Pediatric Symptom Checklist Youth Report Name (Y-PSC) DOB: Date

Complain of aches and pains Spend more time alone Tire easily, little energy Fidgety, unable to sit still Have trouble with reacher Are afraid of new situations Feel sad, unhappy Are irritable, angry Feel hopeless Have trouble concentrating Less interested in friends Fight with other children Visit doctor with doctor finding nothing wrong Have trouble sleeping Visit doctor with doctor finding nothing wrong Have trouble sleeping Want to be with parent more than before Fel hat you are bad Act younger than children your age Do not listen to rules Address Phone Phone Address Phone		Discourse designed and the best designed to the state of the second	NI	0	0(1		
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YOUTH EMOTIONAL HEALTH SCREENING PROGRAM

Screening Consent Form

IF CHILD IS ALREADY RECEIVING EMOTIONAL HEALTH SERVICES, DO NOT COMPLETE THIS FORM

I DO WANT MY CHILD TO PARTICIPATE IN THIS SCREENING

I,Please Print	Your Name, give I	permission for my child to participate in the		
Family Services Y	Youth Emotional Health Scre	ening Program.		
Parent/Guardian S	Signature:	Date:		
Plea	se Complete All Of Th	ne Following Information		
CI	hild's Name	Student Date of Birth		
Age	Male/Female	Home Address		
	School	City, State, Zip		
	Grade	County		
		Home Phone		
Child Lives: With	Parent; In Foster Care _	; With Guardian		

Mail completed forms to: Family Services of Chemung County Inc. Attn: Marilyn Cristofaro 300 Pennsylvania Ave Elmira, NY 14904