

DATE: _____

PATIENT NAME: _____

Pediatric Symptom Checklist - Youth Report (Y-PSC)

AGE 12 – 17 YEARS OLD

Please mark under the heading that best fits you.

		NEVER	SOMETIMES	OFTEN
	PTS	(0)	(1)	(2)
1. Complain of aches or pains	1.			
2. Spend more time alone	2.			
3. Tire easily, have little energy	3.			
4. Fidgety, unable to sit still	4.			
5. Have trouble with a teacher	5.			
6. Less interested in school	6.			
7. Act as if driven by a motor	7.			
8. Daydream too much	8.			
9. Easily distracted	9.			
10. Afraid of new situations	10.			
11. Feel sad, unhappy	11.			
12. Feel irritable, angry	12.			
13. Feel hopeless	13.			
14. Have trouble concentrating	14.			
15. Less interested in friends	15.			
16. Fight with other children	16.			
17. Absent from school	17.			
18. School grades dropping	18.			
19. Down on yourself	19.			
20. Visit doctor with doctor finding nothing wrong	20.			
21. Have trouble sleeping	21.			
22. Worry a lot	22.			
23. Want to be with parent more than before	23.			
24. Feel that you are bad	24.			
25. Take unnecessary risks	25.			
26. Get hurt frequently	26.			
27. Seem to be having less fun	27.			
28. Act younger than children your age	28.			
29. Do not listen to rules	29.			
30. Do not show feelings	30.			
31. Do not understand other people's feelings	31.			
32. Tease others	32.			
33. Blame others for your troubles	33.			
34. Take things that do not belong to you	34.			
35. Refuse to share	35.			

Do you receive any services (therapy, psychologist)? () Y () N
 If yes, what services?