

PANS RATING SCALE

PEDIATRIC NEUROPSYCHIATRIC SYMPTOM RATING

Name/Subject ID: _____ Date: _____ Completed by: Mother Father Other _____

| Symptom type: | Please check box 0-10 to best represent severity and frequency | | | | | | | | | | | | Symptom Change Rating | | | | |
|---|--|-----------------|---|---|----------|---|---|---|-----------------|---|----|--------------------|-------------------------------------|------|--------|-------|--|
| | Never | Mild/infrequent | | | Moderate | | | | Severe/frequent | | | Score | In past month or specify time _____ | | | | |
| | 0/NA | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Staff will fill in | New | Same | Better | Worse | |
| 1. Obsessions | | | | | | | | | | | | | | | | | |
| 2. Compulsions | | | | | | | | | | | | | | | | | |
| 3. Food refusal/avoidance | | | | | | | | | | | | | | | | | |
| 4. Anxiety (fears/phobias, separation anxiety) | | | | | | | | | | | | | | | | | |
| 5. Mood swings/moodiness | | | | | | | | | | | | | | | | | |
| 6. Suicidal ideation/behavior | | | | | | | | | | | | | | | | | |
| 7. Depression/sadness | | | | | | | | | | | | | | | | | |
| 8. Irritability | | | | | | | | | | | | | | | | | |
| 9. Aggressive behaviors | | | | | | | | | | | | | | | | | |
| 10. Oppositional behaviors | | | | | | | | | | | | | | | | | |
| 11. Hyperactivity or impulsivity | | | | | | | | | | | | | | | | | |
| 12. Trouble paying attention | | | | | | | | | | | | | | | | | |
| 13. Behavioral regression | | | | | | | | | | | | | | | | | |
| 14. Worsening of school performance | | | | | | | | | | | | | | | | | |
| 15. Worsening of handwriting/copying | | | | | | | | | | | | | | | | | |
| 16. Sleep disturbances | | | | | | | | | | | | | | | | | |
| 17. Daytime wetting or bedwetting | | | | | | | | | | | | | | | | | |
| 18. Urinary frequency | | | | | | | | | | | | | | | | | |
| 19. Bothered by sounds, smells, textures, or lights | | | | | | | | | | | | | | | | | |
| 20. Hallucinations | | | | | | | | | | | | | | | | | |
| 21. Dilated/big pupils | | | | | | | | | | | | | | | | | |
| 22. Tics (movements) | | | | | | | | | | | | | | | | | |
| 23. Tics (sounds) | | | | | | | | | | | | | | | | | |

For items 1-4, any suddenly worse? Yes No If yes, please describe: _____

of hours/day involved in obsessions: _____ # hours/day involved in compulsions/rituals: _____