Child SCOAT6™

Sport Concussion Office Assessment Tool Supplementary Material

For Children Ages 8 to 12 Years

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Developed by: The Concussion in Sport Group (CISG)

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Supplementary Material for Child Sport Concussion Office Assessment Tool 6 - Child SCOAT6™

Child SCOAT6™ PACE Self-Efficacy Questionnaire

Self Report (10+ Years)

Name: **Date of Examination:** **Age:**

Gender: **Male** ☐ **Female** ☐ **Other** **Prefer not to say** ☐

MR #: **Date of Birth:** **Date of Injury:**

Visit Number (Circle One): 1 2 3 4 5 6

Administered (Circle One): **Pre-Interview** **Post-Interview/Pre-Testing** **Post-Testing** **Post-Feedback**

Please rate how confident you are in doing the following actions as they relate to your concussion.

Rate your degree of confidence that you can do the following actions now. Tell us by writing a number from 0 (Not confident I can do it) to 10 (Highly Confident I can do it) in the box next to each action statement using the scale below:

Not confident I can do it — Somewhat confident I can do it — Highly confident I can do it

0 1 2 3 4 5 6 7 8 9 10

	Practice: I am confident...	Confidence 0-10
P1	I can lift a 10 pound/5kg weight	
P2	I can lift a 250 pound/115kg weight	

	Think about your concussion recovery. I am confident...	Confidence 0-10
1	I can make sure that my symptoms do not stress me out.	
2	I can identify sources of stress in my life that affect my recovery.	
3	I can control things in my life to allow my brain to heal.	
	Managing my Stress Scale/ Mean Total =	∑ 1-3= /3 =
4	I can know when to take breaks and when to push myself.	
5	I can identify which classes or activities do not increase my symptoms.	
6	I can stop myself from "pushing through" my symptoms when working on schoolwork.	
7	I can speak up for myself so that I can take breaks and manage symptoms.	
8	I can find the right amount of activity that is not too little and not too much.	
9	I can block out times during the day when I need to take rest breaks.	
	Managing my Activity Scale/ Mean Total =	∑ 4-9= /6 =
10	I can go to my teachers when I need help with my symptoms in school.	
11	I can work with my parents or school to build a schedule that is manageable.	
12	I can help my parents, teachers, or doctors develop and adjust a plan to help me get better.	
13	I can ask an adult to help me find things that make me feel better.	
	Seeking Adult Assistance Scale/ Mean Total =	∑10-13= /4 =
14	I can continue doing some things that I enjoy, even though I have a concussion.	
15	I can see myself returning to my normal life.	
16	I can tell that I can do more since I was first injured.	
17	I can stay positive during my recovery.	
	Maintaining Positive Outlook Scale/ Mean Total =	∑14-17= /4 =
	PACE-SE Total Mean Score =	∑ = /4 =

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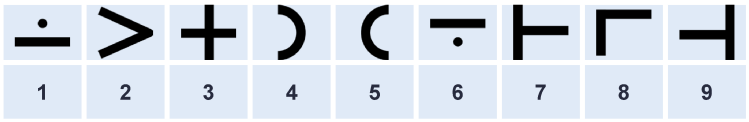
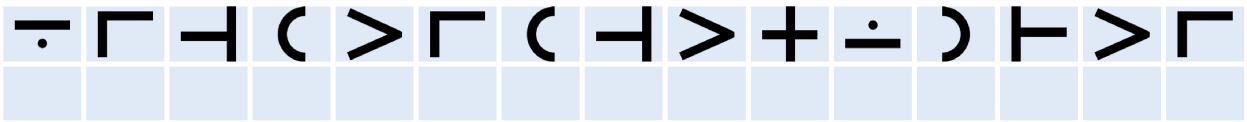
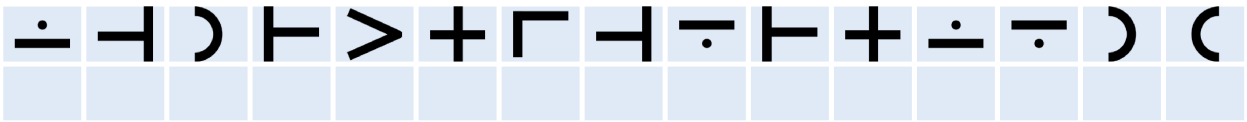
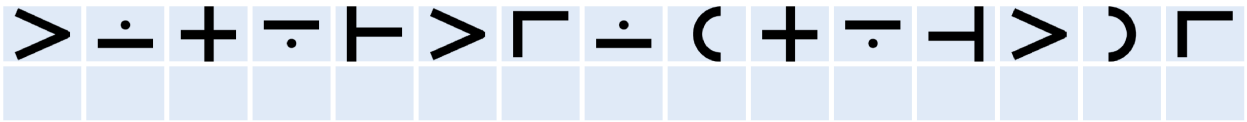
Child SCOAT6™ Symbol Digit Modalities Test

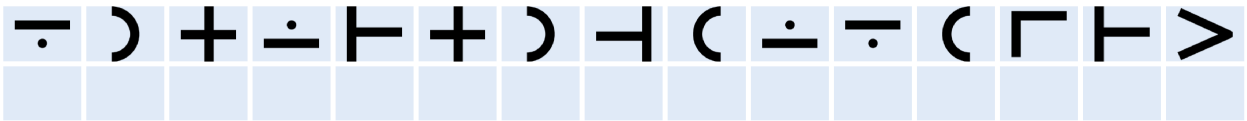
Key:

