**A Survey From Your Healthcare Provider**

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| Name: | | | | | | | Date: | | | | | | |
| **Please mark under the answer that best fits you** | | | | | | | **Never** | | | **Sometimes** | | | **Often** |
| 1. Complain of aches or pains | | | | | | |  | | |  | | |  |
| 1. Spend more time alone | | | | | | |  | | |  | | |  |
| 1. Tire easily, little energy | | | | | | |  | | |  | | |  |
| 1. Fidgety, unable to sit still | | | | | | |  | | |  | | |  |
| 1. Have trouble with teacher | | | | | | |  | | |  | | |  |
| 1. Less interested in school | | | | | | |  | | |  | | |  |
| 1. Act as if driven by motor | | | | | | |  | | |  | | |  |
| 1. Daydream too much | | | | | | |  | | |  | | |  |
| 1. Distract easily | | | | | | |  | | |  | | |  |
| 1. Are afraid of new situations | | | | | | |  | | |  | | |  |
| 1. Feel sad, unhappy | | | | | | |  | | |  | | |  |
| 1. Are irritable, angry | | | | | | |  | | |  | | |  |
| 1. Feel hopeless | | | | | | |  | | |  | | |  |
| 1. Have trouble concentrating | | | | | | |  | | |  | | |  |
| 1. Less interested in friends | | | | | | |  | | |  | | |  |
| 1. Fight with other children | | | | | | |  | | |  | | |  |
| 1. Absent from school | | | | | | |  | | |  | | |  |
| 1. School grades dropping | | | | | | |  | | |  | | |  |
| 1. Down on yourself | | | | | | |  | | |  | | |  |
| 1. Visit doctor with doctor finding nothing wrong | | | | | | |  | | |  | | |  |
| 1. Have trouble sleeping | | | | | | |  | | |  | | |  |
| 1. Worry a lot | | | | | | |  | | |  | | |  |
| 1. Want to be with parent more than before | | | | | | |  | | |  | | |  |
| 1. Feel that you are bad | | | | | | |  | | |  | | |  |
| 1. Take unnecessary risks | | | | | | |  | | |  | | |  |
| 1. Get hurt frequently | | | | | | |  | | |  | | |  |
| 1. Seem to be having less fun | | | | | | |  | | |  | | |  |
| 1. Act younger than children your age | | | | | | |  | | |  | | |  |
| 1. Do not listen to rules | | | | | | |  | | |  | | |  |
| 1. Do not show feelings | | | | | | |  | | |  | | |  |
| 1. Do not understand other people’s feelings | | | | | | |  | | |  | | |  |
| 1. Tease others | | | | | | |  | | |  | | |  |
| 1. Blame others for your troubles | | | | | | |  | | |  | | |  |
| 1. Take things that do not belong to you | | | | | | |  | | |  | | |  |
| 1. Refuse to share | | | | | | |  | | |  | | |  |
| During the past three months, have you thought of killing yourself? | | | | | | | | | | Yes | | | No |
| Have you ever tried to kill yourself? | | | | | | | | | | Yes | | | No |
| FOR OFFICE USE ONLY | | | | | | | | | | **TS**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Cutoff scores for Interpretation | | Internalizing problems ≥ 5 | | Externalizing problems ≥ 7 | | Attention Problems ≥ 7 | | | Q36 or Q37= Y | | | TS ≥ 30 | |
| Plan for follow-up | | | | | | | | | | | | | |
| Annual Screening | Return visit w/ PCP | | Referred to counselor | | Parent declined | | | Already in treatment | | | Referred to other professional | | |

Source: Pediatric Symptom Checklist – Youth Report (PSC-Y)