

UCLA PTSD Reaction Index for DSM-5 Children/Adolescents ©

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Child/Adolescent Name: _____	ID # _____	Age: _____	Sex: <input type="checkbox"/> Girl <input type="checkbox"/> Boy
Grade in School _____	School: _____	Teacher: _____	City/State _____
Interviewer Name/I.D. _____	Date (month, day, year) ____/____/____		(Session # _____)

TRAUMA/LOSS HISTORY SCREENING QUESTIONS: Use the questions in the screening form provided below to ask about history of different types of trauma and loss. Place a check mark in the box on the left for each type of trauma /loss experience that has occurred. In interviewing the child/adolescent, you may ask: *Sometimes people have scary or violent things that happen to them where someone could have been or was badly hurt or killed. I’m going to ask you some questions about whether any of these kinds of things have happened to you so that you can tell me if they did.* [For those children/adolescents able to complete the form on their own, you may instruct them to place a check mark in the box on the left of the screening form to indicate that the trauma/loss has happened to them.] In either case, follow up on those items endorsed using the **TRAUMA/LOSS DETAILS** form provided in the next section.

TRAUMA/LOSS HISTORY SCREENING QUESTIONS	
<input type="checkbox"/>	1) Serious Accidental Injury: Have you ever <u>been in</u> a bad accident (like a serious car, bus, train or bicycle accident or a bad fall) where you or someone else was or could have been badly hurt or killed? Have you ever <u>seen</u> a bad accident where someone was badly hurt or killed?
<input type="checkbox"/>	2) Illness/Medical Trauma: Have you ever been so <u>sick</u> that you and your parents (or people taking care of you) were scared that you might die? Did you have a <u>medical treatment</u> that was very scary or painful? Did you ever see someone you really care about get so sick that you were scared they might die?
<input type="checkbox"/>	3) Community Violence: Did you ever see a <u>bad fight or shooting</u> in your neighborhood, like between gangs? Were you <u>afraid</u> of getting badly hurt or killed? Have you seen someone mugged, robbed, stabbed or killed in your neighborhood?
<input type="checkbox"/>	4) Domestic Violence: Have you ever <u>seen</u> adults you live with get in a <u>bad fight</u> with each other, where someone got punched, kicked or hit with something? Have adults you live with threatened to hurt each other? Have you ever <u>seen</u> an adult you live with forced to do something sexual by another adult you live with?
<input type="checkbox"/>	5) School Violence/Emergency: Were you ever <u>at school</u> when something really scary happened, like a shooting, a stabbing, a fire, where you or someone got badly beaten up or someone attempted or committed suicide?
<input type="checkbox"/>	6) Physical Assault: Have you ever <u>been badly physically hurt</u> (punched, kicked, stabbed, shaken) by someone <u>outside</u> of your family or who was <u>not</u> taking care of you? Have you ever been badly hurt (punched, kicked, stabbed) by someone <u>outside</u> your family, like someone in your neighborhood or a stranger?
<input type="checkbox"/>	7) Disaster: Have you ever been in a natural disaster, like a hurricane, tornado, earthquake, flood or wildfire where you were hurt or could have been hurt or killed? Have you been in a natural disaster where you saw someone badly hurt or killed? Have you been in a place where there was a chemical spill or explosion?
<input type="checkbox"/>	8) Sexual Abuse: Did someone who was <u>taking care of you</u> ever force you to do something sexual? Did someone <u>taking care of you</u> ever make you watch something sexual?
<input type="checkbox"/>	9) Physical Abuse: Have you ever <u>been badly hurt</u> (punched, kicked, stabbed, shaken) by someone who <u>is</u> in your family or <u>was</u> taking care of you? Have you seen another child in your family being badly physically hurt by a parent, caregiver or legal guardian?
<input type="checkbox"/>	10) Neglect: Has there ever been a time when someone who <u>should</u> have been taking care of you <u>didn't</u> , like they didn't take you to a doctor when you were really sick, they left you alone for too long, didn't make sure you were going to school or didn't do their best to keep you healthy or safe?
<input type="checkbox"/>	11) Psychological Maltreatment/Emotional Abuse: Did anyone in your family ever keep telling you that you are no good, keep yelling at you or keep threatening to leave you or send you away? Were you often punished at home in ways that felt very unfair?
<input type="checkbox"/>	12) Interference with Caregiving: Was there ever a time when someone who was <u>supposed</u> to take care of you <u>couldn't</u> , like they were too sick, they were so sad they stayed in bed or they had a drinking or drug problem?

