

PEDIATRIC SYMPTOM CHECKLIST-17
(PARENT FORM)

First Name:Last Name:

Subject's Name:

Today's Date:

Directions: This instrument asks questions about your child's feelings, complaints, or behaviors. All of the items below will be true for every child at sometime in his or her life. Please read each question carefully and fill in the circle for the response that you believe is **most true for your child during the past 6 months**.

Does your child:	Never	Sometimes	Often
1. Fidget, is unable to sit still.	☐	☐	☐
2. Act as if driven by a motor.	☐	☐	☐
3. Daydream too much.	☐	☐	☐
4. Distract easily.	☐	☐	☐
5. Feel sad.	☐	☐	☐
6. Feel hopeless.	☐	☐	☐
7. Have trouble concentrating.	☐	☐	☐
8. Fight with other children.	☐	☐	☐
9. Feel down on him/herself.	☐	☐	☐
10. Worry a lot.	☐	☐	☐
11. Seem to be having less fun.	☐	☐	☐
12. Not listen to rules.	☐	☐	☐
13. Not understand other people's feelings.	☐	☐	☐
14. Tease others.	☐	☐	☐
15. Blame others for his/her troubles.	☐	☐	☐
16. Refuse to share.	☐	☐	☐
17. Take things that do not belong to him/her.	☐	☐	☐