Trauma Screen + CPSS - Caregiver Completed

Child Name___________________________ Date______________ **Side 1**

Stressful or scary events happen to many kids. Below is a list of stressful and scary events that sometimes happen. Please answer to the best of your knowledge. Mark YES if it happened to your child. Mark No if it didn't happen to your child.

1. Serious natural disaster like a flood, tornado, hurricane, earthquake, or fire. ☐ Yes ☐ No
2. Serious accident or injury like a car/bike crash, dog bite, sports injury. ☐ Yes ☐ No
3. Robbed by threat, force or weapon. ☐ Yes ☐ No
4. Slapped, punched, or beat up in your family. ☐ Yes ☐ No
5. Slapped, punched, or beat up by someone not in the family. ☐ Yes ☐ No
6. Seeing someone in the family slapped, punched or beat up. ☐ Yes ☐ No
7. Seeing someone in the community slapped, punched or beat up. ☐ Yes ☐ No
8. Someone older touching your child's private parts when they shouldn't. ☐ Yes ☐ No
9. Someone forcing or pressuring sex, or when your child couldn't say no. ☐ Yes ☐ No
10. Someone close to your child dying suddenly or violently. ☐ Yes ☐ No
11. Attacked, stabbed, shot at or hurt badly. ☐ Yes ☐ No
12. Seeing someone attacked, stabbed, shot at, hurt badly or killed. ☐ Yes ☐ No
13. Stressful or scary medical procedure. ☐ Yes ☐ No
14. Being around war. ☐ Yes ☐ No
15. Other stressful or scary event? ☐ Yes ☐ No
    Describe: ____

Which one is bothering your child the most now? _____________

If you answered **NO** to all of the above questions, ***STOP***
If you answered **YES** to any of the above questions, please complete the rest of this form.

What were your child's feelings when the event happened?

Afraid s/he would die or be hurt badly. ☐ Yes ☐ No

Afraid someone else would die or be hurt badly. ☐ Yes ☐ No

Helpless to do anything. ☐ Yes ☐ No

Ashamed or disgusted. ☐ Yes ☐ No

Please complete both sides of this document if you answered YES to 1-15.

Child PTSD Symptom Scale CPSS (4-17 years) Caregiver Completed

Mark 0, 1, 2 or 3 for how often the following things have bothered your child in the last two weeks:

0 Not at all
1 Once a week or less
2 2 to 4 times a week
3 5 or more times a week

1.	Your child having unwanted, upsetting thoughts or images about the traumatic event .	0	1	2	3
2.	Your child having bad dreams or nightmares.	0	1	2	3
3.	Your child acting or feeling as if the event were happening again.	0	1	2	3
4.	Your child feeling upset when s/he thinks about or hears about the event.	0	1	2	3
5.	Your child having feelings in the body when thinking or hearing about the event.(Heart beating fast, upset stomach, breaking out in a sweat).	0	1	2	3
6.	Your child trying not to think about, talk about or have feelings about the event.	0	1	2	3
7.	Your child trying to avoid activities or people, or places that remind you of the event.	0	1	2	3
8.	Your child not being able to remember an important part of the upsetting event.	0	1	2	3
9.	Your child having much less interest or not doing the things s/he used to do.	0	1	2	3
10.	Your child not feeling too close to the people around him/her.	0	1	2	3
11.	Your child not being able to have strong feelings (being able to cry or feel really happy).	0	1	2	3
12.	Your child feeling as if his/her future hopes or plans will not come true.	0	1	2	3
13.	Your child having trouble falling or staying asleep.	0	1	2	3
14.	Your child feeling irritable or having fits of anger.	0	1	2	3
15.	Your child having trouble concentrating.	0	1	2	3
16.	Your child being overly careful (checking to see who is around).	0	1	2	3
17.	Your child being jumpy or easily startled.	0	1	2	3

Please mark YES or NO if the problems above interfered with the following:

1. Saying prayers ☐ Yes ☐ No
2. Doing chores ☐ Yes ☐ No
3. Friendships ☐ Yes ☐ No
4. Hobbies/Fun ☐ Yes ☐ No
5. Schoolwork ☐ Yes ☐ No
6. Family relationships ☐ Yes ☐ No
7. General happiness ☐ Yes ☐ No