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*											Score *Staff will fill in*	Symptom Change Rating *in past month or specify time_____*			
	Never	Mild/infrequent			Moderate				Severe/frequent				New	Same	Better	Worse
	0/NA	1	2	3	4	5	6	7	8	9	10					
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:_____