Pali ades
Pediatric

Dr. Ha cares a lot about how you are doing. We would like you to answer a few questions for us before your visit starts to help us talk about how things are going for you.

Has anything ever happened to you or someone else that was really scary, dangerous or violent?

YES ( ) NO ( )

Please go to the next page and when you are finished answering the questions fold up the pages and give it to the receptionist. The answers to all questions will be kept confidential. If you cannot answer a particular question or feel uncomfortable answering it, please leave it blank. Please fill out the questionnaire as honestly as possible. You are welcome to ask the receptionist if you can sit in another room for privacy.

Name: _____ Record #: _____

Date of Birth: _____ Today's Date: _____

Youth Pediatric Symptom Checklist 17 (Y PSC-17)

Please mark under the heading that best fits you:		Never	Sometimes	Often
❖ **Fidgety, unable to sit still**	❖	0	1	2
▯ Feel sad, unhappy	▯	0	1	2
❖ **Daydream too much**	❖	0	1	2
● Refuse to share	●	0	1	2
● **Do not understand other people's feelings**	●	0	1	2
▯ Feel hopeless	▯	0	1	2
❖ **Have trouble concentrating**	❖	0	1	2
● Fight with other children	●	0	1	2
▯ **Down on yourself**	▯	0	1	2
● Blame others for your troubles	●	0	1	2
▯ **Seem to be having less fun**	▯	0	1	2
● Do not listen to rules	●	0	1	2
❖ **Act as if driven by a motor**	❖	0	1	2
● Tease others	●	0	1	2
▯ **Worry a lot**	▯	0	1	2
● Take things that do not belong to you	●	0	1	2
❖ **Distract easily**	❖	0	1	2

OFFICE USE ONLY

Total ❖ _____ Total ● _____ Total ▯ _____ Grand Total ❖ + ● + ▯ _____

Form adapted with permission for *Feelings Need Check-Ups Too*, 2004

S11+
INITIAL

OFFICE USE ONLY
Score: _____

How are You Doing?

Child's Name ..... (circle one) Male Female

Date of Birth .....

* Overall, do you think that you have difficulties in one or more of the following areas: emotions, concentration, behavior or being able to get along with other people?

No	Yes-minor difficulties	Yes-definite difficulties	Yes-severe difficulties
☐ 0	☐	☐	☐

If you have answered "Yes", please answer the following questions about these difficulties:

- How long have these difficulties been present?

Less than a month	1-5 months	6-12 months	Over a year
☐	☐	☐	☐

- Do the difficulties upset or distress you?

Not at all	A little	A medium amount	A great deal
☐ 0	☐ 1	☐ 2	☐ 3

- Do the difficulties interfere with your everyday life in the following areas?

	Not at all	A little	A medium amount	A great deal
HOME LIFE	☐ 0	☐ 1	☐ 2	☐ 3
FRIENDSHIPS	☐ 0	☐ 1	☐ 2	☐ 3
CLASSROOM LEARNING	☐ 0	☐ 1	☐ 2	☐ 3
LEISURE ACTIVITIES	☐ 0	☐ 1	☐ 2	☐ 3

- Do the difficulties make it harder for those around you (family, friends, teachers, etc.)?

Not at all	A little	A medium amount	A great deal
☐	☐	☐	☐

Signature ..... Date .....

Mother/Father/Other (please specify): .....

Thank you very much for your help