TRAUMA/LOSS HISTORY SCREENING QUESTIONS

- 13) **Sexual Assault:** Did someone outside your family ever force you to do something sexual? Did you ever see someone else being forced to do something sexual?
- 14) **Kidnapping/Abduction:** Have you ever been stolen or kidnapped (taken somewhere against your will) by someone without the permission of your parent or legal guardian?
- 15) **Terrorism:** Were you ever there when a terrorist attack happened, like a bombing, chemical attack or where people were taken hostage?
- 16) **Bereavement:** Has someone really close to you ever died?
- 17) **Separation:** Were you ever separated for a long time from someone you depend on, like a parent went to jail or was hospitalized, or you were placed in foster care?
- 18) **War/Political Violence:** Have you lived in a country where a war or armed conflict was happening (like soldiers or armed groups were fighting)? Did you see people who had been badly hurt or killed in a war or armed conflict?
- 19) **Forced Displacement:** Have you ever been forced to move out of your house due to war, armed conflict or disaster, like having to move to a trailer or refugee camp?
- 20) **Trafficking/Sexual Exploitation:** Have you ever done sexual things for money, food, clothes or protection? Were you ever sold to someone to work for them? Have you been forced into prostitution or pornography?
- 21) **Bullying:** Has someone your age or a student at your school ever bullied you, like kept calling you dirty names, making sexual comments, threatening to beat you up or spreading mean rumors around school or online?
- 22) **Attempted Suicide:** Have you ever tried to kill yourself?
- 23) **Witnessed Suicide:** Have you ever seen someone after he/she attempted or committed suicide?

TRAUMA/LOSS DETAILS: For each experience endorsed on the Trauma/Loss History Screening Questions form, place a check mark to indicate whether the specified trauma details were present, whether the child/adolescent was a *victim*, *witness* or *learned about** the trauma, and the age(s) over which the trauma occurred. (Both of these forms may be updated over the course of treatment as additional information about trauma history is revealed or as additional traumas occur.) **Learned about only* refers to indirect exposure in learning aversive details of violent personal assault, homicide, suicide, serious accident, or serious injury to a close relative or friend. It does **not** include learning about death due to natural causes.

