

BMS Pediatric Self Report 13-17 Interview Form II: Research Staff Instructions

Instructions: This form is designed to aid in the interview process. If you are handing the form to the participant for them to fill out, use the mail version of this form instead. Instructions to the interviewer appear throughout the survey in italics, and scripts to read aloud to the participants appear using quotation marks. The scripts to read aloud are also boxed and shaded in light gray. Use these scripts as suggestions for how to move through the survey while establishing rapport with the participant.

Missing codes appear throughout this interview in small boxes. If a participant doesn't want to answer any item or doesn't know the answer, circle "88" (Declined to Answer/Refused) or "99" (Unknown) in that item's corresponding missing code box. Some items have missing codes built into their response options and therefore don't have those code boxes.

Remember to fill out the Medical Record Abstraction Form II. For the pain medication items, check the medical record to determine if there were any pain medications prescribed within the data collection window. Note on the Medical Record Abstraction Form II form and enter in the appropriate field during data entry.

Form II Administration:		
Follow-up period <input type="checkbox"/> 1. 6-month follow-up <input type="checkbox"/> 2. 12 month follow-up <input type="checkbox"/> 3. 24 month follow-up <input type="checkbox"/> 4. 5 year follow-up <input type="checkbox"/> 5. 10 year follow-up <input type="checkbox"/> 6. 15 year follow-up	What is the method of administration of this form? <input type="checkbox"/> 1. In person interview <input type="checkbox"/> 3. Telephone interview <input type="checkbox"/> 5. Medical Record Review	What is the language of administration of this form? <input type="checkbox"/> 1. English <input type="checkbox"/> 2. Spanish
What is the status of this follow-up assessment? <input type="checkbox"/> 1. Some or all assessment done <input type="checkbox"/> 2. Death due to burn related complications (update date and cause of death on Patient Status Form) <input type="checkbox"/> 3. Death due to non- burn related complications (update date and cause of death on Patient Status Form) <input type="checkbox"/> 4. Unable to locate <input type="checkbox"/> 5. Refused this assessment <input type="checkbox"/> 6. Unable to test/med comp/incapable of responding <input type="checkbox"/> 7. Failed to respond <input type="checkbox"/> 8. Did not consent to future assessment/withdrew <input type="checkbox"/> 11. Incarcerated <input type="checkbox"/> 13. Still in hospital (not discharged yet) <input type="checkbox"/> 14. Unable to travel for assessment <input type="checkbox"/> 15. Death (unknown causes) (update date and cause of death on Patient Status Form)		If follow-up status is "unable to locate," mark the best reason, below: <input type="checkbox"/> 1. Homeless at previous data collection <input type="checkbox"/> 2. International place of residence <input type="checkbox"/> 3. Participant is child who was/is in CPS custody or foster care and no contact information is available <input type="checkbox"/> 4. No known current contact info <input type="checkbox"/> 5. Other reasons <input type="checkbox"/> 6. Unable to contact due to Shriners Hospital regulations

Burn Model System Follow-up Survey

Introduction Script (replace this script with your personalized center introduction script if applicable or modify as needed to facilitate the flow and rapport of the interview):

“Hi my name is _____ and I am calling from _____ to ask you some questions about how you have been doing (since your injury)... or (since we last spoke with you on (last follow-up date)). Thank you for continuing to participate in our study. The aim of the study is to learn about how young people do after a burn injury. Your answers will help us understand the experiences of all people with burn injury and I appreciate your willingness to share those experiences. I'll be asking questions about your burn injury, your health, and other questions about you and people around you. I will guide you as we go along. You may notice that some questions are similar and feel repetitive. This is not a mistake and is part of the research process. All information will be kept confidential.

If you are unsure how to answer a question, please give the answer that fits you best. You can choose to skip any questions you don't want to answer or feel uncomfortable answering. Just tell me, “skip.” Please let me know at any time if you have any questions.”

