# Sample Interview for Youth Scoring Positive On the Pediatric Symptom Checklist

**Identifying Information:**

**PATIENT NAME:_____ PATIENT NO:_____**

**DOB:_____ AGE:_____ SEX:_____**

**PARENT/GUARDIAN:_____ DATE OF INTERVIEW:_____**

**SCREEN RESULTS: _____Positive _____Negative _____Other**

**Before Beginning the Interview:**

The purpose of this interview is to provide guidelines for assessing youth who score positive for behavioral health problems on the Pediatric Symptom Checklist (PSC). The protocol provides follow-up questions for the primary care provider (PCP) to probe in the problem areas identified by the parent or youth responses on the Pediatric Symptom Checklist or the Pediatric Symptom Checklist-Youth.

Before beginning the interview, the responses on the PSC should be reviewed and recorded in the shaded areas of the protocol. The PCP should use the probing questions in the problem areas of **Depression** and **Suicide Ideation** no matter what the score on the critical items associated with these problem areas. The **Substance Abuse** probing questions should be used with all youth over the age of 11 years. The PCP can use the probing questions in the other problem areas when the critical item score approaches the cutoff score for that problem area.

The protocol also provides a space for the PCP to follow up on general questions on the PSC that are not related to a specific problem area, but have been endorsed by the parent or youth with a "sometimes" or "often" response.

For children under 8 years and those who may appear to have symptoms of psychosis, it may be necessary to interview the parent or guardian. In this case, the probing questions can be adapted for use with the caregiver.

The last section of the interview tool provides space to identify suicidal youth, summarize the presenting problems confirmed by the interview, and list next steps for treatment or referral. It is recommended that the completed interview tool be sent to the behavioral health provider upon referral.

**Beginning the Interview**

| Rapport-Building Questions | Comments |
|---|---|
| 1. How has school been: What grades are you getting? | |
| 2. How are you getting along with people these days? Do you have friends that you can really trust? | |

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| 3. How are things at home? How are you getting along with your parents? | |
| 4. What do you like to do for fun? | |

**Depression (MANDATORY) Internalizing Items 11☐ 13☐ 19☐ 22☐ 27☐ Total ☐**
**Cutoff: ≥5**

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|---|---|
| **1. Depressed Mood:** **YES____ NO_____**<br>How has your mood been over the last 3 months? How often are you sad, depressed? How long are you sad, depressed? | **Comments:** |
| **2. Irritability:** **YES____ NO_____**<br>Do you often feel irritable/grumpy? How long do these feelings last? | **Comments:** |
| **3. Lack of Pleasure/Interest**: **YES____ NO_____**<br>Have you been doing your favorite activities? Are these activities still fun for you or are you just going through the motions? | **Comments:** |
| **4. Sleep Disturbance:** **YES____ NO_____**<br>How do you sleep at night? What time do you go to sleep/wake up? Do you have trouble getting to sleep? Wake up too early? | **Comments:** |
| **5. Appetite/ Weight Change:** **YES____ NO_____**<br>How is your eating? Have you gained/lost weight recently without trying? You are still growing, have you been gaining weight too? | **Comments:** |
| **6. Guilt/Worthlessness** **YES____ NO_____**<br>How do you feel about yourself lately? Do you feel you are not as good as other kids? Feel badly about things you have done/not done? | **Comments:** |
| **7. Hopelessness** **YES____ NO_____**<br>Do you feel things will get better for you in the future? Or are you feeling that nothing will work out for you? | **Comments:** |
| **8. Fatigue/Loss of Energy** **YES____ NO_____**<br>How is your energy level? Do you feel tired nearly every day? | **Comments:** |
| **9. Decreased Concentration/Indecisiveness YES____ NO_____**<br>Have you had any trouble concentrating or making decisions? Have you had trouble reading or focusing on your schoolwork? | **Comments:** |
| **10. Agitation/Retardation** **YES____ NO____**<br>Do you often feel like you are in slow motion? Do you often feel very restless? Have others noticed these behaviors? | **Comments:** |
| **11. Distress/Impairment** **YES____ NO____**<br>What kinds of problems have these feelings caused for you at school, at home, with your friends? | **Comments:** |

