ID:__________ Date:______________

Memorial Symptom Assessment Scale (PEDIATRICS 7–12)

We want to find out how you have been feeling the last 2 days. Use a pencil or crayon to circle your answers.

EXAMPLE

Did you have any pain yesterday or today?

Yes or No

If Yes

* How much of the time did you have pain?

1-A very short time 2-A medium amount 3-Almost all the time

* How much pain did you feel?

1-A little 2-A medium amount 3-A lot

* How much did the pain bother you or trouble you?

0-Not at all 1-A little 2-A medium amount 3-Very much

1. Did you feel more tired yesterday or today than you usually do?

   Yes or No

   If Yes

   * How long did it last?

   1-A very short time 2-A medium amount 3-Almost all the time

   * How tired did you feel?

   1-A little 2-A medium amount 3-Very tired

   * How much did being tired bother you or trouble you?

   0-Not at all 1-A little 2-A medium amount 3-Very much

2. Did you feel yesterday or today?

   Yes or No

   If Yes

   * How long did you feel sad?

   1-A very short time 2-A medium amount 3-Almost all the time

   * How sad did you feel?

   1-A little 2-A medium amount 3-Very sad

   * How much did feeling sad bother you or trouble you?

   0-Not at all 1-A little bit 2-A medium amount 3-Very much

3. Were you itchy yesterday or today?

   Yes or No

ID:____________ Date:__________________

If Yes

* How much of the time were you itchy?

1-A very short time 2-A medium amount 3-Almost all the time

* How itchy were you?

1-A little 2-A medium amount 3-Very itchy

* How much did being itchy bother you or trouble you?

0-Not at all 1-A little 2-A medium amount 3-Very much

4. Did you have any pain yesterday or today?

Yes or No

If Yes

* How much of the time did you have pain?

1-A very short time 2-A medium amount 3-Almost all the time

* How much pain did you feel?

1-A little 2-A medium amount 3-A lot

* How much did the pain bother you or trouble you?

0-Not at all 1-A little 2-A medium amount 3-Very much

5. Did you feel worried yesterday or today?

Yes or No

If Yes

* How much of the time did you feel worried?

1-A very short time 2-A medium amount 3-Almost all the time

* How worried did you feel?

1-A little 2-A medium amount 3-Very worried

* How much did feeling worried bother you or trouble you?

0-Not at all 1-A little 2-A medium amount 3-Very much

6. Did you feel like eating yesterday or today as you normally do?

Yes or No

If No

* How long did this last?

1-A very short time 2-A medium amount 3-Almost all the time

* How much did this bother you or trouble you?

0-Not at all 1-A little 2-A medium amount 3-Very much

ID:____________ Date:________________

7. Did you feel like you were going to vomit (or going to throw up) yesterday or today?

Yes or No

If Yes
* How much of the time did you feel like you *could* vomit (or could throw up)?
1-A very short time 2-A medium amount 3-Almost all the time

* How much did this feeling bother you or trouble you?
0-Not at all 1-A little 2-A medium amount 3-Very much

8. Did you have trouble going to sleep the last 2 nights?
Yes or No

If Yes
* How much did not being able to sleep bother you or trouble you?
0-Not at all 1-A little 2-A medium amount 3-Very much

Other:
If you had anything else which made you feel bad or sick yesterday or today, write it here:

How much did this bother you or trouble you?
0-Not at all 1-A little bit 2-A medium amount 3-Very much

* How much did this bother you or trouble you?
0-Not at all 1-A little bit 2-A medium amount 3-Very much

1. Did you feel like you were going to vomit (or going to throw up) yesterday or today?

   Yes or No

   If so, how much did you feel like you could vomit (or could throw up)?
   Please put a mark on the line

   Not at all-- Almost all the time

2. How sad have you been feeling in the last 2 days?
   Please put a mark on the line

   Not at all Sad---Very Sad

3. During the past 2 days how has your body been feeling?
   Please put a mark on the line

   Normal--Very Sick

ID:____________ Date:_________________

4. PAIN SCALE:
   Mark on the line below how much pain you had during the past 2 days.

   No Pain--A lot of pain