

Form ID Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Child's Initials: \_\_\_\_\_  
Center ID Subcenter ID Child ID First Middle Last

**System Screening Information**

**Complete the following.**

1. **Child's initials** \_\_\_\_\_ (Enter a dash if no middle initial)  
First Middle Last
  
2. **Child's date of birth:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year
  
3. **Child's gender:**  
<sub>1</sub> Male  
<sub>2</sub> Female
  
4. **Has this child been seen at another NCTSN network center(s) for a previous episode(s) of care?**  
<sub>0</sub> No  
<sub>1</sub> Yes → **If Yes: Was this child enrolled in the NCTSN's Core Data Set?**  
<sub>0</sub> No  
<sub>1</sub> Yes → **If Yes: STOP and call NCTSN @ (919) 668-8182 for further instructions!**
  
5. **Has this child been seen at this center for a previous episode(s) of care?**  
<sub>0</sub> No  
<sub>1</sub> Yes → **If Yes: Was this child already enrolled in the NCTSN's Core Data Set?**  
<sub>0</sub> No → **Click Submit to continue Enrollment**  
<sub>1</sub> Yes → **If Yes: STOP, do not proceed with enrollment.**  
**If Yes: GO to the Follow-up Assessment and create a Follow up Visit record.**

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**Baseline Visit and Demographic Information**

Complete the following.

1. Date of visit: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

**Baseline Visit Information**

2. Is this the child's first visit at this center for the **current** episode of care?  
<sub>0</sub> No → If No: How many visits (including today's visit) has the child had at your center for the current episode of care? Number of Visits \_\_\_\_\_  
<sub>1</sub> Yes
3. From whom are you collecting information for this form? (Check all that apply)  
 Parent  
 Other adult relative  
 Foster parent  
 Agency staff  
 Child/adolescent/self  
 Other, Specify: \_\_\_\_\_
4. Who is currently the legal guardian for this child? (Check only one)  
<sub>1</sub> Parent  
<sub>2</sub> Other adult relative  
<sub>3</sub> State  
<sub>4</sub> Emancipated minor (self)  
<sub>98</sub> Other, Specify: \_\_\_\_\_  
<sub>99</sub> Unknown

**Demographic Information**

5. Child's ethnicity (Check only one):  
<sub>1</sub> Hispanic or Latino  
<sub>2</sub> Not Hispanic or Latino  
<sub>99</sub> Unknown
6. Child's race (If multiracial, check all that apply):  
 American Indian or Alaska Native  
 Asian  
 Black/African American  
 Native Hawaiian or other Pacific Islander  
 White  
 Unknown
7. Was the child born in the United States?  
<sub>0</sub> No → If No: In what country was the child born? \_\_\_\_\_  
<sub>1</sub> Yes  
<sub>99</sub> Unknown
8. Is the child (and/or family) a refugee, asylum seeker, or immigrant with a history of exposure to community violence?  
<sub>0</sub> No  
<sub>1</sub> Yes  
<sub>99</sub> Unknown

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**Baseline Visit and Demographic Information (continued)**

Complete the following.

**9. Is this child currently participating in the Cross-Site Evaluation?**

<sub>99</sub> Unknown

<sub>0</sub> No

<sub>1</sub> Yes → **If Yes**, were all of the standard assessments (CBCL, PTSD-RI &/or TSCC-A) completed within the timeframe allowed by the **Cross-Site Evaluation** (30 days from Intake or visit date specified for question 1 above)?

<sub>1</sub> Yes

<sub>0</sub> No → **If No: Please provide visit date(s) the standard assessments were administered.**

**Date:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ **Assessment:** \_\_\_\_\_  
Month Day Year

**Date:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ **Assessment:** \_\_\_\_\_  
Month Day Year

**Date:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ **Assessment:** \_\_\_\_\_  
Month Day Year

**NOTE: Provide the date an assessment was completed if it was administered over multiple dates.**

**10. Please provide an identifier for the health care provider currently caring for this child.** \_\_\_\_\_

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**Brief Intervention Services Information**

Brief Intervention refers to the number of sessions that a child/family may receive. If a child/family is receiving 3 – 6 sessions, then complete the following.