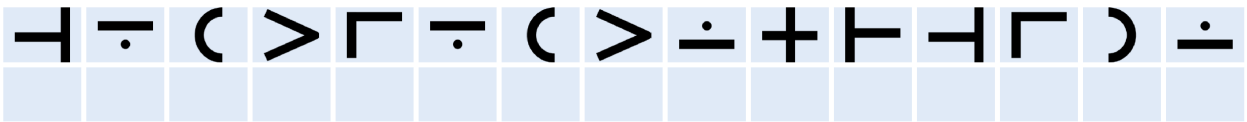












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Child SCOAT6™ Pediatric Anxiety Short Form 8a

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

In the past 7 days...	Never	Almost Never	Sometimes	Often	Almost Always
I felt like something awful might happen	1	2	3	4	5
I felt nervous	1	2	3	4	5
I felt scared	1	2	3	4	5
I felt worried	1	2	3	4	5
I worried when I was at home	1	2	3	4	5
I got scared really easy	1	2	3	4	5
I worried about what could happen to me	1	2	3	4	5
I worried when I went to bed at night	1	2	3	4	5

Anxiety Screen Score:

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Child SCOAT6™ Pediatric Depressive Symptoms

Short Form 8a

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

In the past 7 days...	Never	Almost Never	Sometimes	Often	Almost Always
I could not stop feeling sad	1	2	3	4	5
I felt alone	1	2	3	4	5
I felt everything in my life went wrong	1	2	3	4	5
I felt like I couldn't do anything right	1	2	3	4	5
I felt lonely	1	2	3	4	5
I felt sad	1	2	3	4	5
I felt unhappy	1	2	3	4	5
It was hard for me to have fun	1	2	3	4	5

Depression Screen Score:

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Child SCOAT6™

Pediatric Sleep Disturbance

Short Form 4a

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

In the past 7 days...	Never	Almost Never	Sometimes	Often	Almost Always
I had difficulty falling asleep	1	2	3	4	5
I slept through the night	1	2	3	4	5
I had a problem with my sleep	1	2	3	4	5
I had trouble sleeping	1	2	3	4	5

Sleep Disturbance Score:

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Child SCOAT6™ Pediatric Sleep-Related Impairment

Short Form 4a

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

In the past 7 days...	Never	Almost Never	Sometimes	Often	Almost Always
I was sleepy during the daytime	1	2	3	4	5
I had a hard time concentrating because I was sleepy	1	2	3	4	5
I had a hard time getting things done because I was sleepy	1	2	3	4	5
I had problems during the day because of poor sleep	1	2	3	4	5

Sleep-Related Impairment Score:

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Supplementary Material for Child Sport Concussion Office Assessment Tool 6 - Child SCOAT6™

Child SCOAT6™ The Pediatric Fear Avoidance Behavior After Traumatic Brain Injury Questionnaire (PFAB-TBI)

Child Report	Strongly Disagree			Strongly Agree
1. I have put parts of my life on hold	0	1	2	3
2. I have avoided my usual activities	0	1	2	3
3. I cannot do activities which (might) make my symptoms worse	0	1	2	3
4. My school work might harm my brain	0	1	2	3
5. I should not do my normal school work with my present symptoms	0	1	2	3
6. My head pain is telling me that I have something dangerously wrong	0	1	2	3
7. I worry that when I have to think or concentrate too hard that I will bring on a headache	0	1	2	3
8. My headaches put my head and brain at risk for the rest of my life	0	1	2	3
9. I purposely avoid doing activities that might elicit a headache	0	1	2	3
10. I'm afraid that I might make my headache pain worse by concentrating too much or being too mentally active	0	1	2	3
11. I wouldn't have this much pain if there weren't something potentially dangerous going on in my head	0	1	2	3
12. I avoid external reminders of a stressful experience (for example, people, places, conversations, activities, objects, or situations)	0	1	2	3
13. I stop what I am doing when my symptoms start to get worse	0	1	2	3
14. If I know that something will make my symptoms worse I don't do it anymore	0	1	2	3
15. Because of my symptoms most days I spend more time resting than doing activities	0	1	2	3
16. Most days my symptoms keep me from doing much at all	0	1	2	3

Fear Avoidance Behaviour: Child Score:

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Child SCOAT6™ The Pediatric Fear Avoidance Behavior After Traumatic Brain Injury Questionnaire (PFAB-TBI)

Parent Report	Strongly Disagree			Strongly Agree
1. My child has put parts of his/her life on hold	0	1	2	3
2. My child has avoided his/her usual activities	0	1	2	3
3. My child cannot do activities which (might) make his/her symptoms worse	0	1	2	3
4. My child's school work might harm his/her brain	0	1	2	3
5. My child should not do his/her normal school work with his/her present symptoms	0	1	2	3
6. My child's head pain is telling me that she/he has something dangerously wrong	0	1	2	3
7. My child worries that when she/he has to think or concentrate too hard that she/he will bring on a headache	0	1	2	3
8. My child's headaches put his/her head and brain at risk for the rest of his/her life	0	1	2	3
9. My child purposely avoids doing activities that might elicit a headache	0	1	2	3
10.My child is afraid that she/he might make his/her headache pain worse by concentrating too much or being too mentally active	0	1	2	3
11. My child wouldn't have this much pain if there weren't something potentially dangerous going on in his/her head	0	1	2	3
12. My child avoids external reminders of a stressful experience (for example, people, places, conversations, activities, objects, or situations)	0	1	2	3
13. My child stops what he/she is doing when his/her symptoms start to get worse	0	1	2	3
14. If my child knows that something will make his/her symptoms worse he/she won't do it anymore	0	1	2	3
15. Because of my child's symptoms most days he/she spends more time resting than doing activities	0	1	2	3
16. Most days my child's symptoms keep him/her from doing much at all	0	1	2	3

Fear Avoidance Behaviour: Parent Score:

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