

Health of the Nation Scale for Children and Adolescents (E-HoNOSCA-SR)

Self-assessment

This questionnaire is about how well you have been coping overall recently and what difficulties you have experienced in your everyday life. For each particular area, you can answer that you experienced no problems at all, minor problems, minor to moderate problems, moderately severe problems or severe problems. For each question, please choose the answer option that best applies to your situation in **the last 7 days** before admission or discharge (for stays of less than 7 days, you should consider the period since your admission, minimum the last 24 hours). If a question lists several problems, please answer the question for the problem that gave you **the most** trouble. Take as much time as you need to answer the questions and please provide an answer to all 13 questions.

		Not at all	Insignifi- cantly	Mild but definitely	Moder- ately	Severely
1.	Have you been troubled by your disruptive behaviour, physical or verbal aggression?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Have you suffered from lack of concentration or restlessness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Have you done anything to injure or harm yourself on purpose?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Have you had problems as a result of your use of Alcohol, Drugs or Solvents?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Have you experienced difficulties keeping up with your usual educational abilities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	Has any physical illness or disability restricted your activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	Have you been troubled by hearing voices, seeing things, suspicious or abnormal thoughts?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	Have you suffered from self induced vomiting, head/stomach aches with no physical cause, bedwetting or soiling?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	Have you been feeling in a low or anxious mood, or troubled by fears, obsessions or rituals?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	Have you been troubled by a lack of satisfactory friendships or bullying?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11.	Have you found it difficult to look after yourself or take responsibility for your independence?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12.	Have you been troubled by relationships in your family or substitute home?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13.	Have you stopped attending your education sessions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>