Coastal Children's Clinic

New Bern (252)-633-2900 Havelock (252)447-8100 Maysville (910)743-2022

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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	☐	☐	☐
2. Feels hopeless	☐	☐	☐
3. Is down on self	☐	☐	☐
4. Worries a lot	☐	☐	☐
5. Seems to be having less fun	☐	☐	☐
6. Fidgety, unable to sit still	☐	☐	☐
7. Daydreams too much	☐	☐	☐
8. Distracted easily	☐	☐	☐
9. Has trouble concentrating	☐	☐	☐
10. Acts as if driven by a motor	☐	☐	☐
11. Fights with other children	☐	☐	☐
12. Does not listen to rules	☐	☐	☐
13. Does not understand other people's feelings	☐	☐	☐
14. Teases others	☐	☐	☐
15. Blames others for his/her troubles	☐	☐	☐
16. Refuses to share	☐	☐	☐
17. Takes things that do not belong to him/her	☐	☐	☐

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: _____
DOB: _____ Chart number: _____
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 | failing grades
suspension this year | 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?

_____