1. Is this child/family receiving brief intervention services?  
 <sub>0</sub> No  
 <sub>1</sub> Yes → If Yes: Please press the Add Entry button and complete the requested information for EACH episode of care where the child/family receives brief intervention services. A new entry is required for each type of treatment and each different set of start/stop dates.

1. What treatment component(s) is the child/family receiving for this brief episode of care? (Check all that apply)

- Screening
- Assessment
- Case Consultation
- Case Management
- Child and Family Traumatic Stress Intervention (CFTSI)
- Crisis Management
- Referral Services
- Psycho-education
- Safety Planning
- Individual Therapy
- Family Therapy
- Group Therapy
- Support Group
- Other, Specify: \_\_\_\_\_

2. Date this brief episode of care began: \_\_/\_\_/\_\_\_\_

NOTE: Answer question 3 after the child/family has completed the selected treatment component(s).

3. Did this child/family complete the treatment component(s) offered during this brief episode of care?  
 <sub>0</sub> No, left treatment before completing → If No: Date left treatment: \_\_/\_\_/\_\_\_\_  
 <sub>1</sub> Yes, completed treatment → If Yes: Date completed treatment: \_\_/\_\_/\_\_\_\_

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**NCTSN Breakthrough Series/Learning Collaboratives**

Complete the following.

1. Is this child/family receiving a treatment from a therapist participating in a breakthrough series or learning collaborative for that treatment?

<sub>0</sub> No

<sub>1</sub> Yes → If Yes: Please press the Add Entry button and complete the requested information for each treatment the child/family is receiving through a breakthrough series or learning collaborative. A new entry is required for each type of treatment and each different set of start/stop dates.

1. What treatment is this child/family receiving through a therapist participating in a breakthrough series or other learning collaborative? (Check only one)

- <sub>1</sub> Trauma-Focused Cognitive Behavior Therapy (TF-CBT)
- <sub>2</sub> Life Skills/Life Stories
- <sub>3</sub> Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)
- <sub>4</sub> Trauma Adaptive Recovery Group Education and Therapy TARGET (TARGET)
- <sub>5</sub> Trauma Systems Therapy (TST)
- <sub>6</sub> Child Parent Psychotherapy (CPP)
- <sub>7</sub> Cognitive-Behavioral Intervention for Trauma in Schools (CBITS)
- <sub>98</sub> Other, Specify name of treatment: \_\_\_\_\_

2. Date this treatment began: \_\_/\_\_/\_\_\_\_

NOTE: Complete question 3 after the child/family has terminated this treatment.

3. Did this child/family complete this treatment?

<sub>0</sub> No, left this treatment before completing → If No: Date left this treatment: \_\_/\_\_/\_\_\_\_

<sub>1</sub> Yes, completed treatment → If Yes: Date completed this treatment: \_\_/\_\_/\_\_\_\_

**Insurance Information and Domestic Environment**

**Insurance Information**

1. Is the child currently covered by any type of public or private health insurance?

- \_0 No
- \_1 Yes → If Yes: Specify type
- \_99 Unknown

2. Type of public or private health insurance currently covering the child (Check all that apply)

- Public:
  - Medicare
  - Medicaid
  - Indian health service
  - Children's health insurance program (CHIP)
  - Other public, Specify: \_\_\_\_\_
- Private:
  - HMO
  - PPO
  - Fee-for-service
  - Other private, Specify: \_\_\_\_\_