Trauma Type	Trauma Details	Role in Event	Age(s) Experienced																	
			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Serious Accidental Injury	<input type="checkbox"/> Motor Vehicle Accident <input type="checkbox"/> Fall with Serious Injury <input type="checkbox"/> Severe Burn <input type="checkbox"/> Dog Bite Requiring Stitches <input type="checkbox"/> Near Drowning <input type="checkbox"/> Hospitalized <input type="checkbox"/> Other _____	<input type="checkbox"/> Victim <input type="checkbox"/> Witness <input type="checkbox"/> Learned about	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Trauma Type	Trauma Details	Role in Event	Age(s) Experienced																	
			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Illness/Medical Trauma	<input type="checkbox"/> Child <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Type of Illness _____ <input type="checkbox"/> Extended Hospitalization <input type="checkbox"/> Major Medical Procedures <input type="checkbox"/> Catastrophic Medical Event	<input type="checkbox"/> Victim <input type="checkbox"/> Witness <input type="checkbox"/> Learned about	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Community Violence	<input type="checkbox"/> Someone Injured or Killed <input type="checkbox"/> Mugging <input type="checkbox"/> Drug Dealing <input type="checkbox"/> Gang-Related <input type="checkbox"/> Home Robbery <input type="checkbox"/> High Crime Community <input type="checkbox"/> Witness Arrest of a Family Member <input type="checkbox"/> Other _____	<input type="checkbox"/> Victim <input type="checkbox"/> Witness <input type="checkbox"/> Learned about	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Domestic Violence	<input type="checkbox"/> Witnessed Physical Attack or Fight <input type="checkbox"/> Heard Threatened Harm <input type="checkbox"/> Heard Screams of Distress <input type="checkbox"/> Witnessed Sexual Assault <input type="checkbox"/> Weapon Used <input type="checkbox"/> Serious Injury <input type="checkbox"/> Police Response <input type="checkbox"/> Restraining Order	<input type="checkbox"/> Witness <input type="checkbox"/> Learned about	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
School Violence/Emergency	<input type="checkbox"/> Shooting <input type="checkbox"/> Stabbing <input type="checkbox"/> Fire <input type="checkbox"/> Bomb threat <input type="checkbox"/> Hostage Situation <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Acute Medical Death <input type="checkbox"/> Witnessed Resuscitation Efforts <input type="checkbox"/> Other _____	<input type="checkbox"/> Victim <input type="checkbox"/> Witness <input type="checkbox"/> Learned about	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Physical Assault	<input type="checkbox"/> Punched <input type="checkbox"/> Kicked <input type="checkbox"/> Stabbed <input type="checkbox"/> Shaken <input type="checkbox"/> Weapon Used <input type="checkbox"/> Reported to police <input type="checkbox"/> Other _____	<input type="checkbox"/> Victim <input type="checkbox"/> Witness <input type="checkbox"/> Learned about	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Trauma Type	Trauma Details	Role in Event	Age(s) Experienced																	
			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Disaster	<input type="checkbox"/> Earthquake <input type="checkbox"/> Fire <input type="checkbox"/> Flood <input type="checkbox"/> Hurricane <input type="checkbox"/> Tornado <input type="checkbox"/> Chemical spill <input type="checkbox"/> Explosion <input type="checkbox"/> Evacuated <input type="checkbox"/> Lost Home <input type="checkbox"/> Injury <input type="checkbox"/> Death of family member <input type="checkbox"/> Other _____	<input type="checkbox"/> Victim <input type="checkbox"/> Witness <input type="checkbox"/> Learned about	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>																	
Sexual Abuse	<input type="checkbox"/> Forced sexual behavior <input type="checkbox"/> Watch something sexual <input type="checkbox"/> Penetration occurred <input type="checkbox"/> Perpetrator _____ <input type="checkbox"/> Child Protective Services Report <input type="checkbox"/> Investigation conducted <input type="checkbox"/> Charges filed <input type="checkbox"/> Conviction <input type="checkbox"/> Perpetrator removed from home <input type="checkbox"/> Child Removed from Home	<input type="checkbox"/> Victim <input type="checkbox"/> Witness <input type="checkbox"/> Learned about	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>																	
Physical Abuse	<input type="checkbox"/> Badly Physically Hurt <input type="checkbox"/> Punched <input type="checkbox"/> Kicked <input type="checkbox"/> Stabbed <input type="checkbox"/> Shaken <input type="checkbox"/> Weapon Used <input type="checkbox"/> Perpetrator _____ <input type="checkbox"/> Child Protective Services Report <input type="checkbox"/> Investigation Conducted <input type="checkbox"/> Charges Filed <input type="checkbox"/> Conviction <input type="checkbox"/> Perpetrator Removed From Home <input type="checkbox"/> Child Removed From Home	<input type="checkbox"/> Victim <input type="checkbox"/> Witness <input type="checkbox"/> Learned about	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>																	

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			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Neglect	<input type="checkbox"/> Medical Neglect	<input type="checkbox"/> Victim <input type="checkbox"/> Witness	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>																	
	<input type="checkbox"/> School Neglect																			
	<input type="checkbox"/> Left Alone/Unsupervised																			
	<input type="checkbox"/> Failure to promote health																			
	<input type="checkbox"/> Failure to promote safety																			
	<input type="checkbox"/> Other _____																			
	<input type="checkbox"/> Perpetrator _____																			
	<input type="checkbox"/> Child Protective Services Report																			
	<input type="checkbox"/> Investigation Conducted																			
	<input type="checkbox"/> Charges Filed																			
	<input type="checkbox"/> Conviction																			
	<input type="checkbox"/> Perpetrator Removed from Home																			
Psychological Maltreatment/ Emotional Abuse	<input type="checkbox"/> Berating	<input type="checkbox"/> Victim <input type="checkbox"/> Witness	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>																	
	<input type="checkbox"/> Threatened Abandonment																			
	<input type="checkbox"/> Excessive Punishment																			
	<input type="checkbox"/> Other _____																			
	<input type="checkbox"/> Perpetrator _____																			
	<input type="checkbox"/> Child Protective Services Report																			
	<input type="checkbox"/> Investigation Conducted																			
	<input type="checkbox"/> Charges Filed																			
	<input type="checkbox"/> Conviction																			
	<input type="checkbox"/> Perpetrator Removed From Home																			
	<input type="checkbox"/> Child Removed From Home																			

