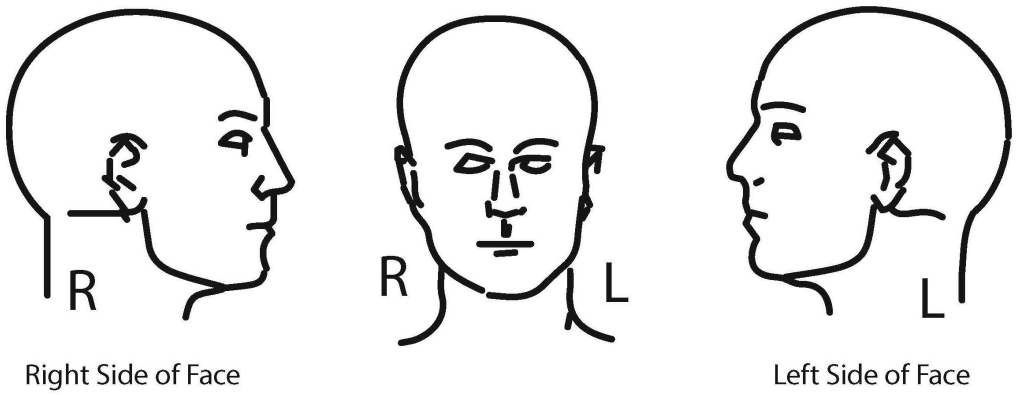
Patient ID CODE: _____

Date: _____

In the past week...

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
1. My forehead or face felt different	1	2	3	4	5
2. My forehead or face felt numb (i.e. no feeling)	1	2	3	4	5
3. I had pain in my forehead or face	1	2	3	4	5
4. I had pain in my forehead or face when touched	1	2	3	4	5
5. The skin on my forehead or face didn't like the feeling of cold objects or the cold weather	1	2	3	4	5
6. I had concerns about the feeling in my forehead or face	1	2	3	4	5
7. The skin on my forehead or face looked different than in other kids	1	2	3	4	5
8. I had difficulty raising my eyebrows	1	2	3	4	5
9. I had difficulty with moving in my face	1	2	3	4	5

Where in your forehead or face are you having these problems? Please shade in or circle the areas in the diagram below.



Tell us how much you agree with the following:

	Strongly Agree	Agree	Don't Know	Disagree	Strongly Disagree
10. I feel that I injure my face more than other kids	1	2	3	4	5
11. I cannot do the same things as other kids my age because of the feeling in my face.	1	2	3	4	5
12. I cannot do the same things as other kids my age because of the movement in my face.	1	2	3	4	5

What things are you not able to do?