Child's Name _____ Record Number _____
Today's Date _____ Filled out by _____
Date of Birth _____

Pediatric Symptom Checklist

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions or learning, you may help your child get the best care possible by answering these questions. Please mark under the heading that best fits your child.

			Never (0)	Sometimes (1)	Often (2)
1.	Complains of aches/pains	1			
2.	Spends more time alone	2			
3.	Tires easily, has little energy	3			
4.	Fidgety, unable to sit still	4			
5.	Has trouble with a teacher	5			
6.	Less interested in school	6			
7.	Acts as if driven by a motor	7			
8.	Daydreams too much	8			
9.	Distracted easily	9			
10.	Is afraid of new situations	10			
11.	Feels sad, unhappy	11			
12.	Is irritable, angry	12			
13.	Feels hopeless	13			
14.	Has trouble concentrating	14			
15.	Less interest in friends	15			
16.	Fights with others	16			
17.	Absent from school	17			
18.	School grades dropping	18			
19.	Is down on him or herself	19			
20.	Visits doctor with doctor finding nothing wrong	20			
21.	Has trouble sleeping	21			
22.	Worries a lot	22			
23.	Wants to be with you more than before	23			
24.	Feels he or she is bad	24			
25.	Takes unnecessary risks	25			
26.	Gets hurt frequently	26			
27.	Seems to be having less fun	27			
28.	Acts younger than children his or her age	28			
29.	Does not listen to rules	29			
30.	Does not show feelings	30			
31.	Does not understand other people's feelings	31			
32.	Teases others	32			
33.	Blames others for his or her troubles	33			
34.	Takes things that do not belong to him or her	34			
35.	Refuses to share	35			

Total score _____

Does your child have any emotional or behavioral problems for which she/he needs help? ( ) N ( ) Y
Are there any services that you would like your child to receive for these problems? ( ) N ( ) Y

If yes, what services?_____

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Pediatric Symptom Checklist Score Sheet

Client Name: _____

Client Number (From CareVoyant): _____

Scoring:

Test is invalid if 4 or more questions are left blank

Children 6 – 18:

28 and above = impaired

27 and below = not impaired

Children 3 – 5: ignore questions 5, 6, 17, 18

24 and above = impaired

23 and below – not impaired

Total Score: _____

Subscale: **Score**

Attention Problems Subscale (Questions 4, 7, 8, 9, 14) _____

*Score of 7 or higher is at risk of having significant problems in attention

Internalizing Problems Subscale (Questions 11, 13, 19, 22, 27) _____

*Score of 5 or higher may have significant impairments with anxiety and/or Depression.

Externalizing Problems Subscale (Questions 16, 29, 31, 32, 33, 34, 35) _____

*Score of 7 or higher may have significant problems with conduct

CHILDHOOD DEVELOPMENTAL HISTORY

Person Completing Form _____Relationship to Child _____Date_____

Child's Name_____Birthdate_____Age_____

Home Address_____
(Street) (City/Town) (State) (Zipcode)

Home Telephone_____ Child's School_____ Grade_____

Special School Placement or Services (if any)_____

Adults living with Child_____
(name and relationship)

Siblings (name and age)_____

PARENTS

Father_____ Occupation_____ Work Telephone_____

Mother_____ Occupation_____ Work Telephone_____

Pregnancy Complications

Vomiting____ Staining or blood loss_____ Infections____ Toxemia____ Threatened Miscarriage___
Other Illness_____
Smoking During Pregnancy____Number of cigarettes per day _____ Drug or alcohol use_____
Duration of Pregnancy (weeks)_____Other Complications_____

DELIVERY

Type of labor: Spontaneous____ Induced____ Duration (hours) ____ Birth Weight _____
Type of Delivery: Normal ____ Breech ____ Cesarean ____
Complications: Cord around neck ____ Hemorrhage__ Infant Injury ____
POST DELIVERY: Jaundice ____ Cyanosis (blue baby) ____ Incubator Care____ Infection _____
(specify)

INFANCY:

Difficult to calm or comfort _____ Colicky _____ Excessively irritable_____ Head Banging_____
Difficulty nursing____ Disturbed sleep patterns (describe)_____
Other:_____

