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Imagery/Discomfort Questionnaire*

General Information

1. Young person's name _____
Preferred or nickname _____
Special pronunciation _____
Birth date _____

2. Mother's name _____
Address _____

3. Father's name _____
Address _____

4. Young person's primary physician
Doctor's name _____
Address _____

Phone _____

5. Other doctors involved with young person's care
Doctor's name _____
Address _____

Phone _____

*Adapted from: Olness KN Kohen DP: *Hypnosis and Hypnotherapy with Children*. Guilford Press, ed 3., 1996.

The following questions are for the child or teen-ager to answer.

6. What kinds of things make you laugh most often?

- | | |
|--|-------------------------------------|
| <input type="checkbox"/> Jokes | <input type="checkbox"/> Silly Play |
| <input type="checkbox"/> Cartoons/Comics | <input type="checkbox"/> Stories |
| <input type="checkbox"/> Other stuff: | |

7. What is your favorite place away from home?

- | | | |
|---------------------------------------|-------------------------------------|---|
| <input type="checkbox"/> Park | <input type="checkbox"/> Ocean | <input type="checkbox"/> Friend's house |
| <input type="checkbox"/> Beach | <input type="checkbox"/> Lake | <input type="checkbox"/> Zoo |
| <input type="checkbox"/> Mountains | <input type="checkbox"/> River | <input type="checkbox"/> Amusement |
| <input type="checkbox"/> Desert | <input type="checkbox"/> School | <input type="checkbox"/> Park |
| <input type="checkbox"/> Cabin | <input type="checkbox"/> A City | |
| <input type="checkbox"/> Forest/woods | <input type="checkbox"/> Playground | |
| <input type="checkbox"/> Other _____ | | |

8. What activity is the most fun for you? Circle the *most* fun activity and check four others.

- | | | |
|--|--|--|
| <input type="checkbox"/> Reading | <input type="checkbox"/> Dancing | <input type="checkbox"/> Studying |
| <input type="checkbox"/> Watching TV | <input type="checkbox"/> School | <input type="checkbox"/> Going to the zoo |
| <input type="checkbox"/> Listening to
music | <input type="checkbox"/> Playing with
friends | <input type="checkbox"/> Sledding |
| <input type="checkbox"/> Playing with
toys/dolls | <input type="checkbox"/> Gymnastics | <input type="checkbox"/> Soccer |
| <input type="checkbox"/> Computer stuff | <input type="checkbox"/> Running | <input type="checkbox"/> Snow Skiing |
| <input type="checkbox"/> Daydreaming | <input type="checkbox"/> Football | <input type="checkbox"/> Doing puzzles |
| <input type="checkbox"/> Playing a
musical instrument | <input type="checkbox"/> Walking/hiking | <input type="checkbox"/> Chess/checkers |
| <input type="checkbox"/> Water skiing | <input type="checkbox"/> Swimming | <input type="checkbox"/> Baseball |
| <input type="checkbox"/> Gardening | <input type="checkbox"/> Boating | <input type="checkbox"/> Basketball |
| <input type="checkbox"/> Other stuff: | <input type="checkbox"/> Fishing | <input type="checkbox"/> Hockey |
| | <input type="checkbox"/> Hunting | <input type="checkbox"/> Playing with pets |
| | | <input type="checkbox"/> Board games |

9. What do you do best?

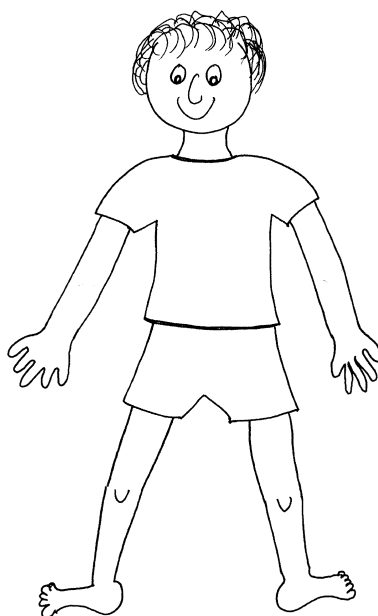
- | | | |
|--------------------------------------|----------------------------------|----------------------------------|
| <input type="checkbox"/> School work | <input type="checkbox"/> Art | <input type="checkbox"/> Camping |
| <input type="checkbox"/> Dance | <input type="checkbox"/> Sports | <input type="checkbox"/> Reading |
| <input type="checkbox"/> Music | <input type="checkbox"/> Writing | <input type="checkbox"/> Other |

Your discomfort/pain

10. Select and describe what bothers you the *most* at this time. Please choose just one:

- | | | |
|--|---|--|
| <input type="checkbox"/> Pain | <input type="checkbox"/> Anxiety/Worries | <input type="checkbox"/> Fatigue/tiredness |
| <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Loss of appetite | |
| <input type="checkbox"/> Other stuff: | | |

11. Please draw in the areas where you have this discomfort. Add any notes you want to:



12. Do you have any other discomfort at the same time? Yes No

If you answered yes, what is the discomfort like?

