Which Caregiver/Adult Was Involved (Client Name)?

_____

Date of Activity:_____/_____/_____

Program

- Becoming a Mom
- Family Planning
- Maternal Child Health (MCH/M&I)
- Pregnancy Maintenance (PMI)
- Teen Pregnancy (TPTCM)
- Kansas Connecting Communities

Pediatric Symptom Checklist (PSC-17 Caregiver)

Please mark under the heading that best describes your child:

	Never (0)	Sometimes (1)	Often (2)
1. Feels sad, unhappy	☐	☐	☐
2. Feels hopeless	☐	☐	☐
3. Is down on self	☐	☐	☐
4. Worries a lot	☐	☐	☐
5. Seems to be having less fun	☐	☐	☐
6. Fidgety, unable to sit still	☐	☐	☐
7. Daydreams too much	☐	☐	☐
8. Distracted easily	☐	☐	☐
9. Has trouble concentrating	☐	☐	☐
10. Acts as if driven by a motor	☐	☐	☐
11. Fights with other children	☐	☐	☐
12. Does not listen to rules	☐	☐	☐
13. Does not understand other people's feelings	☐	☐	☐
14. Teases others	☐	☐	☐
15. Blames others for his/her troubles	☐	☐	☐
16. Refuses to share	☐	☐	☐
17. Takes things that do not belong to him/her	☐	☐	☐
Totals			

Totals (of all boxes) = _____

Does your child have any emotional or behavioral problems for which she/he needs help? ____ No ____ Yes

Programs Providing Follow-Up: (select all that apply)

- Becoming a Mom
- Family Planning
- Maternal Child Health (MCH/M&I)
- Pregnancy Maintenance Initiative (PMI) Teen Pregnancy Targeted Case Management(TPTCM)
- Kansas Connecting Communities (KCC)

Was a brief intervention provided?

- Yes
- No

If yes, what brief intervention was provided?

- Reviewed screening results
- Made clinical recommendations
- Provided education community, and/or treatment resources
- Measured patient-motivation and/or readiness to change
- Reinforced self-efficacy
- Other **Specify other intervention:**

_____

Why was a brief intervention not provided?

Was a referral provided?

- Yes
- No

What provider type was client referred to?

- Beacon Health Options
- Substance Use Treatment Provider
- Internal Mental Health Provider
- External Mental Health Provider CMHC
- External Mental Health Provider Private Practice
- MCO/MCO Care Coordinator
- Community-Based Support Group
- Primary Care Provider
- Other

If other, please specify: _____

Why was a referral not provided?

Was the client in crisis?

- Yes
- No

If yes, what action was taken?