Today's Date: ____ / ____ / ____

“As a reminder, your last research study questionnaire was completed on ____ / ____ / ____.”

“We're going to go ahead and get started.”

Section I

1. Since your last research study questionnaire, have you spoken with other burn survivors to get support for problems related to your burn injury?

- ☐ 1. Yes
☐ 2. No
☐ 99. I don't know

88/Refused

<p>2. To your knowledge, in the last year have you had COVID-19?</p> <p><i>Or, since your last research study questionnaire if your burn was less than a year ago, have you had COVID-19?</i></p> <p> <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> 99. I don't know </p>	<p>(If yes), What month and year did you have COVID-19? (if you've had COVID-19 more than once, provide the month and year of your <u>first</u> illness)</p> <p>Month: _____ Year: _____</p> <p>What level of care did you receive for COVID-19?</p> <p> <input type="checkbox"/> 1. Did not seek medical care <input type="checkbox"/> 2. Received medical care but was not hospitalized <input type="checkbox"/> 3. Was hospitalized </p> <p style="margin-left: 40px;">In the hospital... (if applicable)</p> <p> <input type="checkbox"/> 1. I was NOT on a ventilator (breathing machine with tube down your throat) <input type="checkbox"/> 2. I was on a ventilator <input type="checkbox"/> 3. I don't know </p>
<div style="border: 1px solid black; padding: 2px; display: inline-block;">88/Refused</div>	<div style="border: 1px solid black; padding: 2px; display: inline-block;">88/Refused</div> <div style="border: 1px solid black; padding: 2px; display: inline-block;">99/Unknown</div>
<p>3. Since your last research study questionnaire, have you received any of the following services at home or outpatient? (Choose <i>all that apply</i>)</p> <p> <input type="checkbox"/> 1. No services <input type="checkbox"/> 2. Occupational therapy <input type="checkbox"/> 3. Physical therapy <input type="checkbox"/> 4. Speech language pathology <input type="checkbox"/> 5. Social work <input type="checkbox"/> 6. Psychological services <input type="checkbox"/> 7. Vocational services or child life services <input type="checkbox"/> 99. I don't know </p>	
<div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p><i>If clarification is needed, say</i> “Examples of occupational therapy include helping with adjusting to a school environment after injury. Examples of physical therapy include range of motion and walking exercises.”</p> </div>	
<div style="border: 1px solid black; padding: 2px; text-align: right;">88/Refused</div>	
<p>Interviewer Instructions: If the participant didn't receive any services OR if you didn't receive PT/OT, skip to #8 on page 4</p>	
<p>4. If yes to OT and/or PT, How many sessions of occupational and/or physical therapy have you had in the past 4 weeks? (If you don't know exactly, use your best guess)</p> <p> <input type="checkbox"/> 1. One <input type="checkbox"/> 2. 2 to 4 <input type="checkbox"/> 3. 5 to 10 <input type="checkbox"/> 4. More than 10 <input type="checkbox"/> 77. Not applicable (no OT/PT received) → skip to #8 on page 4 <input type="checkbox"/> 99. I don't know </p>	
<div style="border: 1px solid black; padding: 2px; display: inline-block;">88/Refused</div>	
<p><i>If yes to OT and/or PT, “Since your last research study questionnaire, <u>where</u> did you receive your outpatient occupational or physical burn therapy?”</i></p>	
<p>5. At the burn center?</p> <p> <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> 77. Not applicable (no OT/PT received) <input type="checkbox"/> 99. I don't know </p>	
<div style="border: 1px solid black; padding: 2px; display: inline-block;">88/Refused</div>	

6. At any other facility? <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> 77. Not applicable (no OT/PT received) <input type="checkbox"/> 99. I don't know	88/Refused
7. Using telehealth? (for example, meeting with your therapist using video conferencing) <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> 77. Not applicable (no OT/PT received) <input type="checkbox"/> 99. I don't know	88/Refused
8. Since your last research study questionnaire, have you had any burn related surgeries (such as surgeries for open wounds or scar management)? <input type="checkbox"/> 1. Yes → <input type="checkbox"/> 2. No <input type="checkbox"/> 99. I don't know	(If you <u>did</u> have burn related surgeries) Have you had any burn-related surgeries outside of this clinical center? <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> 99. I don't know

Section 2

Instructions: Please answer each question with a “yes” or “no”.

