





About CHEQ

menu

Questionnaire

CHEQ 2.0

Mini-CHEQ

Old version

menu

New about CHEQ

2.0

menu

Publications


menu

Info to Family

menu

Collaboration

menu

Current language: 

Change language here



CHEQ 2.0

Question 10 of 27



Open a plastic box with a lid (for example an ice-cream box)

Do you usually use one hand, both hands together or get help?

- ☐ One hand  
☒ Both hands  
☐ Get help

How do you think your hand works?

- ☐ 1      ☐ 2      ☒ 3      ☐ 4  
Bad      Good

How much time do you need to do the whole task, compared to peers?

- ☐ 1      ☐ 2      ☐ 3      ☒ 4  
Considerably longer      Equally long

Does your hand function bother you in this activity / situation?

- ☐ 1      ☒ 2      ☐ 3      ☐ 4  
It bothers me a lot      It does not bother me at all

Previous question

Next question

Also Visit:



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# Report

Children's Hand-use Experience Questionnaire

Name: Test Sample

Age: 13 years

Sex: Boy

Reduced hand-/armfunction on right side caused by obstetric brachial plexus palsy.

Answered by: Myself

Report created 9/28/2018

	Two hands	Use hand *	Time required **	Feeling ***
Pull up track suit trousers	Yes	3	3	3
Remove a straw from the front of a juice box and insert it. (Refers to the whole process, including taking off the wrapping of the straw)	Yes	2	1	2
Put on socks	Help	2	3	3
Eat out of a small container of yoghurt	Yes	2	2	3
Spread out glue on paper using a glue stick	Yes	2	2	3
Cut out a picture using scissors	Help	1	3	3
Butter a slice of soft bread	Yes	2	3	3
Open a small box (for example a box of mints)	Yes	1	2	3
Put toothpaste on a toothbrush	One hand	1	2	2
Cut up a pancake (or other food easy to cut up) on the plate	Help	3	3	2
Remove the wrapping from a piece of candy	Help	2	1	2
Open the zipper on a small bag (e.g. pencil case or purse)	Yes	2	3	3
Handle playing-cards (Refers to the whole process; holding, selecting and placing cards in the hand while playing)	Yes	2	2	2
Pick money out of a purse or wallet	Yes	2	2	3
Carry a tray (for example in the canteen)	Yes	3	3	3
Pull up the zipper of a jacket	Yes	2	3	3
Button up the trousers	Help	1	1	2
Open a plastic box with a lid (for example an ice-cream box)	Yes	3	4	2
Screw off the cap of a small, unopened softdrink bottle.	One hand	1	2	3
Remove the wrapping from an ice-cream	Yes	2	2	3
Cut on a chopping board (for example fruit, vegetables, bread)	Yes	2	3	2
Peel an orange	Help	1	2	2
Open a bag (for example a bag of crisps)	Yes	2	2	2
Take off the protective plastic backing of a Elastoplast	Help	2	3	3
Cut meat (or other food hard to cut up) on a plate	Help	1	2	1
Open up a box of milk or juice	Yes	3	3	3
Tie shoelaces	Help	3	3	4

\* How do you think your hand works? Bad, 1-----2-----3-----4, Good

\*\* How much time do you need to do the whole task, compared to peers? Considerably longer, 1-----2-----3-----4, Equally long

\*\*\* Does your hand function bother you in this activity / situation? It bothers me a lot, 1-----2-----3-----4, It does not bother me at all



## BRACHIAL PLEXUS OUTCOME MEASURE

ACTIVITY SCALE	Functional Movement Score
<b>SHOULDER</b>	
<b>Combs Back of Head</b> - Uses affected hand to reach the back of head to comb hair	
<b>Places Container Above Head</b> - Uses both hands to reach forward to place a container directly above their head	
<b>Undo Button at Midline</b> - Undo button or snap at navel level with both hands	
<b>Hand to Back Pant Pocket</b> - Puts affected fingers into ipsilateral back pant pocket	
<b>ELBOW AND FOREARM</b>	
<b>Pretends to Eat Candy</b> - Hold plate with unaffected hand, pick up bead with affected hand from plate and bring it up to mouth	
<b>Uses Computer Mouse</b> - Uses affected hand with isolated finger flexion to click on mouse	
<b>Plays Drums</b> - Hits drumsticks on container with both hands	
<b>Holds Plate with Palm Up</b> - Holds plate with affected hand palm up	
<b>WRIST, FINGER, AND THUMB</b>	
<b>Opens Large Container</b> - Uses both hands to open 5" diameter container with snap on lid; abducts thumb with affected hand	
<b>Pulls Apart Theraputty</b> - Uses power grasp to pull apart theraputty with active wrist extension with both hands	
<b>Strings Bead</b> - Uses both hands to string bead; uses precision grasp (pinch) with affected hand	