- | | | |
|---|-----------------------------------|-------------------------------------|
| <input type="checkbox"/> Stomachache | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Drowsiness |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Fear | <input type="checkbox"/> Sweating | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Loss of Appetite | <input type="checkbox"/> Sneezing | <input type="checkbox"/> Runny nose |
| <input type="checkbox"/> Tired | <input type="checkbox"/> Sadness | |

Pain (describe it):

Other (describe it):

13. What do you do or how do you act when you are...

Afraid/worried _____

Happy _____

Frustrated _____

14. My discomfort feels...(Check all that apply)

- | | | |
|---|------------------------------------|--------------------------------------|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Squeezing | <input type="checkbox"/> Sickening |
| <input type="checkbox"/> Stabbing | <input type="checkbox"/> Sensitive | <input type="checkbox"/> Exhausting |
| <input type="checkbox"/> Jabbing | <input type="checkbox"/> Intense | <input type="checkbox"/> Throbbing |
| <input type="checkbox"/> Achy | <input type="checkbox"/> Itchy | <input type="checkbox"/> Dull |
| <input type="checkbox"/> Pulsing | <input type="checkbox"/> Gnawing | <input type="checkbox"/> Suffocating |
| <input type="checkbox"/> Shooting | <input type="checkbox"/> Tight | <input type="checkbox"/> Hot/burning |
| <input type="checkbox"/> Out of control | <input type="checkbox"/> Wretched | <input type="checkbox"/> Blah! |
| <input type="checkbox"/> Stinging | <input type="checkbox"/> Fearful | |
| <input type="checkbox"/> Twisting | <input type="checkbox"/> Hopeless | |

15. The color of my discomfort is usually...

- | | | |
|---------------------------------------|---------------------------------|--------------------------------|
| <input type="checkbox"/> Purple | <input type="checkbox"/> Yellow | <input type="checkbox"/> Black |
| <input type="checkbox"/> Blue | <input type="checkbox"/> Orange | <input type="checkbox"/> White |
| <input type="checkbox"/> Green | <input type="checkbox"/> Red | |
| <input type="checkbox"/> Other: _____ | | |

16. The shape of my discomfort is usually...

- | | | |
|---------------------------------------|-------------------------------------|---------------------------------|
| <input type="checkbox"/> Circle | <input type="checkbox"/> Triangle | <input type="checkbox"/> Cloudy |
| <input type="checkbox"/> Rectangle | <input type="checkbox"/> Big blotch | |
| <input type="checkbox"/> Square | <input type="checkbox"/> Jagged | |
| <input type="checkbox"/> Other: _____ | | |

17. The discomfort occurs...

- | | |
|---|---|
| <input type="checkbox"/> Constantly | <input type="checkbox"/> 4-5 times a week |
| <input type="checkbox"/> Rarely | <input type="checkbox"/> many times daily |
| <input type="checkbox"/> Once a day | |
| <input type="checkbox"/> 1-3 times a week | |

18. My discomfort keeps me from... (number the top five)

- | | |
|--|---|
| <input type="checkbox"/> Wakes me at night | <input type="checkbox"/> Having more energy |
| <input type="checkbox"/> Going to school | <input type="checkbox"/> Eating |
| <input type="checkbox"/> Doing my homework | <input type="checkbox"/> Being on a team |
| <input type="checkbox"/> Concentrating at school | <input type="checkbox"/> Baseball |
| <input type="checkbox"/> Playing outside | <input type="checkbox"/> Football |
| <input type="checkbox"/> Playing with pets | <input type="checkbox"/> Soccer |
| <input type="checkbox"/> Playing with friends | <input type="checkbox"/> Basketball |
| <input type="checkbox"/> Reading | <input type="checkbox"/> Hockey |
| <input type="checkbox"/> Playing sports | <input type="checkbox"/> Dancing |
| <input type="checkbox"/> Riding my bike | <input type="checkbox"/> Tennis |
| <input type="checkbox"/> Sleeping at friends | <input type="checkbox"/> Swimming |
| <input type="checkbox"/> Playing music | <input type="checkbox"/> Track |
| <input type="checkbox"/> Feeling better | <input type="checkbox"/> Gymnastics |
| <input type="checkbox"/> Watching TV/Movies | |

Other: _____

19. What is your favorite color? _____

20. What is your favorite kind of music? _____

21. Do you like to play imaginary games? Yes No

22. Can you imagine a...

Smell? Which smell? _____

Taste? Which taste? _____

Song? Which song(s)? _____

23. Can you imagine the feeling of floating in a bathtub or swimming pool?

Yes No

24. Can you imagine the feeling of petting a favorite pet?

Yes No

25. Is there anything else you want to write or draw about what you like to imagine? You may use this page.