



The Cleft Collective
Closing the Gap in Cleft Research
A Scar Free Foundation Initiative

ID LABEL

You and Your Cleft at 15 years

Young person's questionnaire



University of
BRISTOL



University of the
West of England



December 2024 - Version 1

For office use only

About this research

You are being asked to complete this questionnaire because you are part of The Cleft Collective Cohort Study.

We work with all of the cleft teams in the UK to investigate the causes of cleft, the best treatments for cleft and how having a cleft may affect a person and their family.

About this questionnaire

This questionnaire has five sections:

- A. School and Other Experiences** - This section asks you questions related to school and other experiences
- B. Your Speech and Hearing** - This section asks about your speech and language development and your hearing
- C. Your Teeth** - This section asks questions about your teeth and dental treatment
- D. Your Wellbeing** - This sections asks about how you have been feeling recently
- E. Additional Questions About You** - This section includes questions not covered in any other section

Please try to answer all of the questions, even if some of them sound strange to you.

We need to ask a wide range of questions to help us understand how we can help those who have a cleft and their families.

There are no right or wrong answers. If you do not want to answer a question then just leave it blank.





How to fill in this questionnaire

Please use a black pen.

To answer the questions please put a cross in the box like this:



If you make a mistake, shade the box in like this:



then cross the correct box.

If you are answering questions which ask you to give further details, please make sure you write inside the boxes.

Who to talk to for support

If you have any questions or if you feel worried before/during/after completing this questionnaire and would like some extra help, please speak to an adult you trust. This could be your Doctor or your Cleft Team. You can also get support from the charities CLAPA (www.clapa.com) or Changing Faces (www.changingfaces.org.uk).

Thank you for completing this questionnaire!



SECTION A - SCHOOL AND OTHER EXPERIENCES

A1. These questions ask about how you feel about going to school and what it's like being there:

My school is a place where...	Strongly			Strongly	Don't know
	agree	Agree	Disagree	disagree	
a) I really like to go each day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) I learn to get along with other people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Other pupils accept me as I am	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) I like to be	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) I like to do extra work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) I feel happy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) I feel lonely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) I feel proud to be a pupil	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) I feel worried	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) People trust me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) I have a lot of fun	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l) I enjoy what I do in class	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m) I can learn what I need to know	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n) I get excited about the work we do	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o) I get upset	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p) I know people think a lot of me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
q) I get on well with other pupils in my classes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
r) People can depend on me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
s) Other pupils are very friendly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
t) I feel restless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

A2. In the past 6 months how frequently has any of the following happened to you?

	Never	1-3 times in past 6 months	More than 4 times but less than once a week	At least once a week
a) Had belongings taken	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Been threatened / blackmailed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Been hit / beaten up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Been tricked in a nasty way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Been called bad / nasty names	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Others wouldn't play with you to upset you	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Been made to do things you didn't want to do	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Had lies / nasty things said about you	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) Had games spoilt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) Had private email, messages or photos forwarded to someone else or where others can see it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) Had rumours spread about you online	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l) Got threatening or aggressive emails, instant messages, text messages or tweets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m) Had embarrassing pictures posted online without permission	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

A3. How often do any of your brothers or sisters do any of the following to you at home?

	Never	Not much (1-3 times in past 6 months)	Quite a lot (more than 4 times in the last six months)	A lot (a few times every week)	I don't have any brothers or sisters living with me at home
a) Hit, kick or push you	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Take your belongings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Call you nasty names	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Make fun of you	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION B - YOUR SPEECH & HEARING

B1. a) My talking concerns/worries me...

- Not at all A little bit A lot All the time

B1. b) Compared to my friend's talking, my speech is...

- Not at all different A little bit different Quite a lot different Very different

B1. c) The way my speech sounds, stops me talking on the phone...

- Not at all A little bit A lot All the time

B1. d) I find it easy talking to my family...

- All the time Most of the time Some of the time Never

B1. e) I find it easy to talk to friends...

- All the time Most of the time Some of the time Never

B1. f) My speech stops me from talking up in class/answering questions in class...

- Not at all A little bit A lot All the time

B1. g) My speech stops me talking to people I don't know very well (e.g in a shop)...