### FUNCTIONAL MOVEMENT SCALE

1. Cannot complete task
2. Completes task using only unaffected arm
3. Completes task  
Absent active movement in primary mover(s). May use passive range of motion to complete movement pattern
4. Completes task  
Initiates all movement actively or position of primary mover(s) is sufficient for function. Compensatory techniques used to complete movement pattern
5. Completes task with normal movement pattern

## SELF-EVALUATION SCALE

My arm works . . .

	_____	
Very POORLY		Very WELL

My hand works . . .

	_____	
Very POORLY		Very WELL

My arm and hand looks . . .

	_____	
Very BAD		Very GOOD



## Pediatric Global Health 7

Please respond to each question or statement by marking one box per row.

		Excellent	Very Good	Good	Fair	Poor
Global01R1	In general, would you say your health is:.....	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
Global02R1	In general, would you say your quality of life is:.....	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
Global03R1	In general, how would you rate your physical health? .....	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
Global04R1	In general, how would you rate your mental health, including your mood and your ability to think? .....	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
		Never	Rarely	Sometimes	Often	Always
PedGlobal2R1	How often do you feel really sad? .....	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
		Always	Often	Sometimes	Rarely	Never
PedGlobal5R1	How often do you have fun with friends? .....	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
PedGlobal6R1	How often do your parents listen to your ideas? .....	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1

ID# \_\_\_\_\_

Date: \_\_\_\_\_

# PedsQL™

## Pediatric Quality of Life Inventory

Version 4.0

### PARENT REPORT for CHILDREN (ages 8-12)

#### 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:

- 0 if it is **never** a problem
- 1 if it is **almost never** a problem
- 2 if it is **sometimes** a problem
- 3 if it is **often** a problem
- 4 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.

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



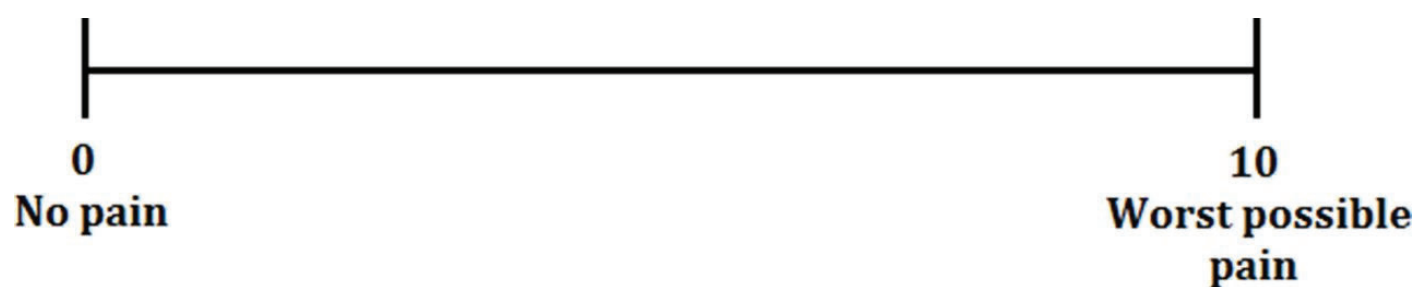
<b>PHYSICAL FUNCTIONING (<i>problems with...</i>)</b>	<b>Never</b>	<b>Almost Never</b>	<b>Some- times</b>	<b>Often</b>	<b>Almost Always</b>
1. Walking more than one block	0	1	2	3	4
2. Running	0	1	2	3	4
3. Participating in sports activity or exercise	0	1	2	3	4
4. Lifting something heavy	0	1	2	3	4
5. Taking a bath or shower by him or herself	0	1	2	3	4
6. Doing chores around the house	0	1	2	3	4
7. Having hurts or aches	0	1	2	3	4
8. Low energy level	0	1	2	3	4

<b>EMOTIONAL FUNCTIONING (<i>problems with...</i>)</b>	<b>Never</b>	<b>Almost Never</b>	<b>Some- times</b>	<b>Often</b>	<b>Almost Always</b>
1. Feeling afraid or scared	0	1	2	3	4
2. Feeling sad or blue	0	1	2	3	4
3. Feeling angry	0	1	2	3	4
4. Trouble sleeping	0	1	2	3	4
5. Worrying about what will happen to him or her	0	1	2	3	4

