

Parent or Guardian to Fill Out

Patient Name: _____

Date: _____

Patient Date of Birth: _____

Pediatric Symptom Checklist-17 (PSC-17)

As per the American Academy of Pediatrics clinical guidelines, depression screenings for anyone 5 years and older are now standard of care in pediatric offices. Please answer the questions on the screening questionnaire. Your clinician will review the form during your appointment today.

Does your child:	Please mark under the heading that best fits your child.			<i>For Office Use</i>		
	Never	Sometimes	Often	I	A	E
1. Feel sad.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
2. Feel hopeless.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
3. Feel down on him/herself.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
4. Worry a lot.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
5. Seem to be having less fun.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
6. Fidget, is unable to sit still.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
7. Daydream too much.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
8. Distract easily.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
9. Have trouble concentrating.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
10. Act as if driven by a motor.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
11. Fight with other children.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
12. Not listen to rules.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
13. Not understand other people's feelings.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
14. Tease others.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
15. Blame others for his/her troubles.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
16. Refuse to share.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
17. Take things that do not belong to him/her.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
TOTAL						

Patient Name: _____

DOB: _____

Risk Assessment 7 years and older

TB risk

Was your child born in Africa/Asia/Latin America/Caribbean/Eastern Europe? YES NO

Has your child traveled to Africa/Asia/Latin America/Caribbean/Eastern Europe? YES NO

Has a family member or contact had tuberculosis or a positive tuberculin skin test? YES NO

Is your child infected with HIV? YES NO

Has your child spent time with anyone during the past year who has been in jail or a shelter, uses illegal drugs, or has HIV? YES NO

Cholesterol

Does your child have a parent or grandparent who had a stroke or heart problem before age 55? YES NO

Does your child have a parent with elevated blood cholesterol (240 or higher) or who is taking cholesterol medication? YES NO

Anemia

Is your child's diet lacking in iron-rich foods such as meat, eggs, beans, leafy green vegetables, or iron-fortified cereals? YES NO

Is your child on a vegetarian or vegan diet? YES NO

Has your child ever been treated for anemia? YES NO