

Child's Name _____

Record Number _____

Today's Date _____

Filled out by _____

Date of Birth _____

Pediatric Symptom Checklist

Please mark under the heading that best fits your child:

		Never	Sometimes	Often
1	Complains of aches/pains.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Spends more time alone.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Tires easily, little energy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	Fidgety, unable to sit still.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	Has trouble with a teacher.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	Less interested in school.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	Acts as if driven by a motor.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	Daydreams too much.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	Distracted easily.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	Is afraid of new situations.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	Feels sad, unhappy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12	Is irritable, angry.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13	Feels hopeless.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14	Has trouble concentrating.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15	Less interest in friends.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16	Fights with others.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17	Absent from school.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18	School grades dropping.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19	Is down on him or herself.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20	Visits doctor with doctor finding nothing wrong.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21	Has trouble sleeping.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22	Worries a lot.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23	Wants to be with you more than before.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24	Feels he or she is bad.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25	Takes unnecessary risks.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26	Gets hurt frequently.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27	Seems to be having less fun.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28	Acts younger than children his or her age.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29	Does not listen to rules.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30	Does not show feelings.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31	Does not understand other people's feelings.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32	Teases others.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33	Blames others for his or her troubles.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34	Takes things that do not belong to him or her.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35	Refuses to share.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other comments