

Pediatric Symptom Checklist (PSC)

Historian Name _____ Relationship to child _____ Date _____

Please indicate how often your child does the following: <i>(Use "✓" to indicate your answer"</i>	Never	Some- times	Often
1. Complains of aches and pains	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Spends more time alone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Tires easily, has little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Fidgety, unable to sit still	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Has trouble with teacher	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Less interested in school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Acts as if driven by a motor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Daydreams too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Distracted easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Is afraid of new situations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Feels sad, unhappy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

12. Is irritable, angry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Feels hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Has trouble concentrating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Less interested in friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Fights with other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Absent from school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. School grades dropping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Is down on him or herself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Visits the doctor w/doctor finding nothing wrong	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Has trouble sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Worries a lot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Want to be with you more than before	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

24. Feel he or she is bad	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Takes unnecessary risks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. Gets hurt frequently	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. Seems to be having less fun	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. Acts younger than children his/her age	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. Does not listen to rules	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. Does not show feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31. Does not understand other people's feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32. Teases others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33. Blames others for his/her troubles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34. Takes things that do not belong to him/her	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35. Refuses to share	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please include any comments, up to 200 characters: