

A Survey From Your Healthcare Provider — PSC-Y

TeenScreen® Primary Care

Name		Date	ID
Please mark under the heading that best fits you or circle Yes or No		Never 0	Sometimes 1
-	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 _____

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

Q 36 or Q 37=Y ◆

TS ≥ 30

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