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.

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

*Patient Name:*________________________________ *DOB:*__________

*Risk Assessment **12 months to 6 years***

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
Lead		
Does your child live in or frequently visit a house/ building built before 1950?	YES	NO
Does your child live in or frequently visit a house/ building built before 1978 with recent or ongoing renovations within the last 6 months?	YES	NO
Does your child have any siblings/housemates/ playmates that are being treated for lead poisoning?	YES	NO
Fluoride		
Do you have well water?	YES	NO
Does your family use bottled water exclusively?	YES	NO
Anemia		
Does your child consume more than 24 ounces of milk per day?	YES	NO
Is your child on a vegetarian or vegan diet?	YES	NO
Has your child ever been treated for anemia?	YES	NO
If your child is 18 months of age or older, is his or her diet lacking in iron-rich foods such as meat, eggs, beans, leafy green vegetables, or iron-fortified cereals?	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