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			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Interference with Caregiving	<p><u>Impairment Due to:</u></p> <input type="checkbox"/> Medical illness <input type="checkbox"/> Mental health problem <input type="checkbox"/> Alcohol use/abuse/addiction <input type="checkbox"/> Drug use/abuse/addiction <input type="checkbox"/> Extended hospitalization or rehabilitation <p><u>Affected Caregiver:</u></p> <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other relative <input type="checkbox"/> Other (non-related) adult <input type="checkbox"/> Other _____	<input type="checkbox"/> Victim <input type="checkbox"/> Witness	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>																	
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Sexual Assault	<p><u>Perpetrator:</u></p> <input type="checkbox"/> Relative <input type="checkbox"/> Position of trust (teacher, coach, step-parent, minister, clergy, relative not in the home) <input type="checkbox"/> Acquaintance (neighbor, etc.) <input type="checkbox"/> Stranger <p><u>Trauma Details:</u></p> <input type="checkbox"/> Weapon used <input type="checkbox"/> Object used <input type="checkbox"/> Penetration occurred <input type="checkbox"/> Date/Acquaintance rape <input type="checkbox"/> Reported to police <input type="checkbox"/> Investigation conducted <input type="checkbox"/> Charges filed <input type="checkbox"/> Conviction <input type="checkbox"/> Other _____	<input type="checkbox"/> Victim <input type="checkbox"/> Witness <input type="checkbox"/> Learned about	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>																	
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			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Kidnapping/ Abduction	Perpetrator: <input type="checkbox"/> Parent <input type="checkbox"/> Relative <input type="checkbox"/> Step-parent <input type="checkbox"/> Position of trust (teacher, coach, clergy) <input type="checkbox"/> Acquaintance (neighbor, etc.) <input type="checkbox"/> Stranger <input type="checkbox"/> Length of time _____ <input type="checkbox"/> Reported to police <input type="checkbox"/> Investigation conducted <input type="checkbox"/> Charges filed <input type="checkbox"/> Conviction	<input type="checkbox"/> Victim <input type="checkbox"/> Witnessed <input type="checkbox"/> Learned about	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Terrorism	<input type="checkbox"/> Shooting <input type="checkbox"/> Bombing <input type="checkbox"/> Suicide bombing <input type="checkbox"/> Chemical agent <input type="checkbox"/> Biological agent <input type="checkbox"/> Radiological agent <input type="checkbox"/> Hostages taken <input type="checkbox"/> Parent or caregiver injured <input type="checkbox"/> Parent or caregiver killed <input type="checkbox"/> Other _____	<input type="checkbox"/> Victim <input type="checkbox"/> Witnessed <input type="checkbox"/> Learned about	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Bereavement	<p>Deceased/Cause</p> <p><input type="checkbox"/> Primary Caregiver # _____</p> <p><input type="checkbox"/> Parent # _____</p> <p><input type="checkbox"/> Sibling # _____</p> <p><input type="checkbox"/> Grandparent # _____</p> <p><input type="checkbox"/> Other Relative # _____</p> <p><input type="checkbox"/> Friend # _____</p> <p><input type="checkbox"/> Other _____ # _____</p> <p>Cause of Death</p> <p>1.Natural Causes (illness, age)</p> <p>2.Accident (car, drowning, fall)</p> <p>3.Drug overdose</p> <p>4.Natural disaster</p> <p>5.Homicide</p> <p>6.Suicide</p> <p>7.Other _____</p>	<p><input type="checkbox"/> Witnessed</p> <p><input type="checkbox"/> Learned about</p>	<p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>																	
	<p>Cause of Separation</p> <p><input type="checkbox"/> Parental death</p> <p><input type="checkbox"/> Parents separated</p> <p><input type="checkbox"/> Parents divorced</p> <p><input type="checkbox"/> Parent hospitalized</p> <p><input type="checkbox"/> Parent/sibling incarcerated</p> <p><input type="checkbox"/> Immigration proceeding</p> <p><input type="checkbox"/> Military deployment</p> <p style="padding-left: 20px;"><input type="checkbox"/> Combat</p> <p><input type="checkbox"/> Child placed in foster care</p> <p><input type="checkbox"/> Parent removed from the home</p> <p><input type="checkbox"/> In refugee situation</p> <p><input type="checkbox"/> Due to immigration situation</p> <p><input type="checkbox"/> Other _____</p>	<p><input type="checkbox"/> Victim</p>	<p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>																	

