Comprehensive screening is important to understand the total health of your child. Please complete this page if you have any questions about your child's mental or behavioral health.

PEDIATRIC SYMPTOM CHECKLIST (PSC -17)

PARENT COMPLETED VERSION

Child/Youth's Name: ____

Today's Date: ____________________

Date of Birth: ____________________

Person Completing Form:____

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions, or learning, you may help your child get the best care possible by answering these questions. Please indicate which statement best describes your child.				**Office Use**		
	Never (0)	**Sometimes (1)**	**Often (2)**	**I**	**A**	**E**
Does your child (Please Mark)	**0**	**1**	**2**			
1.Feel sad.						
2. Feel hopeless.						
3. Feel down on themselves.						
4. Worry a lot.						
5. Seem to be having less fun.						
6. Fidget, is unable to sit still.						
7. Daydreams too much.						
8. Distract easily.						
9. Have trouble concentrating.						
10. Act if driven by a motor.						
11. Fight with other children.						
12. Not listen to rules.						
13. Not understand people's feelings.						
14. Tease others.						
15. Blame others for their troubles.						
16. Refuse to share.						
17. Take things that do not belong to them.						
Total						
Highlight if child meets any cut off score in any area	**≥ 15**			**≥ 5**	**≥ 7**	**≥ 7**

Do any of the above concerns impact your child's performance at school, home, or with friends? Yes No

Does the child's biological mother, father, or siblings had any of the following concerns? (Please circle)

ADHD Anxiety Obsessive Compulsive Disorder Depression Bipolar Disorder Learning Disorders