Pediatric Symptom Checklist (PSC)

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 indicate which statement best describes your child.

Name of Child:

Name of Person Filling Out The Form:

Please mark under the heading that best describes your child

			Never	Sometimes	Often
1.	Complains of aches and 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 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 interested in friends	15			
16.	Fights with other children	16			
17.	Absent from school	17			
18.	School grades dropping	18			
19.	Is down on him or herself	19			
20.	Visits the 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			

Does your child have any emotional or behavioral problems for which she or he needs help? N Y

Are there any services that you would like your child to receive for these problems? If yes, what services? N Y

Download and Email Completed Form to info@hwmcgc.org

Parent/Guardian Information Sheet

Please complete all know information.

Child Name: DOB: Age:

Person Completing This Form: Email:

Phone/Cell: Address:

Bio Mother: Age: Visitations: Yes No ☐ Single ☐ Married ☐ Divorced

Bio Father: Age: Visitations Yes No ☐ Single ☐ Married ☐ Divorced

Stepmother: Stepfather:

Who has legal responsibility over child?

Please tell us everyone who lives in your home:

Name: Age: Sibling Client Other Family Member (Specify)

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Name: Age: Sibling Client Other Family Member (Specify)

REFERRAL SOURCE: Who referred you to Child Guidance?

☐ It was my idea ☐ School ☐ Physician ☐ Probation ☐ Family Court ☐ Other:

CURRENT PROBLEM? Please check only those that are bringing you in today.

Conduct Problems:

- ☐ Loses temper
- ☐ Argues
- ☐ Hits
- ☐ Annoys
- ☐ Refuses Directions
- ☐ Steals
- ☐ Fights
- ☐ Runs away
- ☐ Cruel to animals
- ☐ Cruel to people
- ☐ Threatens Violence
- ☐ Sexual misconduct

Attention Problems:

- ☐ Inattentive
- ☐ Distractible
- ☐ Forgetful
- ☐ Poor Concentration
- ☐ Hyperactive
- ☐ Fidgety
- ☐ Blurts Out or Interrupts
- ☐ Impulsive (acts without thinking)

Mood:

- ☐ Depressed
- ☐ Hopeless
- ☐ Helpless
- ☐ Withdrawn
- ☐ Cries Frequently
- ☐ Isolates Frequently
- ☐ Irritable
- ☐ Angry
- ☐ Sad
- ☐ Anxious/Nervous frequently
- ☐ Thoughts of suicide

Where is your child having difficulty with these problems now?

☐ School ☐ Relationships ☐ Other:

☐ Home ☐ Self-Care

How often do these problems occur?

When did these problems start?

Using the scale below, where would you rate your problems now?

Poor		Fair		Good		Very Good		Excellent	
1	2	3	4	5	6	7	8	9	10

PREVIOUS TREATMENT: History of Child's Previous Treatment: (Check all that apply)

☐ None ☐ Outpatient Counseling/Mental Health Treatment ☐ Drug/Alcohol Counseling

☐ Inpatient Psych. Hospitalization ☐ Current or Past Psychotropic Meds-Name of meds

Has your child been treated for mental health problems? (When, where, for how long, and how effective was it?)

Has your child been in a hospital/residential program due to mental health problems or risky behaviors?

SUBSTANCE USE:
Does anyone in the home consume caffeine, tobacco, alcohol or drugs? If yes, please put a 'check' in the appropriate box. Drugs (Marijuana, RX pills, Cocaine, Heroin, Spice, etc.)

Child Sibling Client Other Family Member Living in home

Tobacco (cigarettes or chew) ☐ Child ☐ Sibling ☐ Client ☐ Other Family Member Living in Home

Alcohol (beer, wine, etc.) ☐ Child ☐ Sibling ☐ Client ☐ Other Family Member Living in Home

Caffeine (soda, coffee, tea, energy drinks, etc.) ☐ Child ☐ Sibling ☐ Client ☐ Other Family Member Living in Home

PARENT: Do you think your child using any drugs? ☐ Yes ☐ No ☐ I don't know

My child has used the following drugs:

CHILD MEDICAL/PHYSICAL CARE:

Physician: Name: Address: Phone:

Last Medical Appt: Last Dental Appt:

Child's immunizations up to date? ☐ Yes ☐ No / Child's Height: Weight:

Is the child's vision, speech, and hearing normal? ☐ Yes ☐ No If No, Explain?

List any major medical concerns your child may have**:**

CHILD DEVELOPMENTAL HISTORY:

Parents, did you have proper prenatal care? (Check One) ☐ Yes ☐ No ☐ N/A

Child's Birth Weight: Birth Length:

Was the child born premature? Explain:

Delivery method: (Check One): Natural C-Section N/A

Age of parents at child's birth: Mom: Dad: Any complications? Explain:

Prenatal Exposure to drugs? YES NO (If Yes, Please Explain)

Did the child reach his/her milestones on time? (Crawling, Walking, Talking, Potty Trained) ☐ Yes ☐ No ☐ N/A

FAMILY, SOCIAL, CULTURAL HISTORY

Are there any family members with mental illness? If yes, what kind:

Religious affiliation/How often attending services: Ethnicity/Race:

Social/Family Concern

Social/Family Strengths: Primary form of transportation?

EDUCATION/VOCATION INFORMATION:

Is your child currently in school/training program? ☐ Yes ☐ No School Name: Grade:

Special Education? ☐ Yes ☐ No Can the child read/write: ☐ Yes ☐ No

Overall academic performance: ☐ Excellent ☐ Above Average ☐ Average ☐ Below Average ☐ Failing

Attendance: ☐ Regular ☐ Poor ☐ Other: Has your child ever been held back? YES NO

If Yes, What grade?

School Conduct Issues: ☐ None ☐ Referrals ☐ Suspensions ☐ Expulsions

Please Explain:

Is the child currently employed? ☐ YES ☐ NO If yes, where:

FINANCIAL AND LEGAL HISTORY:

Place of employment of parents/legal guardians:

Do you have any current legal or financial problems? ☐ YES ☐ NO If yes, describe:

Custody Arrangement:

Is your child at risk for suicide or violence against others? ☐ Yes ☐ No

*Other risky behaviors?

☐ Substance Use *complete substance use section*
☐ Over/Under eating
☐ In abusive relationship
☐ Cutting or other self-harming
☐ Previous suicide attempt
☐ Other risky behavior:

Has your child ever experienced traumatic events? What event?

What triggers the child?

What helps them cope?

Do you have any treatment preferences?

Download and Email Completed Form to: info@hwmcgc.org or print and fax to West Bakersfield office: 661-322-7334, North Bakersfield Office: 661-393-4075, Delano Office: 661-725-1845