

A Survey From Your Healthcare Provider – PSC-Y

Name		Date	ID		
Please mark under the heading that best fits you or circle Yes or No			Never 0	Sometimes 1	Often 2
-	1. Complain of aches or pains				
-	2. Spend more time alone				
-	3. Tire easily, little energy				
●	4. Fidgety, unable to sit still				
-	5. Have trouble with teacher				
-	6. Less interested in school				
●	7. Act as if driven by motor				
●	8. Daydream too much				
●	9. Distract easily				
-	10. Are afraid of new situations				
▲	11. Feel sad, unhappy				
-	12. Are irritable, angry				
▲	13. Feel hopeless				
●	14. Have trouble concentrating				
-	15. Less interested in friends				
■	16. Fight with other children				
-	17. Absent from school				
-	18. School grades dropping				
▲	19. Down on yourself				
-	20. Visit doctor with doctor finding nothing wrong				
-	21. Have trouble sleeping				
▲	22. Worry a lot				
-	23. Want to be with parent more than before				
-	24. Feel that you are bad				
-	25. Take unnecessary risks				
-	26. Get hurt frequently				
▲	27. Seem to be having less fun				
-	28. Act younger than children your age				
■	29. Do not listen to rules				
-	30. Do not show feelings				
■	31. Do not understand other people's feelings				
■	32. Tease others				
■	33. Blame others for your troubles				
■	34. Take things that do not belong to you				
■	35. Refuse to share				
◆	36. During the past three months, have you thought of killing yourself?			Yes	No
◆	37. Have you ever tried to kill yourself?			Yes	No

● = A ≥ 7 ▲ = I ≥ 5 ■ = E ≥ 7 | Note — the sub scores do not impact the overall score; they are for interpretation purposes only.

TS _____

FOR OFFICE USE ONLY

- Plan for Follow-up Annual screening Return visit w/ PCP Referred to counselor
 Parent declined Already in treatment Referred to other professional

Q 36 or Q 37=Y ◆ TS ≥ 30