



Patient Name _____

Date of Birth _____

Date of Appt _____

MR# _____

Pediatric Symptom Checklist (PSC-17 Child)

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

Office use only

Total ◆	Total □	Total ✱	Grand Total ◆+□+✱
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