Name:
DOB:

A Survey From Your Healthcare Provider — PSC-Y

Name	Date	ID

	Please mark under the heading that best fits you or circle Yes or No	Never 0	Sometimes 1	Often 2
-	1. Complain of aches or 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 three 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

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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)