**Suspected Thought Disorder (Two or more symptoms below for at least 6 months)**

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|---|---|
| **1. Delusions** **YES____ NO____**<br>Do you feel your imagination plays tricks on you? Do you often believe someone is out to get you? Or do you often feel that you have special powers? Or do you think people on TV talk about | **Comments:** |

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|---|---|
| you? | |
| **2. Hallucinations YES____ NO____**<br>Do you hear voices or see things that aren't really there? | **Comments:** |
| **3. Disorganized Speech YES____ NO____**<br>Is child's speech grossly disorganized/incoherent? | **Comments:** |
| **4. Disorganized or Catatonic Behavior YES____ NO____**<br>Is youth's appearance messy, disheveled? Does child have trouble completing simple tasks such as brushing teeth? Do they sit rigidly for long periods of time and resist being moved? | |
| **5. Other Negative Symptoms YES____ NO____**<br>Does child's have flat affect with minimal eye contact? Does the child give only brief, empty replies? Does the child fail to initiate daily tasks, sit for long periods, and lack interest in social activity? | **Comments:** |

**Suicidal Ideation ( MANDATORY)* Suicidality Items 36 37 Total Score**
**Cutoff: ≥ 1**

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|---|---|
| **Thoughts of killing self: YES____ NO____**<br>Do you ever have thoughts about dying? Do you ever think about killing yourself? When was the first time you had those thoughts? When was the most recent time you had those thoughts? How often do you have thoughts of killing yourself? | **Onset:**<br>**Frequency:**<br>**Recency:** |
| **Suicide Plan/Methods associated with thoughts**<br>How close have you come to acting on your thoughts to end your life? What did you do? If no, have you thought about how you would end your life? What would you do? When do you think you would do it? Where do you think you would do it? | **No Plan:**<br>**Vague Plan:**<br>**Specific Plan:** |
| **Method(s) available: YES____ NO____ UNKNOWN____**<br>Are (guns, pills, or other methods) (at home, easy to get)? If so, how do you think you would use these methods to end your life? What other methods have you thought of that might work for you? Have you ever started to do something with (a gun, pills, other methods) and someone/something stopped you? How did that feel? | **Strength of intent/Wish to die:** |
| **Precipitants/Triggers of suicide ideation:** What kinds of things make you think about killing yourself? Have you ever started to do something with (a gun, pills, other methods) and changed your mind? What made you change your mind? | **Deterrents to suicidal actions:** |
| **Passive suicidal ideation (e.g., Wish were dead, never wake up):**<br>Do you wish you were dead? Have you felt that life is not worth living? Do you wish you could go to sleep and never wake up? Do you think about killing yourself? What made you have these thoughts? | **Onset, frequency, recency:** |

**Suicidal Behavior* - Number of Attempts in Lifetime:_____**

| Most RECENT Suicide Attempt | Most SERIOUS Suicide Attempt |
|---|---|
| **Date** | **Date** |
| **Method:** _____Planned _____Impulsive<br><br>Details:<br><br>**Believed action would result in death** (intent):<br><br>_____No _____Uncertain _____Yes<br><br>**___Self -Disclosed ___Was Discovered ____Stopped**<br><br>**Details:**<br><br>**Attempts to conceal:**<br><br>**Lethality/Medical attention:**<br><br>**Stressors/Mood just prior to attempt:**<br><br>**Substance use just prior to attempt:** | **Method:** _____Planned _____Impulsive<br><br>Details:<br><br>**Believed action would result in death** (intent):<br><br>_____No _____Uncertain _____Yes<br><br>**_____Disclosed _____Was Discovered _____Stopped Self**<br><br>**Details:**<br><br>**Attempts to conceal:**<br><br>**Lethality/Medical attention:**<br><br>**Stressors/Mood just prior to attempt:**<br><br>**Substance use just prior to attempt:** |
| **History of Suicide in Family:** | |

