



**Coastal
Children's
Clinic**

New Bern
(252)-633-2900

Havelock
(252)447-8100

Maysville
(910)743-2022

WWW.COASTALCHILDRENS.COM

Name: _____
 DOB: _____ Chart number: _____
 Date: _____

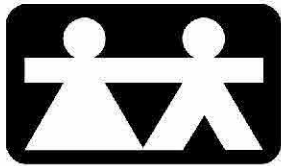
Pediatric Symptom Checklist (PSC-17)

Please mark under the heading that best describes your child:

	(0) NEVER	(1) SOMETIMES	(2) OFTEN
1. Feels sad, unhappy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Feels hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Is down on self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Worries a lot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Seems to be having less fun	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<hr/>			
6. Fidgety, unable to sit still	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Daydreams too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Distracted easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Has trouble concentrating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Acts as if driven by a motor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<hr/>			
11. Fights with other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Does not listen to rules	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Does not understand other people's feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Teases others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Blames others for his/her troubles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Refuses to share	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Takes things that do not belong to him/her	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Does your child have any emotional or behavioral problems for which she/he needs help?

__No __Yes



COASTAL CHILDRENS CLINIC

Excellence in Pediatrics For Over 50 Years!

Name: _____	Chart number: _____
DOB: _____	
Date: _____	

Adolescent Screen >12 yr old Patient

Circle or write in your answers

Who lives in your house with you? Mother, Father, Sister, Brother, _____

Do you feel safe at home? Yes/No

How many days per week do you exercise (any non-stop physical activity)? _____
How long each day? _____

When riding in a car, do you always wear a seat belt, no matter who you are with? Yes/No

Do your parents have high cholesterol (over 240) or take cholesterol medicine? Yes/No

Do you have any problems in school? (circle any potential problems)

grades worse than last year
suspension this year

failing grades
fighting

missing school

In the past 2 weeks,

How many days have you felt depressed, irritable or hopeless? None, a few days, more than half, most days

How many days have you had little interest or enjoyment doing things? None, a few days, more than half, most days

Poor appetite, weight loss, or overeating? None, a few days, more than half, most days

Feel tired or have no energy? None, a few days, more than half, most days

Feeling bad about yourself or that you are a failure, or have let your family down? None, a few days, more than half, most days

Trouble concentrating on school work, reading, or watching TV? None, a few days, more than half, most days

In the last 12 months,

Did you drink alcohol (more than a few sips)? Yes/No

Did you use marijuana? Yes/No

Did you use anything else to get high? Yes/No

Do you smoke? Yes/No

Would you like a urine test for sexually transmitted diseases today? Yes/No

Do you have any concerns you would like to talk about today?