If you answer “yes”, then please indicate to what extent this problem affects your daily activities using these responses:

Interviewer instructions: Write in 88 for refused or 99 for unknown for this section

1 Not at all	2 To a very small extent	3 To a small extent	4 To a moderate extent	5 To a fairly great extent	6 To a great extent	7 To a very great extent				
Do you have problems...			Problem?	1	2	3	4	5	6	7
1. Seeing?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Hearing?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Learning and understanding?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Speaking or communicating in other ways (eg, signs, gestures, picture cards, or sounds that are not words)?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Controlling emotions or behavior?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. with Seizures or epilepsy?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. involving the Mouth (eg, chewing, swallowing, and drooling)?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. with Teeth and gums?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. with Digestion (eg reflux, vomiting, or constipation)?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. with Type 1 or Type 2 diabetes?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. with Growth?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Sleeping?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. with Repeated infections?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you have problems...	Problem?	1	2	3	4	5	6	7
14. with Breathing (eg asthma)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. with Chronic open skin areas (eg chronic open wounds)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. with other Skin problems (eg eczema)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. with the Heart (such as a birth defect)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. with Pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Do you have any other health problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, specify problem:						

Section 3	
1. Are you currently taking <u>prescription</u> medication for pain on a regular basis?	88/Refused
<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> 99. I don't know	
2. Are you currently taking <u>prescription</u> medication for itch on a regular basis?	88/Refused
<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> 99. I don't know	
3. In the past 12 months , did you take medication for being, worried, tense, or anxious?	88/Refused
<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> 99. I don't know	
4. In the past 12 months, did you take medication for being sad, empty, or depressed?	88/Refused
<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> 99. I don't know	
5. Since your last research study questionnaire, have you received psychological therapy or counseling due to your burn injury?	88/Refused
<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> 99. I don't know	

Interviewer instructions: Write in 88 for refused or 99 for unknown for this section

Section 4					
The following questions ask about your appearance:					
	Definitely true = 1	Mostly true = 2	Not sure = 3	Mostly false = 4	Definitely false = 5
1. I feel that the burn is unattractive to others.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. I think people would not want to touch me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. I feel unsure of myself among strangers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Changes in my appearance have interfered with my relationships.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Interviewer instructions: Write in 88 for refused or 99 for unknown for this section

Section 5				
This is a list of problems that kids sometimes have after experiencing an upsetting event. Read each one carefully and then choose the response that best describes how often that problem has bothered you IN THE LAST 2 WEEKS.				
	Not at all or only at one time=0	Once a week or less/ once in a while=1	2 to 4 times a week/ half the time=2	5 or more times a week/ almost always=3
1. Having upsetting thoughts or images about your burn injury that came into your head when you didn't want them to	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Having bad dreams or nightmares	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Acting or feeling as if your burn injury was happening again (hearing something or seeing a picture about it and feeling as if I am there again)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Feeling upset when you think about it or hear about your burn injury (for example, feeling scared, angry, sad, guilty, etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Having feelings in your body when you think about or hear about your burn injury (for example, breaking out into a sweat, heart beating fast)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Trying not to think about, talk about, or have feelings about your burn injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Not at all or only at one time=0	Once a week or less/ once in a while=1	2 to 4 times a week/ half the time=2	5 or more times a week/ almost always=3
7. Trying to avoid activities, people, or places that remind you of your burn injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Not being able to remember an important part of your burn injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Having much less interest or doing things you used to do	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Not feeling close to people around you	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Not being able to have strong feelings (for example, being unable to cry or unable to feel happy)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Feeling as if your future plans or hopes will not come true (for example, you will not have a job or getting married or having kids)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Having trouble falling or staying asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Feeling irritable or having fits of anger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Having trouble concentrating (for example, losing track of a story on television, forgetting what you read, not paying attention in class)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Being overly careful (for example, checking to see who is around you and what is around you)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Being jumpy or easily startled (for example, when someone walks up behind you)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section 6*Interviewer instructions: Write in 88 for refused or 99 for unknown for this section***Please respond to each item by marking one box per row.**