- Not at all A little bit A lot All the time

B1. h) Talking makes me feel tired...

- Never Some of the time Most of the time All the time

B1. i) I get upset because of my talking...

- Never Some of the time Most of the time All the time

B1. j) People say unkind things about my talking...

- Never Some of the time Most of the time All the time

B1. k) How does this make you feel?



B2. How does your speech affect you?

B3. a) Is there anything you would like to change about your speech?

Yes No

If yes, b) What would you like to change?

B4. Are there any situations you find tricky because of your talking? Which ones?

B5. These questions ask about your hearing...

	Not at all	A little bit	A lot	All of the time
a) I am concerned about my hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) My hearing can change or vary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) I find it hard hearing my family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) I find it hard to hear my friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) I find it hard to hear in social situations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) I find it hard to hear in class	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



B6. Are there any other situations you find tricky because of your hearing?
(Cross all that apply)

0) None

i) Crowded areas

ii) Large rooms

iii) Other (please specify below)

B7. Are you currently using a hearing aid?

Yes

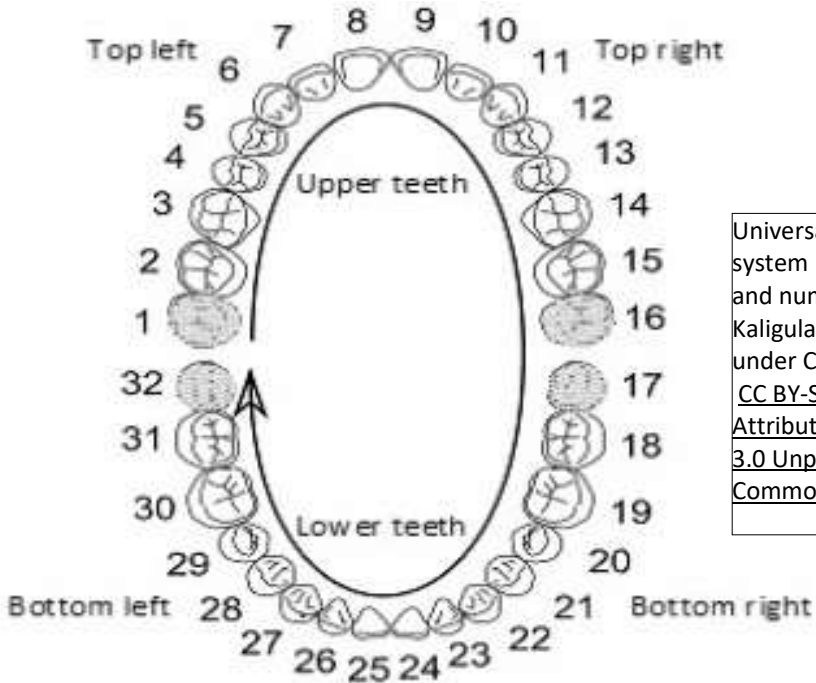
No

B8. Do you have any other concerns about your ears / hearing?



SECTION C - YOUR TEETH

Here is a teeth diagram. Please look at your own mouth carefully with a mirror.
Ignore your wisdom teeth (numbers 1, 16, 17 & 32) if you have them.
You may leave boxes blank if unsure.



Universal numbering system (teeth diagram and numbers) by Kaligula and licensed under CC-BY-SA 3.0 [CC BY-SA 3.0 Deed](#) [Attribution-ShareAlike 3.0 Unported Creative Commons](#).

C1. a) Cross the boxes next to all teeth that have had fillings or other treatments like a cap or crown. Please note that a filling can be silver or white.

Don't know

Top left: 2 3 4 5 6 7 8

Top right: 9 10 11 12 13 14 15

Bottom right: 18 19 20 21 22 23 24

Bottom left: 25 26 27 28 29 30 31



C1. b) Cross the boxes next to all teeth that have been taken out.

Don't know

Top left: 2 3 4 5 6 7 8

Top right: 9 10 11 12 13 14 15

Bottom right: 18 19 20 21 22 23 24

Bottom left: 25 26 27 28 29 30 31

C2. a) Do you like the way your teeth look now?

