Today's Date___/___/_____

Patient's name _____

Date of birth ____/____/_____
(Place sticker here)

AGES 4-14
PEDIATRIC SYMPTOM CHECKLIST – 17

	Please mark under the heading that best fits your child			For office use		
	NEVER	SOMETIMES	OFTEN	*I*	*A*	*E*
1. Fidgety, unable to sit still						
2. Feels sad, unhappy						
3. Daydreams too much						
4. Refuses to share						
5. Does not understand other people's feelings						
6. Feels hopeless						
7. Has trouble concentrating						
8. Fights with other children						
9. Is down on him or herself						
10. Blames others for his or her troubles						
11. Seems to behaving less fun						
12. Does not listen to rules						
13. Acts as if driven by a motor						
14. Teases others						
15. Worries a lot						
16. Takes things that do not belong to him or her						
17. Distracted easily						
TOTAL						

Does your child have any emotional or behavioral problems for which he/she needs help? ( ) N ( ) Y
Are there any services that you would like your child to receive for these problems? ( ) N ( ) Y

If yes, what services? _____

PSC17-Internalizing	≥	5
PSC17-Attention	≥	7
PSC17-Externalizing	≥	7
Total Score	≥	15