In the past 7 days...	Never	Almost Never	Some- times	Often	Almost always
1. I felt mad	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. I felt upset	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. I felt fed up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I was so angry I felt like throwing something	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. I was so angry I felt like yelling at somebody	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section 7*Interviewer instructions: Write in 88 for refused or 99 for unknown for this section***Please respond to each question or statement by marking one box per row.**

Physical Function In the past 7 days...	With no trouble	With a little trouble	With some trouble	With a lot of trouble	Not able to do
I could do sports and exercise that other kids my age could do	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
I could get up from the floor	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
I could walk up stairs without holding on to anything	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
I have been physically able to do the activities I enjoy most	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

<u>Anxiety</u> In the past 7 days...	Never	Almost never	Sometimes	Often	Almost always
I felt like something awful might happen	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
I felt nervous	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
I felt worried	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
I worried when I was at home	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<u>Depressive symptoms</u> In the past 7 days...	Never	Almost never	Sometimes	Often	Almost always
I felt everything in my life went wrong	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
I felt lonely	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
I felt sad	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
It was hard for me to have fun	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<u>Fatigue</u> In the past 7 days...	Never	Almost never	Sometimes	Often	Almost always
Being tired made it hard for me to keep up with my schoolwork	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
I got tired easily	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
I was too tired to do sports or exercise	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
I was too tired to enjoy the things I like to do	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<u>Peer relationships</u> In the past 7 days...	Never	Almost never	Sometimes	Often	Almost always
I felt accepted by other kids my age	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
I was able to count on my friends	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
My friends and I helped each other out	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Other kids wanted to be my friend	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

Pain Interference In the past 7 days...	Never	Almost never	Sometimes	Often	Almost always
I had trouble sleeping when I had pain	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
It was hard for me to pay attention when I had pain	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
It was hard for me to run when I had pain	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
It was hard for me to walk one block when I had pain	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

Pain Intensity In the past 7 days...											
How bad was your pain on average?...	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10
	No pain								Worst pain you can think of		
88/Refused											
99/Unknown											

Section 8 <i>Interviewer instructions: Write in 88 for refused or 99 for unknown for this section</i>					
Indicate how much you agree or disagree:					
	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
1. My life is going well.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
2. My life is just right.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
3. I have a good life.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
4. I have what I want in life.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

Section 9	
Currently:	
1. Do you take personal responsibility for grooming when asked? <input type="checkbox"/> 1. Often <input type="checkbox"/> 2. Sometimes <input type="checkbox"/> 3. Never	88/Refused 99/Unknown

Approximately how many times a month do you usually participate in the following activities outside of your home?	
2. Shopping <input type="checkbox"/> 1. Never <input type="checkbox"/> 2. One to four times <input type="checkbox"/> 3. 5 or more times	<div>88/Refused</div> <div>99/Unknown</div>
3. Leisure activities such as movies, sports, and restaurants. <input type="checkbox"/> 1. Never <input type="checkbox"/> 2. One to four times <input type="checkbox"/> 3. 5 or more times	<div>88/Refused</div> <div>99/Unknown</div>
4. Visiting friends or relatives <input type="checkbox"/> 1. Never <input type="checkbox"/> 2. One to four times <input type="checkbox"/> 3. 5 or more times	<div>88/Refused</div> <div>99/Unknown</div>
5. When you participate in leisure activities do you usually do this alone or with others? <input type="checkbox"/> 1. Mostly alone <input type="checkbox"/> 2. Mostly with friends who have burn injuries <input type="checkbox"/> 3. Mostly with family members <input type="checkbox"/> 4. Mostly with friends who do not have burn injuries <input type="checkbox"/> 5. With a combination of family and friends <input type="checkbox"/> 77. Not applicable (no leisure activities)	<div>88/Refused</div> <div>99/Unknown</div>
6. Do you have a best friend with whom you confide? <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> 99. I don't know	<div>88/Refused</div>