Yes

Yes, but I would change something

No

If no, b) why not? (Cross all that apply)

i) Gaps between teeth

ii) Crooked

iii) Too small

iv) Too big

v) Too brown

vi) Too white

vii) Blotchy

viii) Other (please specify below)

C3. When do you brush your teeth?

Once a day

Twice a day

More than twice a day

Never

C4. Do your gums bleed when you brush your teeth?

Yes

No

C5. a) Do you use a daily fluoride mouthwash?

Yes, after brushing

Yes, at a separate time to brushing

No

Don't know



If yes, b) Did your dentist recommend you use this mouthwash?

- Yes No Don't know

C6. a) What do you drink in the hour before bed? (Cross all that apply)

- 0) Nothing i) Water
 ii) Milk iii) Fruit juice
 iv) Squash v) Fizzy drinks
 vi) Energy drinks vii) Other (please specify)

C6. b) Do you brush your teeth afterwards?

- Yes No Not applicable

C7. a) Do you eat in the last hour before bed?

- Yes No

If yes, b) do you brush your teeth afterwards?

- Yes No Not applicable

C8. a) Do you have or have you ever had:

- | | Yes | No | |
|----------------------------------|--------------------------|--------------------------|--------------------------------------|
| i) Removable braces? | <input type="checkbox"/> | <input type="checkbox"/> | IF NO TO BOTH GO TO SECTION D |
| ii) Fixed braces (train tracks)? | <input type="checkbox"/> | <input type="checkbox"/> | |

If yes, b) were you given retainers at the end of your orthodontic treatment?

- No Yes, fixed to my teeth Yes, one I take in and out

If yes, c) how often do you wear your retainers?

- Every night 2-3 times a week
 Less than 2-3 times a week Never

C9. Have your teeth moved since the braces were removed?

- Yes No
 Don't know My braces have not yet been removed

SECTION D - YOUR WELLBEING

D1. Some people born with a cleft struggle with their speech, hearing or appearance and we would like to know how **you** feel.

Please cross the box to show how happy you are with each of these.



0 = very unhappy

0

1

2

3

4

5

6

7

8

9

10



10 = very happy

a) How happy are you with how your face looks?

b) How happy are you with the whole of your appearance?

c) How happy are you with your speech?

d) How happy are you with your hearing?

The following questions ask about your wellbeing. Please try to answer all of the questions, even if some of them sound strange to you. If you do not wish to answer a question then just leave it blank. All of your answers are anonymous.

If you have any questions or if you feel worried before/during/after completing this questionnaire and would like some extra help, please speak to an adult you trust. This could be your Doctor or your Cleft Team. You can also get support from the charities CLAPA (www.clapa.com) or Changing Faces (www.changingfaces.org.uk).



D2. For each question, please cross the box for 'Not true', 'Somewhat true' or 'Certainly true'.

It would help us if you answered all questions as best you can even if you are not absolutely certain or the question seems daft! Please give your answers on the basis of how things have been for you over **the last six months**.

	Not true	Somewhat true	Certainly true
a) I try to be nice to other people. I care about their feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) I am restless, I cannot stay still for long	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) I get a lot of headaches, stomach-aches or sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) I usually share with others (food, games, pens etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) I get very angry and often lose my temper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) I am usually on my own. I generally play alone or keep to myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) I usually do as I am told	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) I worry a lot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) I am helpful if someone is hurt, upset or feeling ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) I am constantly fidgeting or squirming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) I have one good friend or more	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l) I fight a lot. I can make other people do what I want	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m) I am often unhappy, down-hearted or tearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n) Other people my age generally like me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o) I am easily distracted, I find it difficult to concentrate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p) I am nervous in new situations. I easily lose confidence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
q) I am kind to younger children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
r) I am often accused of lying or cheating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
s) Other children or young people pick on me or bully me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
t) I often volunteer to help others (parents, teachers, children)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
u) I think before I do things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
v) I take things that are not mine from home, school or elsewhere	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
w) I get on better with adults than with people my own age	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
x) I have many fears, I am easily scared	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
y) I finish the work I'm doing. My attention is good	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



D3. These questions are about how **you** may have been feeling or acting recently. For each question, please say how much you have felt or acted this way in the **past two weeks**.

In the past two weeks I...	Not True	Sometimes true	True
a) Felt miserable or unhappy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Didn't enjoy anything at all	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Felt so tired that I just sat around and did nothing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Was very restless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Felt like I was no good anymore	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Cried a lot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Found it hard to think properly or concentrate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Hated myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) Felt I was a bad person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) Felt lonely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) Thought nobody really loved me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l) Thought I could never be as good as other kids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m) Felt I did everything wrong	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D4. Below is a list of sentences that describe how people feel.

For each statement, please tick the response that seems to describe **you** for **the last 3 months**. Please respond to all statements as well as you can, even if some do not seem to concern you.

	Not true or hardly ever true	Somewhat true or sometimes true	Very true or often true
a) When I feel frightened it is hard for me to breathe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) I get headaches when I am at school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) I don't like to be with people I don't know well	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) I get scared if I sleep away from home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) I worry about other people liking me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) When I get frightened, I feel like passing out	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) I am nervous	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



D4. Continued...

	Not true or hardly ever true	Somewhat true or sometimes true	Very true or often true
h) I follow my mother or father wherever they go	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) People tell me that I look nervous	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) I feel nervous with people I don't know well	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) I get stomach-aches at school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l) When I get frightened, I feel like I am going crazy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m) I worry about sleeping alone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n) I worry about being as good as other kids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o) When I get frightened, I feel like things are not real	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p) I have nightmares about something bad happening to my parents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
q) I worry about going to school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
r) When I get frightened, my heart beats fast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
s) I get shaky	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
t) I have nightmares about something bad happening to me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
u) I worry about things working out for me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
v) When I get frightened, I sweat a lot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
w) I am a worrier	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
x) I get really frightened for no reason at all	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
y) I am afraid to be alone in the house	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
z) It is hard for me to talk with people I don't know well	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
aa) When I get frightened, I feel like I am choking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
bb) People tell me that I worry too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
cc) I don't like to be away from my family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
dd) I am afraid of having anxiety (or panic) attacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D4 continued...

	Not true or hardly ever true	Somewhat true or sometimes true	Very true or often true
ee) I worry that something bad might happen to my parents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ff) I feel shy with people I don't know well	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
gg) I worry about what is going to happen in the future	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
hh) When I get frightened, I feel like throwing up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ii) I worry about how well I do things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
jj) I am scared to go to school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
kk) I worry about things that have already happened	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ll) When I get frightened, I feel dizzy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
mm) I feel nervous when I am with other children or adults and I have to do something while they watch me (for example: read aloud, speak, play a game, play a sport)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
nn) I feel nervous when I am going to parties, dances, or any place where there will be people I don't know well	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
oo) I am shy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



SECTION E - ADDITIONAL QUESTIONS ABOUT YOU

E1. a) Are you taking any medication?

Yes

No

IF NO, GO TO QUESTION E2

If yes, b) what medication are you currently taking?

If yes, c) what is the medication for?

E2. a) Since age 10, have you had any surgery to change your appearance?

Yes

No

IF NO, GO TO QUESTION E3

If yes, b) what for? (Cross all that apply)

i) Lips

ii) Nose

iii) Jaw

iv) Other (please specify below)



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SECTION Z

Z1. What is your date of birth?

DD MM YYYY

		/			/				
--	--	---	--	--	---	--	--	--	--

Z2. What is the date today?

DD MM YYYY

		/			/				
--	--	---	--	--	---	--	--	--	--

Z3. Did anyone help you fill in this questionnaire?

No, I did it by myself Yes, Mum or Dad Yes, someone else

Thank you for filling in your questionnaire!

Please use this space for anything else you want to tell us:

Who to talk to for support

If you have any questions or if you feel worried before/during/after completing this questionnaire and would like some extra help, please speak to an adult you trust. You can also get support from the charities CLAPA (www.clapa.com) or Changing Faces (www.changingfaces.org.uk).

When completed please send this back
in the freepost brown envelope to:

**The Cleft Collective
Bristol Dental School
Trinity Quay
Bristol
BS2 0NB**

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<http://www.bristol.ac.uk/cleft-collective>