MEDICAL HISTORY:

Childhood Diseases (describe ages and complications)_____

Hospitalizations_____
Head Injury_____ Coma_____ Convulsions with fever _____ without fever_____
Eye problems (specify)_____ Ear problems (specify) _____
Allergies (specify)_____ Asthma _____
Eating Problems_____
Sleep Disorders_____
Other Problems_____

MENTAL HEALTH HISTORY

Describe any past history of severe social, emotional or behavioral problems_____

Patient Name:_____ Date:_____

Describe any significant history of physical or emotional trauma_____

List previously seen mental health providers and addresses if available_____

PRESENT MEDICAL STATUS

Present illnesses for which the child is being treated_____
Prescription Medications_____
Name of Primary Care or other treating physicians_____
Date of last medical checkup _____
Current Smokers in Household _____

DEVELOPMENTAL MILESTONES

If you can recall, record the age at which your child reached the following developmental milestones. If you do not recall the age, check the categories to the right.

	AGE	EARLY	NORMAL	LATE
Sat without support				
Crawled				
Walked without assistance				
Spoke first words				
Said sentences				
Toilet Trained				

FAMILY HISTORY

For each of the following, please specify which relative (parents, siblings, grandparents, aunts, uncles or cousins) and which side of the family (maternal or paternal) has or had a history of the problem or disorder.

Reading Disorder_____ Thyroid Disorder_____
Math Disorder_____ Genetic Disorder_____
(Specify)
Speech Impairment_____ Depression_____
Mental Retardation_____ Bipolar Disorder_____
Epilepsy_____ Obsessive-Compulsice Disorder_____
Tic Disorder_____ Social Phobia_____
Tourette's Syndrome_____ Panic Disorder_____
Behavior Problems_____ Attention/Hyperactivity Disorder_____
(Childhood)

SCHOOL EXPERIENCE

Rate your child with regard to academic performance

GRADE	GOOD	AVERAGE	POOR
Kindergarten			
Earlier Grades			
Current Grade			

What is your child's grade level in: Reading_____ Spelling_____ Math_____
Has your child ever had to repeat a grade?_____ If so, what grade_____

Patient Name:_____ Date:_____

Has your child ever been evaluated for Special Education?_____ If so, for what reason_____
Has he/she been identified and received services?_____

BEHAVIOR CHECKLIST

Please check all of the following that apply to your child:

Is moody	Has a bad temper	Cries easily
Is a worrier	Has bad dreams	Is often sad
Is often quiet	Is fearful of new situations	Is fearful of being alone
Is often tired	Stutters or stammers	Frequent stomach aches
Frequent headaches	Wets bed or pants often	Soils or has bowel accidents
Frequent diarrhea	Frequent constipation	Overeats
Bites nails	Is slow to trust	Demands to be the center of attention
Fights with siblings	Excessively neat or orderly	Too concerned about germs or cleanliness
Tells lies	Steals	Plays with fire
Bullies other children	Is fresh or rude to adults	Is mean
Destroys own property	Destroys others property	Deliberately provokes adults
Frequently in trouble with neighbors	Is cruel to animals	Is a loner
Has no real friends	Has mostly younger friends	Has mostly older friends
Is bossed by other children	Prefers to play alone	Gets picked on
Is not liked by other children	Difficulty sustaining attention	Makes careless mistakes
Often does not seem to listen	Fails to finish things	Difficulty organizing activities
Avoids sustained mental effort	Often loses things	Easily distracted
Forgetful in daily activities	Often fidgets	Often out of his/her seat in the classroom
Is hyperactive	Difficulty playing quietly	Talks excessively
Blurts out answers before questions are completed	Difficulty waiting turn	Often interrupts or intrudes
IF YOUR CHILD IS 12 YEARS OR OLDER		
Is sexually active	Appears confused about gender	Displays interest in the same sex
Behavior is rigid and repetitive	Is troubled by obsessive thoughts	Has many health complaints
Experiences times of extreme fear or panic	Uses alcohol	Uses illegal drugs
Inhales household chemicals		

Additional Remarks: (use other side of paper if more space is required)