Youth Pediatric Symptom Checklist (Y-PSC)

With Bursch Addendum for Inpatient Units

(Age 11 years or above)

MRN:
Patient Name:
DOB:

Form completed by:_____ Time/Date:_____

Please mark under the heading that best fits you:	**Never (0)**	**Sometimes (1)**	**Often (2)**
1. Fidgety, unable to sit still	☐	☐	☐
2. Feel sad, unhappy	☐	☐	☐
3. Daydream too much	☐	☐	☐
4. Refuse to share	☐	☐	☐
5. Do not understand other people's feelings	☐	☐	☐
6. Feel hopeless	☐	☐	☐
7. Have trouble concentrating	☐	☐	☐
8. Fight with other children	☐	☐	☐
9. Down on yourself	☐	☐	☐
10. Blame others for your troubles	☐	☐	☐
11. Seem to be having less fun	☐	☐	☐
12. Do not listen to rules	☐	☐	☐
13. Act as if driven by a motor	☐	☐	☐
14. Tease others	☐	☐	☐
15. Worry a lot	☐	☐	☐
16. Take things that do not belong to you	☐	☐	☐
17. Distract easily	☐	☐	☐
18. Feel confused	☐	☐	☐
19. Have bad dreams	☐	☐	☐
20. Am talking less than usual	☐	☐	☐
21. Have been refusing to take medication	☐	☐	☐
22. Feel guilty	☐	☐	☐
23. Am fearful (scared) of the doctors and/or nurses	☐	☐	☐
24. Feel the doctors and/or nurses are not listening	☐	☐	☐
25. Am not coping well with being in the hospital	☐	☐	☐
26. Am jumpy (get startled easily)	☐	☐	☐
27. Have been refusing exams or other procedures.	☐	☐	☐
28. Am afraid of new situations	☐	☐	☐
29. Irritable, angry	☐	☐	☐
30. Am crying more than usual	☐	☐	☐
31. Act younger than other children your age	☐	☐	☐

32. Do you have any emotional or behavioral problems for which you want help? ❑No ❑Yes
33. Are you currently seeing a mental health professional? ❑No ❑Yes

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