Trauma Type	Trauma Details	Role in Event	Age(s) Experienced																	
			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
War/Political Violence	<input type="checkbox"/> Lived in war-torn region <input type="checkbox"/> Experienced armed conflict <input type="checkbox"/> Saw wounded people <input type="checkbox"/> Saw dead bodies <input type="checkbox"/> Family members taken as prisoners <input type="checkbox"/> Home damaged/destroyed <input type="checkbox"/> Internally displaced <input type="checkbox"/> War refugee <input type="checkbox"/> Other _____	<input type="checkbox"/> Victim <input type="checkbox"/> Witness <input type="checkbox"/> Learned about	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Forced Displacement	<u>Cause of Displacement:</u> <input type="checkbox"/> War/political violence <input type="checkbox"/> Disaster <input type="checkbox"/> Other _____ <u>Site of Displacement:</u> <input type="checkbox"/> Trailer <input type="checkbox"/> Refugee camp <input type="checkbox"/> Relocation center <input type="checkbox"/> Other _____	<input type="checkbox"/> Victim <input type="checkbox"/> Witness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trafficking/Sexual Exploitation	<input type="checkbox"/> Sex for money, food, clothes <input type="checkbox"/> Pornography <input type="checkbox"/> Sold into prostitution <input type="checkbox"/> Sold into slave labor (unpaid servant or worker) <input type="checkbox"/> Other _____	<input type="checkbox"/> Victim <input type="checkbox"/> Witness <input type="checkbox"/> Learned about	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bullying	<input type="checkbox"/> Verbal insults <input type="checkbox"/> Threats of physical harm <input type="checkbox"/> Injury <input type="checkbox"/> Sexual comments <input type="checkbox"/> Rumors at school/internet <input type="checkbox"/> Exclusion from social activities <input type="checkbox"/> Other _____	<input type="checkbox"/> Victim <input type="checkbox"/> Witness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Trauma Type	Trauma Details	Role in Event	Age(s) Experienced																	
			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Attempted Suicide	Method: <input type="checkbox"/> Drug <input type="checkbox"/> Hanging <input type="checkbox"/> Drowning <input type="checkbox"/> Firearm <input type="checkbox"/> Other _____	<input type="checkbox"/> Victim <input type="checkbox"/> Witness <input type="checkbox"/> Learned about	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>																	
Witnessed Suicide	<input type="checkbox"/> Completed suicide <input type="checkbox"/> Attempted suicide Method <input type="checkbox"/> Overdose <input type="checkbox"/> Knife/Razor <input type="checkbox"/> Firearm <input type="checkbox"/> Hanging <input type="checkbox"/> Jumping from a height <input type="checkbox"/> Other _____ Person <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Other relative <input type="checkbox"/> Close friend <input type="checkbox"/> Acquaintance/schoolmate <input type="checkbox"/> Stranger	<input type="checkbox"/> Witness	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>																	

If only one trauma/loss type is endorsed above, write in the trauma/loss type in this blank: _____.

If more than one trauma/loss type is endorsed, have the child/adolescent choose the trauma/loss experience that **BOTHERS THEM THE MOST NOW** and identify that trauma/loss type in this blank: _____.

Clinician: Provide a brief description of the trauma/loss type that is most bothersome now:

POSTTRAUMATIC STRESS SYMPTOMS

Here is a list of problems people can have after bad things happen. Please think about the bad thing that happened to you that bothers you the most now. For each problem **CIRCLE ONE** of the numbers (0, 1, 2, 3 or 4) that tells how many days the problem happened to you **in the past month**, even if the bad thing happened a long time ago. Use the **Frequency Rating Sheet** to help you decide how many days the problem happened **in the past month**.