<b>SOCIAL FUNCTIONING (<i>problems with...</i>)</b>	<b>Never</b>	<b>Almost Never</b>	<b>Some- times</b>	<b>Often</b>	<b>Almost Always</b>
1. Getting along with other children	0	1	2	3	4
2. Other kids not wanting to be his or her friend	0	1	2	3	4
3. Getting teased by other children	0	1	2	3	4
4. Not able to do things that other children his or her age can do	0	1	2	3	4
5. Keeping up when playing with other children	0	1	2	3	4

<b>SCHOOL FUNCTIONING (<i>problems with...</i>)</b>	<b>Never</b>	<b>Almost Never</b>	<b>Some- times</b>	<b>Often</b>	<b>Almost Always</b>
1. Paying attention in class	0	1	2	3	4
2. Forgetting things	0	1	2	3	4
3. Keeping up with schoolwork	0	1	2	3	4
4. Missing school because of not feeling well	0	1	2	3	4
5. Missing school to go to the doctor or hospital	0	1	2	3	4





NOTE: A mark is placed on the line at the point that represents the level of pain observed. This is measured in millimeter from the left anchor 'no pain' to generate a pain score.  
The word 'distress' replaces 'pain' to create a distress scale



# Brief Pain Inventory (Short Form)

Study ID# \_\_\_\_\_ Hospital # \_\_\_\_\_

Do not write above this line.

Date: \_\_\_\_\_

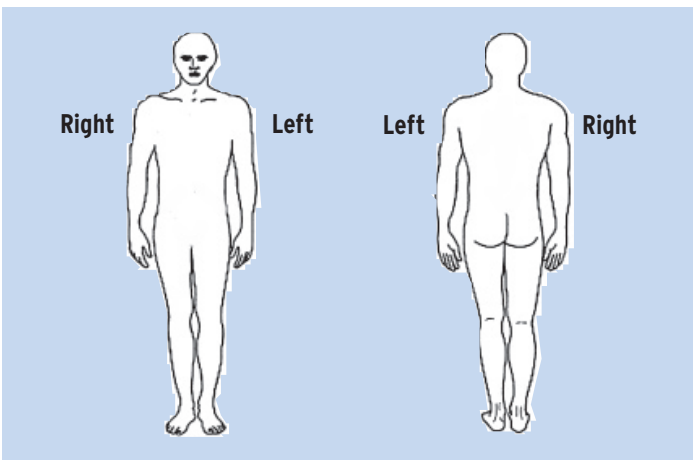
Time: \_\_\_\_\_

Name: \_\_\_\_\_  
Last First Middle Initial

1) Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?

☐ 1. yes ☐ 2. no

2) On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



3) Please rate your pain by circling the one number that best describes your pain at its **WORST** in the past 24 hours.

0 1 2 3 4 5 6 7 8 9 10  
No Pain Pain as bad as you can imagine

4) Please rate your pain by circling the one number that best describes your pain at its **LEAST** in the past 24 hours.

0 1 2 3 4 5 6 7 8 9 10  
No Pain Pain as bad as you can imagine

5) Please rate your pain by circling the one number that best describes your pain on the **AVERAGE**.

0 1 2 3 4 5 6 7 8 9 10  
No Pain Pain as bad as you can imagine

6) Please rate your pain by circling the one number that tell how much pain you have **RIGHT NOW**.

0 1 2 3 4 5 6 7 8 9 10  
No Pain Pain as bad as you can imagine

7) What treatments or medications are you receiving for your pain?

8) In the past 24 hours, how much **RELIEF** have pain treatments or medications provided? Please circle the one percentage that most shows how much relief you have received.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%  
No Relief Complete Relief

9) Circle the one number that describes how, during the past 24 hours, **PAIN HAS INTERFERED** with your:

A. General Activity:  
0 1 2 3 4 5 6 7 8 9 10  
Does not Interfere Completely interferes

B. Mood  
0 1 2 3 4 5 6 7 8 9 10  
Does not Interfere Completely interferes

C. Walking Ability  
0 1 2 3 4 5 6 7 8 9 10  
Does not Interfere Completely interferes

D. Normal work (Includes both work outside the home and housework)  
0 1 2 3 4 5 6 7 8 9 10  
Does not Interfere Completely interferes

E. Relation with other people  
0 1 2 3 4 5 6 7 8 9 10  
Does not Interfere Completely interferes

F. Sleep  
0 1 2 3 4 5 6 7 8 9 10  
Does not Interfere Completely interferes

G. Enjoyment of life  
0 1 2 3 4 5 6 7 8 9 10  
Does not Interfere Completely interferes

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