3. Is the child's parent/guardian covered by any type of insurance?

- \_0 No
- \_1 Yes → If Yes: Specify type
- \_99 Unknown

4. Type of public or private health insurance currently covering the child's parent/guardian (Check all that apply)

- Public:
  - Medicare
  - Medicaid
  - Indian health service
  - Children's health insurance program (CHIP)
  - Other public, Specify: \_\_\_\_\_
- Private:
  - HMO
  - PPO
  - Fee-for-service
  - Other private, Specify: \_\_\_\_\_

**Domestic Environment**

5. Where is the child's current primary residence? (Check only one)

- \_1 Independent (alone or with peers)
- \_2 Home (With parent(s))
- \_3 With relatives or other family
- \_4 Regular foster care
- \_5 Treatment foster care
- \_6 Residential treatment center
- \_7 Correctional facility
- \_8 Homeless
- \_99 Unknown
- \_98 Other, Specify \_\_\_\_\_

6. How many months has the child been living in above setting?

\_\_\_\_\_(Enter number of months or "0" if less than one month)

- OR \_1 Entire life
- OR \_99 Unknown

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**Domestic Environment Details**

**If 'Home with parent(s) or 'With relatives or other family' is selected for primary residence on the Insurance Information and Domestic Environment form at Baseline complete the following questions.**

**1. What types of adults live in the home with the child? (Check all that apply)**

- Mother (Biological or adopted)
- Father (Biological or adopted)
- Parent's partner/significant other
- Grandparent
- Other adult relative
- Other adult non-relative
- Unknown
- Other, Specify: \_\_\_\_\_

**2. Total number of adults (18 years of age or older) living in child's home: \_\_\_\_\_**  
**OR** <sub>99</sub> Unknown

**3. Total number of children younger than 18 years of age (including client) living in child's home: \_\_\_\_\_**  
**OR** <sub>99</sub> Unknown

**4. Please specify zip code of child's current residence: \_ \_ \_ \_ \_ (5 digit zip code)**  
**OR** <sub>99</sub> Unknown

**5. Primary language spoken at home: (Check only one)**

- <sub>1</sub> English
- <sub>2</sub> Spanish
- <sub>3</sub> French
- <sub>4</sub> Mandarin
- <sub>5</sub> Cantonese
- <sub>6</sub> Navaho
- <sub>7</sub> Japanese
- <sub>8</sub> Korean
- <sub>9</sub> Russian
- <sub>99</sub> Unknown
- <sub>98</sub> Other, Specify: \_\_\_\_\_

**6. What is the total income for the child's household for the past year, before taxes and including all sources:**

\$ \_\_\_\_\_ (US\$)  
**OR** <sub>99</sub> Unknown

**Indicators of Severity of Problems**

This section relates to the types of problems and experiences 'child' might have displayed. Indicate if the child experienced these types of problems within the past month (within the last 30 days). Please answer each question.

All responses should be the Indicator of Severity for problems experienced within the past month.