**Summary of Suicide Risk Assessment:** **Low** **Moderate** **High**
Reasons:

***Parents should be informed of current active suicidal ideation (thoughts of killing self within the last 3 months) and past suicide attempts.***

**Anxiety Internalizing Items 11☐ 13☐ 19☐ 22☐ 27☐ Total Score ☐**
**Cutoff ≥ 5**

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|---|---|
| **Panic Attacks** **YES____ NO____**<br>Do you ever get very nervous in a situation that most kids would not think of as scary? Do you get so nervous you feel like you are having a heart attack, feel very hot or cold, feel shaky, feel your heart pounding, or feel like you are choking (even without asthma)? When was the first and last time this happened to you? How often does it happen? | **Onset, frequency, recency:** |
| **Persistent Anxiety/Worry** **YES____ NO____**<br>What situations make you worried or nervous? How much of the time are you worried about something? What kind of problems does your worrying cause you at home? At school? With your friends? | **Impairment: YES___ NO___**<br>**Comments:** |

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| **Social Anxiety YES____ NO____**<br>Do you get nervous is school or in situations with people? Does it happen with kids or adults? Are you able to get through the situation and feel better or do you avoid it even if it means getting marked down in school or getting in trouble? Has this nervousness stopped you from doing things you want to do or caused you problems at home or with your friends? | **Impairment: YES___ NO___**<br>**Comments:** |
| **Other Anxiety YES____ NO____**<br>Do you worry a lot? Can you stop worrying if you try? How often do you feel jumpy, have trouble concentrating, or trouble sleeping? | **Impairment: YES___ NO___**<br>**Comments:** |
| **Obsessions/Compulsions YES____ NO____**<br>Do you ever check or do things over and over again? What do you do? How often? How do you feel if you can't? Do you have upsetting thoughts or images that come back and you can't ignore? | **Impairment: YES___ NO___**<br>**Comments:** |

**Inattention/Hyperactivity Attention Items 4☐ 7☐ 8☐ 9☐ 14☐ Total☐ Cutoff: ≥ 5**

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|---|---|
| **Difficulty sustaining attention(≥6 mos) YES____ NO____**<br>Do you have difficulty paying close attention to schoolwork or play activities and often make careless mistakes? How does this cause you problems in school, at home, or with your friends? | **Impairment YES___ NO___**<br>**Comments:** |
| **Easily distracted or forgetful(≥6 mos) YES____ NO____**<br>Are you easily distracted or forgetful? Do you often lose things necessary to do your schoolwork or other tasks (books, worksheets)?<br>Does this cause problem for you at home, school, or with friends? | **Impairment YES___ NO___**<br>**Comments:** |
| **Difficulty organizing tasks/activities(≥6 mos) YES____ NO____**<br>Do you have difficulty following instructions or organizing your work? How does this affect your schoolwork or homework? | **Impairment YES___ NO___**<br>**Comments:** |
| **Avoids tasks that require sustained mental effort YES____ NO____**<br>Do you avoid, dislike or express reluctance to do school work that requires a lot of mental effort? Is this a problem at school/home? | **Impairment YES___ NO___**<br>**Comments:** |
| **Difficulty engaging in leisure activities quietly YES____ NO____**<br>Do you have difficulty playing quietly? How does this affect you? | **Impairment YES___ NO___**<br>**Comments:** |
| **Fidgets, squirms and runs around excessively YES____ NO____**<br>Do you often fidget, squirm in, or leave your seat? Do you often run about or climb excessive when it is not appropriate? Do you often talk too much? Do these cause problems for you at school or home? | **Impairment YES___ NO___**<br>**Comments:** |

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| **Interrupts or intrudes on others (≥6 mos )** **YES____ NO____**<br>Do you interrupt others who are working or playing? How does this cause problem for you? | **Impairment YES___ NO___**<br>**Comments:** |

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| **Difficulty awaiting turn (≥6 mos) YES____ NO____**<br>Do you blurt out answers or take your turn before the right time? | **Impairment YES___ NO___**<br>**Comments:** |

