# A Survey From Your Healthcare Provider

<table>
<thead>
<tr>
<th>Name</th>
<th>Date</th>
<th>ID</th>
</tr>
</thead>
</table>

**Please mark under the heading that best fits you or circle yes or no**

<table>
<thead>
<tr>
<th>Never</th>
<th>Sometimes</th>
<th>Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

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 ≥ 5
- E ≥ 7
- A ≥ 7
- Q36 or Q37=Y
- TS ≥ 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)