Section 10 Interviewer instructions: Write in 88 for refused or 99 for unknown for this section						
Please respond to each question or statement by marking one box per row.						
In the past 7 days ...		Never	Almost Never	Some-times	Often	Almost Always
I had trouble sleeping when I was itching		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I felt angry when I was itching		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
It was hard for me to pay attention when I was itching		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
It was hard for me to have fun when I was itching		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	N/A (I don't do schoolwork)	Never	Almost Never	Some-times	Often	Almost Always
I had trouble doing schoolwork when I was itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section 11*Interviewer instructions: Write in 88 for refused or 99 for unknown for this section***Please respond to each question or statement by marking one box per row.**

In the past 7 days...	No days	1 day	2-3 days	4-5 days	6-7 days
How many days did you exercise or play so hard that your body got tired?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
How many days did you exercise really hard for 10 minutes or more?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
How many days did you exercise so much that you breathed hard?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
How many days were you so physically active that you sweated?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

Section 12*Interviewer instructions: Write in 88 for refused or 99 for unknown for this section***Please respond to each question or statement by marking one box per row.**

In the past 7 days...	Never	Almost Never	Some-times	Almost always	Always
I had difficulty falling asleep	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
I slept through the night	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
I had a problem with my sleep	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
I had trouble sleeping	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

Section 13*Interviewer instructions: Write in 88 for refused or 99 for unknown for this section***Please respond to each question or statement by marking one box per row.**


In the past 4 weeks...	Never	Rarely	Some-times	Often	Always
I felt I had a strong relationship with my family	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
I felt really important to my family	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
I got all the help I needed from my family	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
My family and I had fun together	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

Section 14*Interviewer instructions: Write in 88 for refused for this section***NEXT ARE SOME QUESTIONS ABOUT WAYS PEOPLE SOMETIMES CHANGE AFTER DIFFICULT EVENTS.****For each of the next statements indicate the degree to which this change happened in your life as a result of your burn injury.**

	No change	A little	Some	A lot	Don't know
I learned how nice and helpful some people can be.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I can now handle big problems better than I used to.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know what is important to me better than I used to.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I understand how God works better than I used to.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel closer to other people (friends or family) than I used to.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I appreciate (enjoy) each day more than I used to.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I now have a chance to do some things I couldn't do before.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My faith (belief) in God is stronger than it was before.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have learned that I can deal with more things than I thought I could before.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have new ideas about how I want things to be when I grow up.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section 15**"This is the last section of the survey"**1. What is your current weight? (lbs) _____ ☐ I don't know 88/Refused2. What is your current height? (feet/inches) _____ ☐ I don't know 88/Refused

