

Pediatric Symptoms Checklist



Patient Name _____ Date _____

Person Completing This Form _____

Instructions Please mark under the heading that best fits your child.

No.	Behavior	Never	Sometimes	Often
1	Complains of aches and 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 other children	<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 himself or herself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20	Visits doctor or with doctor finding nothing wrong	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21	Has trouble with sleeping, rises very early	<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 own 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"/>