Your Doctor will discuss results with you CONFIDENTALLY

Please be HONEST

Mental Health Screening Tool

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= 0

● = 0 = A ≥ 7

▲ = 0 = I ≥ 5

■ = 0 = E ≥ 7

FOR OFFICE USE ONLY

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

Q 36 or Q 37=Y ◆ TS ≥ 30

Source: Pediatric Symptom Checklist – Youth Report (PSC-Y)