☐	☐	☐	☐	☐
GRIP					
Is your child able to:					
- Write or scribble with a pen or pencil?	☐	☐	☐	☐	☐
- Open car doors?	☐	☐	☐	☐	☐
- Open jars which have been previously opened?	☐	☐	☐	☐	☐
- Turn taps on and off?	☐	☐	☐	☐	☐
- Push open a door when he/she has to turn a door knob?	☐	☐	☐	☐	☐
ACTIVITIES					
Is your child able to:					
- Run errands and shop?	☐	☐	☐	☐	☐
- Get in and out of a car to to toy car or school bus?	☐	☐	☐	☐	☐
- Ride bike or tricycle?	☐	☐	☐	☐	☐
- Do household chores (e.g. wash dishes, take out rubbish, hoovering, gardening, make bed, clean room)?	☐	☐	☐	☐	☐
- Run and play?	☐	☐	☐	☐	☐

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

Raised toilet seat	☐	Bath rail	☐
Bath seat	☐	Long-handled appliances for reach	☐
Jar opener (for jars previously opened)	☐	Long-handled appliances in bathroom	☐

- **Please tick any categories for which your child usually needs help from another person BECAUSE OF PAIN OR ILLNESS:**

Hygiene	☐	Gripping and opening things	☐
Reach	☐	Errands and chores	☐

PAIN: How much pain do you think your child has had <u>IN THE PAST WEEK</u>? Place a mark on the line below, to indicate the severity of the pain

No pain — **Very severe pain**

0 — **100**

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GENERAL EVALUATION: Considering all the ways that pain or illness affects your child, rate how he/she is doing by placing a single mark on the line below.

Very well — **Very poor**

0 — **100**

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