

## A Survey From Your Healthcare Provider

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	

FOR OFFICE USE ONLY

Cutoff Scores for Interpretation:

$I \geq 5$

$E \geq 7$

$A \geq 7$

**TS** \_\_\_\_\_

$Q 36 \text{ or } Q 37 = Y$

$TS \geq 30$

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)