<i>HOW MUCH OF THE TIME DURING THE PAST MONTH...</i>		None	Little	Some	Much	Most
1 _{E3}	I am on the lookout for danger or things that I am afraid of (like looking over my shoulder even when nothing is there).	0	1	2	3	4
2 _{D2}	I have thoughts like “I am bad.”	0	1	2	3	4
3 _{C2}	I try to stay away from people, places, or things that remind me about what happened.	0	1	2	3	4
4 _{E1}	I get upset easily or get into arguments or physical fights.	0	1	2	3	4
5 _{B3}	I feel like I am back at the time when the bad thing happened, like it’s happening all over again.	0	1	2	3	4
6 _{D4}	I feel like what happened was sickening or gross.	0	1	2	3	4
7 _{D5}	I don’t feel like doing things with my family or friends or other things that I liked to do.	0	1	2	3	4
8 _{E5}	I have trouble concentrating or paying attention.	0	1	2	3	4
9 _{D2}	I have thoughts like, “The world is really dangerous.”	0	1	2	3	4
10 _{B2}	I have bad dreams about what happened, or other bad dreams.	0	1	2	3	4
11 _{B4}	When something reminds me of what happened I get very upset, afraid, or sad.	0	1	2	3	4
12 _{D7}	I have trouble feeling happiness or love.	0	1	2	3	4
13 _{C1}	I try not to think about or have feelings about what happened.	0	1	2	3	4
14 _{B5}	When something reminds me of what happened, I have strong feelings in my body like my heart beats fast, my head aches or my stomach aches.	0	1	2	3	4
15 _{D3}	I am mad with someone for making the bad thing happen, not doing more to stop it, or to help after.	0	1	2	3	4
16 _{D2}	I have thoughts like “I will never be able to trust other people.”	0	1	2	3	4
17 _{D6}	I feel alone even when I am around other people.	0	1	2	3	4
18 _{B1}	I have upsetting thoughts, pictures or sounds of what happened come into my mind when I don’t want them to.	0	1	2	3	4

HOW MUCH OF THE TIME DURING THE PAST MONTH...		None	Little	Some	Much	Most
19 _{D3}	I think that part of what happened was my fault.	0	1	2	3	4
20 _{E2}	I hurt myself on purpose.	0	1	2	3	4
21 _{E6}	I have trouble going to sleep, wake up often, or have trouble getting back to sleep.	0	1	2	3	4
22 _{D4}	I feel ashamed or guilty about some part of what happened.	0	1	2	3	4
23 _{D1}	I have trouble remembering important parts of what happened.	0	1	2	3	4
24 _{E4}	I feel jumpy or startle easily, like when I hear a loud noise or when something surprises me.	0	1	2	3	4
25 _{D4}	I feel afraid or scared.	0	1	2	3	4
26 _{E2}	I do risky or unsafe things that could really hurt me or someone else.	0	1	2	3	4
27 _{D4}	I want to get back at someone for what happened.	0	1	2	3	4
With Dissociative Symptoms (Dissociative Subtype)						
28 _{A1}	I feel like I am seeing myself or what I am doing from outside my body (like watching myself in a movie).	0	1	2	3	4
29 _{A1}	I feel not connected to my body, like I'm not really there inside.	0	1	2	3	4
30 _{A2}	I feel like things around me look strange, different, or like I am in a fog.	0	1	2	3	4
31 _{A2}	I feel like things around me are not real, like I am in a dream.	0	1	2	3	4

Clinician: Check whether the reactions (thoughts and feelings) above appear to cause clinically significant *distress or functional impairment*.

Clinically Significant Distress: (check if youth endorses #1 below)

Yes No 1. Do these reactions (thoughts and feelings) bother or upset you a lot?

Clinically Significant Functional Impairment: (check if functional impairment at home, at school, in peer relationships, in developmental progression)

Home: (check if youth endorses #1, #2 or #3 below)

Yes No 1. Do these reactions (thoughts and feelings) make it harder for you to get along with people at home?

Yes No 2. Do these reactions (thoughts and feelings) get you into trouble at home?

Yes No 3. Do these reactions (thoughts and feelings) cause some other problem at home?

