Pediatric Symptom Checklist (PSC)

With Bursch Addendum for Inpatient Units

MRN:
Patient Name:
DOB:

Form completed by:_____ Time/Date:_____

Please mark under the heading that best describes <u>your child</u>:	**Never (0)**	**Sometimes (1)**	**Often (2)**
1. Feels sad, unhappy	☐	☐	☐
2. Feels hopeless	☐	☐	☐
3. Is down on self	☐	☐	☐
4. Worries a lot	☐	☐	☐
5. Seems to be having less fun	☐	☐	☐
6. Fidgety, unable to sit still	☐	☐	☐
7. Daydreams too much	☐	☐	☐
8. Distracted easily	☐	☐	☐
9. Has trouble concentrating	☐	☐	☐
10. Acts as if driven by a motor	☐	☐	☐
11. Fights with other children	☐	☐	☐
12. Does not listen to rules	☐	☐	☐
13. Does not understand other people's feelings	☐	☐	☐
14. Teases others	☐	☐	☐
15. Blames others for his/her troubles	☐	☐	☐
16. Refuses to share	☐	☐	☐
17. Takes things that do not belong to him/her	☐	☐	☐
18. Seems confused	☐	☐	☐
19. Is having bad dreams	☐	☐	☐
20. Is talking less than usual	☐	☐	☐
21. Has been refusing to take medication	☐	☐	☐
22. Feels guilty	☐	☐	☐
23. Is fearful of the doctors and/or nurses	☐	☐	☐
24. Feels the doctors and/or nurses are not listening	☐	☐	☐
25. Is not coping well with being in the hospital	☐	☐	☐
26. Is jumpy or gets startled easily	☐	☐	☐
27. Has been refusing exams or other procedures.	☐	☐	☐
28. Is afraid of new situations	☐	☐	☐
29. Is irritable, angry	☐	☐	☐
30. Is crying more than usual	☐	☐	☐
31. Acts younger than other children his or her age	☐	☐	☐

32. Does your child have any emotional or behavioral problems for which she/he needs help? ❑No ❑Yes

33. Does your child have any physical symptoms for which she/he needs help? ❑No ❑Yes

34. Would your child benefit from coping skills training to help with pain management or fear? ❑No ❑Yes

35. Would your child benefit from assistance in talking to or asking questions of the medical team? ❑No ❑Yes

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1-17 >> *Score:*_____ (If >15, or Yes to 32,33, 34 or 35 please notify MD) 1-31>> *Score:*_____