3. Where are you currently living? (Choose only one) <input type="checkbox"/> 1. Private residence <input type="checkbox"/> 2. Nursing home <input type="checkbox"/> 4. Correctional institution <input type="checkbox"/> 5. Hotel/motel <input type="checkbox"/> 6. Homeless <input type="checkbox"/> 7. Hospital		<div style="border: 1px solid black; padding: 2px; margin-bottom: 5px;">88/Refused</div> <div style="border: 1px solid black; padding: 2px;">99/Unknown</div>
4. What is your current zip code? ____-____-____ <input type="checkbox"/> Not applicable (not living in U.S.) <input type="checkbox"/> Not applicable (homeless) (code 99999 for unknown)		
5. Who are you currently living with? (Choose all that apply) <input type="checkbox"/> 4. Parent or step-parent <input type="checkbox"/> 5. Other relative (siblings, grandparents) <input type="checkbox"/> 6. Others, not part of family <input type="checkbox"/> 7. Guardian		<div style="border: 1px solid black; padding: 2px; margin-bottom: 5px;">88/Refused</div> <div style="border: 1px solid black; padding: 2px;">99/Unknown</div>
6. What is your current school status? <input type="checkbox"/> 1. In school <input type="checkbox"/> 2. Not in school	<div style="border: 1px solid black; padding: 2px; margin-bottom: 5px;">88/Refused</div> <div style="border: 1px solid black; padding: 2px;">99/Unknown</div>	<i>If you aren't going to school, why not?</i> <input type="checkbox"/> Burn related <input type="checkbox"/> Other medical problems <input type="checkbox"/> Emotional/social reasons <input type="checkbox"/> Legal reasons/jail <input type="checkbox"/> Substance abuse <input type="checkbox"/> Personal choice <input type="checkbox"/> Other <input type="checkbox"/> Not applicable (going to school) <input type="checkbox"/> I don't know
7. If the participant hadn't already returned to school before their last research study questionnaire, but they are in school now, What was your first date to return to school since your injury? (Please take your best guess if you don't know the exact date): ____/____/____		
8. How many years of education have you completed? (If you have not graduated from high school, please indicate the number of years spent in school). <input type="checkbox"/> 1. 1 year or less <input type="checkbox"/> 2. 2 years <input type="checkbox"/> 3. 3 years <input type="checkbox"/> 4. 4 years <input type="checkbox"/> 5. 5 years <input type="checkbox"/> 6. 6 years <input type="checkbox"/> 7. 7 years <input type="checkbox"/> 8. 8 years <input type="checkbox"/> 9. 9 years <input type="checkbox"/> 10. 10 years <input type="checkbox"/> 11. 11 or 12 years; no diploma <input type="checkbox"/> 12. High school diploma or equivalent (ie, GED) <input type="checkbox"/> 66. Other		<div style="border: 1px solid black; padding: 2px; margin-bottom: 5px;">88/Refused</div> <div style="border: 1px solid black; padding: 2px;">99/Unknown</div>

<p>9. Are you currently receiving <u>disability</u> income such as Social Security Disability or Private Long Term Insurance disability? (Choose all that apply)</p> <div style="display: flex; align-items: flex-start;"> <div style="margin-right: 10px;">  </div> <div> <input type="checkbox"/> 1. I am not receiving disability income <input type="checkbox"/> 2. Social Security Disability <input type="checkbox"/> 3. Private long term insurance disability income <input type="checkbox"/> 4. Supplemental security income (SSI) <input type="checkbox"/> 5. Worker's compensation <input type="checkbox"/> 6. Other (please specify) _____ <input type="checkbox"/> 99. I don't know </div> </div> <div style="margin-top: 10px; text-align: right;"> <div style="border: 1px solid black; padding: 2px 5px; display: inline-block;">88/Refused</div> <div style="border: 1px solid black; padding: 2px 5px; display: inline-block;">99/Unknown</div> </div>	<p><i>If yes, are you receiving disability income due to your burn injury?</i></p> <input type="checkbox"/> 1. Yes, I am receiving disability income due to my burn injury <input type="checkbox"/> 2. No, I am not receiving disability income due to my burn injury <input type="checkbox"/> 77. Not applicable (not receiving disability income) <input type="checkbox"/> 99. I don't know
<p>10. Do you currently have any physical problems, such as a mobility impairment (difficulty moving your arms, legs or body)?</p> <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> 99. I don't know </div> <div style="text-align: right;"> <div style="border: 1px solid black; padding: 2px 5px; display: inline-block;">88/Refused</div> </div> </div>	

Length of interview: _____

"Is there anything else you would like to tell us? _____"

Thank you very much for sharing your experiences with us."