Pediatric Symptom Checklist (PSC)

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? _____

©1988, M.S. Jellinek and J.M. Murphy, Massachusetts General Hospital

CHOC Children's

Patient Health Questionnaire (PHQ-A)

Name: _____ **Clinician:** _____ **Date:** _____

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an "**X**" in the box beneath the answer that best describes how you have been feeling.

	(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

A. In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?

☐Yes ☐No

B. If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?

☐Not difficult at all ☐Somewhat difficult ☐Very difficult ☐Extremely difficult

C. Has there been a time in the **past month** when you have had serious thoughts about ending your life?

☐Yes ☐No

D. Has there been a time in the **past 24 hours** when you have had serious thoughts about ending your life?

☐Yes ☐No

E. Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?

☐Yes ☐No

***If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.*

Office use only: **Severity score:** _____

Modified with permission from the PHQ (Spitzer, Williams & Kroenke, 1999) by J. Johnson (Johnson, 2002)

Psychological Screening for children 3-17 years old

Administer the Pediatric Symptom Checklist (PSC)

- To children 3-17 years old.
- Decide when you want to hand out the PSC.
- Many practices opt to give out the screen during well-child visits.
- In some practices, the front office staff provide the PSC to parents for completion at check in and attach the completed form to the chart for the provider to review at the beginning of the visit.
- Decide on a system that works for you and your practice.

Score the PSC

- The items are rated as: "Never" 0, "Sometimes" 1, or "Often" 2.
- Total score is calculated by adding together the score for each of the 35 items.
- If one to three items are left blank by parents, they are ignored (score = 0).
- If four or more items are left blank, the questionnaire is considered invalid.
- For children ages 3-5, cut-off score is 24 or greater (24 or above = impaired; 23 or below= not impaired). The scores on items 5, 6, 17 and 18 are ignored and a total score based on the 31 remaining items is calculated.
- For children aged 6-18, the cut-off score is 28 (28 or above = impaired; 27 or below = not impaired).

Interpret and Refer

Not impaired/Negative:
0-23 for 3-5 yr. old
0-27 for 6-18 yr. old

Done- Re-assess annually at the next Well Child Visit.

Impaired/Positive:
24 or greater 3-5 yr. old
28 or greater 6-18 yr. old

Please consider managing treatment if symptoms are mild.

Moderate- Refer to CalOptima:
1-855-877-3885

Severe- Refer to OC Behavioral Health:
1-855-OC-Links or 1-855-625-4657

Commercial Insurance: Please refer to the back of the patient's insurance card for the mental health referral phone number/ process.

Consider having the parent sign a Release of Information (ROI) and send with the referral to allow exchange of treatment information.

Psychological Screening for children 11-17 years old

Administer Patient Health Questionnaire (PHQ-A)

- To children 11-17 years old.
- Decide when you want to hand out the PHQ-A.
- Many practices opt to give out the screen during well-child visits.
- In some practices, the front office staff provide the PSC to parents for completion at check in and attach the completed form to the chart for the provider to review at the beginning of the visit.
- Decide on a system that works for you and your practice.

Score the PHQ-A

- Each item on the measure is rated on a 4-point scale (0=Not at all; 1=Several days; 2=More than half the days; and 3=Nearly every day).
- The total score can range from 0 to 27, with higher scores indicating greater severity of depression.
- If 3 or more items are left unanswered, the total raw score on the measure should not be used. Therefore, the child should be encouraged to complete all of the items on the measure.
- **Question 9:** If positive, need to complete suicide risk assessment (active: Have a plan and means, refer for immediate evaluation (ED or CAT team), passive: need appointment with mental health quickly).

Interpret and Refer

0-4 None or minimal depressive symptoms: Provider reviews with Patient; Confirms Negative; Done. Re-assess annually at the next Well Child Visit.

5-14 Mild to moderate depressive symptoms: Please consider managing treatment if symptoms are mild.
Refer to: CalOptima: 1-855-877-3885

15-19 Moderate to severe depressive symptoms: Consider referral to psychiatrist for medication and/or to therapist for therapy services.
Moderate– Refer to: CalOptima: 1-855-877-3885

20-27 Severe depressive symptoms: Refer to psychiatrist for medication and/or to therapist for therapy services.
Severe- Refer to: OC Behavioral Health: 1-855-OC-Links or 1-855-625-4657

Commercial Insurance: Please refer to the back of the patient's insurance card for the mental health referral phone number/process.

Consider having the parent sign a Release of Information (ROI) and send with the referral to allow exchange of treatment information.