**Conduct Problems Externalizing Items 16□ 29□ 31□ 32□ 33□ 34□ 35□ Total □**
**Cutoff: ≥7**

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|---|---|
| **Aggression to people or animals YES____ NO____**<br>Do you often bully or threaten others or initiate physical fights? Have you ever used a weapon to cause serious harm? Have you been physically cruel to people or animals? Have you stolen directly from a victim (i.e. mugging, purse-snatching) or forced someone into sex? | **Impairment YES___ NO___**<br>**Comments:** |
| **Destruction of Property YES____ NO____**<br>Have you deliberately started a fire or done something else to destroy property? | **Impairment YES___ NO___**<br>**Comments:** |
| **Deceitfulness or Theft YES____ NO____**<br>Have you broken into someone's house or car? Do you often lie to obtain goods or favors? Have you stolen items of value without confronting the victim (i.e., shoplifting, forgery)? | **Impairment YES___ NO___**<br>**Comments:** |
| **Serious violations of rules YES____ NO____**<br>Do you often stay out late at night against your parents' wishes? Have you run away from home overnight at least twice? Are you often truant from school and did you start this before age 13 years? | **Impairment YES___ NO___**<br>**Comments:** |
| **Argues with adults, defies adults' requests YES___ NO___**<br>Do you often lose your temper or argue with adults? Do you often actively defy adult requests or rules? | **Impairment YES___ NO___**<br>**Comments:** |
| **Annoying, angry, spiteful, or resentful YES____ NO____**<br>Do you often deliberately annoy people? Are you touchy or easily annoyed by others? Do you often blame your mistakes on others? | **Impairment YES___ NO___**<br>**Comments:** |

**Substance Abuse Problems (MANDATORY for ≥ 11 years)**

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| **1. Alcohol use YES____ NO____**<br>Have you ever used alcohol? If so, when was the last time you used it? What was the situation? Were you with family? With friends? Were you alone? How often do you use? How much at a time? Did you like the feeling you had when you used? Why or why not? Have you been in any situations where you have or could have been hurt or gotten in trouble from using? (Unprotected sex, missed school, driven a car, gotten into fights, tried to kill self? Used more than you planned? Felt depressed, sick after using? Needed someone's help because you used too much? | **Impairment YES___NO___**<br>**Comments:** |

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| **2. Marijuana use** **YES____ NO____**<br>Same questions as in #1 | **Impairment YES___NO___**<br>**Comments:** |
| **3. Other drug use:** **YES____ NO____**<br>Same probing questions as in #1 | **Impairment YES___NO___**<br>**Comments:** |

**Follow-up on General PSC items endorsed as "sometimes" or "often" (check those that apply)**

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| □**1. Complains of aches and pains** |
| □**2. Spend more time alone** |
| □**3. Tire easily, little energy** |
| □**5. Have trouble with teacher** |
| □**6. Less interested in school** |
| □**10. Afraid of new situations** |
| □**12. Irritable, angry** |
| □**15. Less interested in friends** |
| □**17. Absent from school** |
| □**18. School grades dropping** |
| □**20. Visit doctor with doctor finding nothing wrong** |
| □**21. Have trouble sleeping** |
| □**23. Want to be with parent more than before** |
| □**24. Feel that you are bad** |
| □**25. Take unnecessary risks** |
| □**26. Get hurt frequently** |
| □**28. Act younger than children your age** |
| □**30. Do not show feelings** |

**PROVIDER NOTES**

**1. CONFIRMED THRU SCREENING OR DURING INTERVIEW:**

Current active Suicidal Ideation (thoughts of killing self in last 3 months) **YES____ NO_____**

Past Suicide Attempt: Date(s) _____ **YES____ NO____**

**2. SUMMARY OF SCREENING AND/OR INTERVIEW:**

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**3. DISPOSITION/RECOMMENDATION:**

- □ Crisis/Emergency Care
- □ Refer for mental health treatment
- □ PCP will initiate treatment plan
- □ Youth in treatment, discuss findings with parent
- □ No referral, discuss findings with parent

**Signature**_____ **Date**_____