Describe: _____

School: (check if youth endorses #1 or #2 below)

Yes No 1. Do these reactions (thoughts and feelings) make it harder for you to do well in school?

Yes No 2. Do these reactions (thoughts and feelings) cause other problems at school?

Describe: _____

Peer Relationships: (check if youth endorses #1 below)

Yes No 1. Do these reactions (thoughts and feelings) make it harder for you to get along with your friends or make new friends?

Describe: _____

Developmental Progression: (check if youth endorses #1 below)

Yes No 1. Do these reactions (thoughts and feelings) make it harder for you to do important things that other kids your age are doing?

Yes No 2. Other (describe) _____

FREQUENCY RATING SHEET

HOW MANY DAYS DURING THE PAST MONTH
DID THE PROBLEM HAPPEN?

0

1

2

3

4

NONE

LITTLE

SOME

MUCH

MOST

S	M	T	W	H	F	S

S	M	T	W	H	F	S
	X					
					X	

S	M	T	W	H	F	S
		X			X	
		X				
			X			
				X		
	X		X			

S	M	T	W	H	F	S
	X		X		X	
X		X				
	X		X		X	
X	X					

S	M	T	W	H	F	S
X	X	X	X	X	X	X
	X	X	X	X		
	X	X		X	X	
X	X	X	X	X	X	X

NEVER

TWO DAYS
A MONTH

1-2 DAYS
A WEEK

2-3 DAYS
A WEEK

ALMOST
EVERY DAY

SCORE SHEET

Subject ID# _____ Age _____ Sex (circle): M F Date: _____ Subject Name: _____

*For Items 2, 9, and 16: indicate **highest score only** for DSM-5 Symptom D2; for Items 15 and 19: indicate **highest score only** for DSM-5 Symptom D3; for Items 6, 22, 25, and 27: indicate **highest score only** for DSM-5 Symptom D4; for Items 20 and 26: indicate **highest score only** for DSM-5 Symptom E2. Category B Total: Sum scores for symptoms B1-B5; Category C Total: Sum scores for symptoms C1 and C2; Category D Total: Sum scores for symptoms D1-D7; Category E Total: Sum scores for symptoms E1-E6; PTSD-RI Total Scale Score: Sum Category B, C, D, and E.*

Item #	DSM-5 Symptom	Score (0-4)
18	B1	
10	B2	
5	B3	
11	B4	
14	B5	
SYMPTOM CATEGORY B SUMMATIVE SCORE:		

13	C1	
3	C2	
SYMPTOM CATEGORY C SUMMATIVE SCORE:		

Item #	DSM-5 Symptom	Score (0-4)
23	D1	
2*	D2	
9*	D2	_____
16*	D2	
15*	D3	
19*	D3	_____
6*	D4	
22*	D4	
25*	D4	_____
27*	D4	
7	D5	
17	D6	
12	D7	
SYMPTOM CATEGORY D SUMMATIVE SCORE:		

Item #	DSM-5 Symptom	Score (0-4)
4	E1	
20*	E2	
26*	E2	_____
1	E3	
24	E4	
8	E5	
21	E6	
SYMPTOM CATEGORY E SUMMATIVE SCORE:		

Dissociative Symptoms

28. A1 _____

29. A1 _____

(Indicate highest score for A1) _____

30. A2 _____

31. A2 _____

(Indicate highest score for A2) _____

**PTSD-RI
TOTAL SCALE SCORE**

DSM-5 PTSD DIAGNOSIS

B: One or more Category B symptoms present:

C: One or more Category C symptoms present:

D: Two or more Category D symptoms present:

E: Two or more Category E symptoms present:

F: Symptom duration greater than one month:

G: Symptoms cause clinically significant *distress* or *impairment*:

Specify Dissociative Subtype:

One or more dissociative symptoms present:

Estimating Whether DSM-5 PTSD Category B, C, D, and E Symptom Criteria are Met

If symptom score is 3 or 4, then score symptom as “present.” For question #4, #10, and #26; use a rating of 2 or more for symptom presence. Then determine whether one or more B symptoms are present; whether one or more C symptoms are present; whether two or more D symptoms are present; and whether two or more E symptoms are present. If one or more Dissociative Symptoms are present, then assign Dissociative Subtype.