

# Pediatric Symptom Checklist (PSC)

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 indicate which statement best describes your child.

**Please mark under the heading that best describes your child:**

	Never	Sometimes	Often
1. Complains of aches and 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 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 interested in friends	15		
16. Fights with other children	16		
17. Absent from school	17		
18. School grades dropping	18		
19. Is down on him or herself	19		
20. Visits the 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 or 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? \_\_\_\_\_



**TB Questionnaire**

Name of Child \_\_\_\_\_ Date of Birth \_\_\_\_\_

Organization administering questionnaire \_\_\_\_\_ Date \_\_\_\_\_

Tuberculosis (TB) is a disease caused by TB germs and is usually transmitted by an adult person with active TB lung disease. It is spread to another person by coughing or sneezing TB germs into the air. These germs may be breathed in by the child.

Adults who have active TB disease usually have many of the following symptoms: cough for more than two weeks duration, loss of appetite, weight loss of ten or more pounds over a short period of time, fever, chills and night sweats.

A person can have TB germs in his or her body but not have active TB disease (this is called latent TB infection or LTBI).

Tuberculosis is preventable and treatable. TB skin testing (often called the PPD or Mantoux test) is used to see if your child has been infected with TB germs. No vaccine is recommended for use in the United States to prevent tuberculosis. The skin test is not a vaccination against TB.

We need your help to find out if your child has been exposed to tuberculosis.

Place a mark in the appropriate box:	Yes	No	Don't Know
TB can cause fever of long duration, unexplained weight loss, a bad cough (lasting over two weeks), or coughing up blood. As far as you know: has your child been around anyone with any of these symptoms or problems? or has your child had any of these symptoms or problems? or has your child been around anyone sick with TB?			
Was your child born in Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe or Asia?			
Has your child traveled in the past year to Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe or Asia for longer than 3 weeks?  If so, specify which country/countries? _____			
To your knowledge, has your child spent time (longer than 3 weeks) with anyone who is/has been an intravenous (IV) drug user, HIV-infected, in jail or prison or recently came to the United States from another country?			

Has your child been tested for TB? Yes\_\_\_ (if yes, specify date \_\_\_/\_\_\_/\_\_\_) No\_\_\_

Has your child ever had a positive TB skin test? Yes\_\_\_ (if yes, specify date \_\_\_/\_\_\_/\_\_\_) No\_\_\_

**For school/healthcare provider use only**

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PPD administered Yes\_\_\_ No\_\_\_

If yes, Date administered \_\_\_/\_\_\_/\_\_\_ Date read \_\_\_/\_\_\_/\_\_\_ Result of PPD test \_\_\_\_\_ mm response

Type of service provider (i.e. school, Health Steps, other clinics) \_\_\_\_\_

PPD provider \_\_\_\_\_ signature \_\_\_\_\_ printed name \_\_\_\_\_

Provider phone number \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_

If positive, referral to healthcare provider Yes\_\_\_ No\_\_\_

If yes, name of provider \_\_\_\_\_





**HEALTH QUESTIONNAIRE**

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Please answer YES or NO to the following questions. If you answer YES to any question please explain in the space provided below.**

- 1. **Yes**\_\_ **No**\_\_ Since the last check-up, have you had any injury or serious illness?
- 2. **Yes**\_\_ **No**\_\_ Since the last check-up, have you been hospitalized overnight?
- 3. **Yes**\_\_ **No**\_\_ Since the last check-up, have you had surgery?
- 4. **Yes**\_\_ **No**\_\_ Do you take any medication?
- 5. **Yes**\_\_ **No**\_\_ Have you experienced lightheadedness, dizziness, or chest pain during exercise?
- 6. **Yes**\_\_ **No**\_\_ Have you ever fainted during exercise?
- 7. **Yes**\_\_ **No**\_\_ Is there a family history of heart disease before 50 years old?
- 8. **Yes**\_\_ **No**\_\_ Do you have asthma?
- 9. **Yes**\_\_ **No**\_\_ Have you experienced cough, wheezing or shortness of breath during exercise?
- 10. **Yes**\_\_ **No**\_\_ Have you ever had a concussion or a significant head injury?
- 11. **Yes**\_\_ **No**\_\_ Do you have a history of severe headaches?
- 12. **Yes**\_\_ **No**\_\_ Have you ever experienced numbness or tingling in your extremities?
- 13. **Yes**\_\_ **No**\_\_ Do you have a single organ (kidney, testicle, etc.)?

**If you have answered YES to any question, please explain below.**

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**Signature of parent or legal guardian**

**Date**