

11+ PEDIATRIC SYMPTOM CHECKLIST-17 (Y PSC-17)

Child's Name: _____ Record #: _____
 Child's DOB: _____ Today's Date: _____

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
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Patient to fill out by him/herself