Patient Name: _____ Date: _____

Pediatric Symptom Checklist – PSC-Y

	Please mark under the heading that best fits you or circle Yes or No			For Office Use		
	NEVER 0	SOMETIMES 1	OFTEN 2	I	A	E
1. Complain of aches and pains						
2. Spend more time alone						
3. Tire easily, little energy						
4. Fidgety, unable to sit still						
5. Have trouble with teacher						
6. Less interested in school						
7. Act as if driven by motor						
8. Daydream too much						
9. Distract easily						
10. Are afraid of new situations						
11. Feel sad, unhappy						
12. Are irritable, angry						
13. Feel hopeless						
14. Have trouble concentrating						
15. Less interested in friends						
16. Fight with other children						
17. Absent from school						
18. School grades dropping						
19. Down on yourself						
20. Visit doctor with doctor finding nothing wrong						
21. Have trouble sleeping						
22. Worry a lot						
23. Want to be with parent more than before						
24. Feel that you are bad						
25. Take unnecessary risks						
26. Get hurt frequently						
27. Seem to be having less fun						
28. Act younger than children your age						
29. Do not listen to rules						
30. Do not show feelings						
31. Do not understand other people's feelings						
32. Tease others						
33. Blame others for your troubles						
34. Take things that do not belong to you						
35. Refuse to share						
36. During the past 3 months, have you thought of killing yourself?		YES	NO			
37. Have you ever tried to kill yourself?		YES	NO			

A ≥ 7 I ≥ 5 E ≥ 7

Note – the sub scores do not impact the overall score; they are for interpretation purposes only.

TS_____

Q 36 or Q 37 = Y TS ≥ 30

FOR OFFICE USE ONLY:

Plan for Follow-up: ☐ **Annual screening** ☐ **Return visit w/PCP** ☐ **Referred to counselor**

☐ **Parent declined** ☐**Already in treatment** ☐ **Referred to other professional**