<p><b>1. Academic problems</b> (e.g., Problems with school work or grades)</p>	<p><input type="checkbox"/><sub>0</sub> Not a problem <input type="checkbox"/><sub>99</sub> Unknown  <input type="checkbox"/><sub>1</sub> Somewhat/sometimes a problem  <input type="checkbox"/><sub>2</sub> Very much/often a problem</p>
<p><b>2. Behavior problems in school or daycare</b> (e.g., Getting into trouble, detention, suspension, expulsion)</p>	<p><input type="checkbox"/><sub>0</sub> Not a problem <input type="checkbox"/><sub>99</sub> Unknown  <input type="checkbox"/><sub>1</sub> Somewhat/sometimes a problem  <input type="checkbox"/><sub>2</sub> Very much/often a problem</p>
<p><b>3. Problems with skipping school or daycare</b> (e.g., Where he /she skipped at least 4 days in the past month, or skipped parts of the day on at least half of the school days)</p>	<p><input type="checkbox"/><sub>0</sub> Not a problem <input type="checkbox"/><sub>99</sub> Unknown  <input type="checkbox"/><sub>1</sub> Somewhat/sometimes a problem  <input type="checkbox"/><sub>2</sub> Very much/often a problem</p>
<p><b>4. Behavior problems at home or community</b> (e.g., Violent or aggressive behavior; breaking rules, fighting, destroying property, or other dangerous or illegal behavior)</p>	<p><input type="checkbox"/><sub>0</sub> Not a problem <input type="checkbox"/><sub>99</sub> Unknown  <input type="checkbox"/><sub>1</sub> Somewhat/sometimes a problem  <input type="checkbox"/><sub>2</sub> Very much/often a problem</p>
<p><b>5. Suicidality</b> (e.g., Thinking about killing himself/herself or attempting to do so)</p>	<p><input type="checkbox"/><sub>0</sub> Not a problem <input type="checkbox"/><sub>99</sub> Unknown  <input type="checkbox"/><sub>1</sub> Somewhat/sometimes a problem  <input type="checkbox"/><sub>2</sub> Very much/often a problem</p>
<p><b>6. Other self-injurious behaviors</b> (e.g., Cutting him/herself, pulling out his/her own hair)</p>	<p><input type="checkbox"/><sub>0</sub> Not a problem <input type="checkbox"/><sub>99</sub> Unknown  <input type="checkbox"/><sub>1</sub> Somewhat/sometimes a problem  <input type="checkbox"/><sub>2</sub> Very much/often a problem</p>
<p><b>7. Developmentally inappropriate sexualized behaviors</b> (e.g., Saying or doing things about sex that children his/her age do not usually know)</p>	<p><input type="checkbox"/><sub>0</sub> Not a problem <input type="checkbox"/><sub>99</sub> Unknown  <input type="checkbox"/><sub>1</sub> Somewhat/sometimes a problem  <input type="checkbox"/><sub>2</sub> Very much/often a problem</p>
<p><b>8. Alcohol use</b> (e.g., Use of alcohol)</p>	<p><input type="checkbox"/><sub>0</sub> Not a problem <input type="checkbox"/><sub>99</sub> Unknown  <input type="checkbox"/><sub>1</sub> Somewhat/sometimes a problem  <input type="checkbox"/><sub>2</sub> Very much/often a problem</p>
<p><b>9. Substance use</b> (e.g., Use of illicit drugs or misuse of prescription medication)</p>	<p><input type="checkbox"/><sub>0</sub> Not a problem <input type="checkbox"/><sub>99</sub> Unknown  <input type="checkbox"/><sub>1</sub> Somewhat/sometimes a problem  <input type="checkbox"/><sub>2</sub> Very much/often a problem</p>
<p><b>10. Attachment problems</b> (e.g., Difficulty forming and maintaining trusting relationships with other people)</p>	<p><input type="checkbox"/><sub>0</sub> Not a problem <input type="checkbox"/><sub>99</sub> Unknown  <input type="checkbox"/><sub>1</sub> Somewhat/sometimes a problem  <input type="checkbox"/><sub>2</sub> Very much/often a problem</p>
<p><b>11. Criminal activity</b> (e.g., Activities that have resulted in being stopped by the police or arrested)</p>	<p><input type="checkbox"/><sub>0</sub> Not a problem <input type="checkbox"/><sub>99</sub> Unknown  <input type="checkbox"/><sub>1</sub> Somewhat/sometimes a problem  <input type="checkbox"/><sub>2</sub> Very much/often a problem</p>
<p><b>12. Running away from home</b> (e.g., Staying away for at least one night)</p>	<p><input type="checkbox"/><sub>0</sub> Not a problem <input type="checkbox"/><sub>99</sub> Unknown  <input type="checkbox"/><sub>1</sub> Somewhat/sometimes a problem  <input type="checkbox"/><sub>2</sub> Very much/often a problem</p>
<p><b>13. Prostitution</b> (e.g., Exchanging sex for money, drugs or other resources)</p>	<p><input type="checkbox"/><sub>0</sub> Not a problem <input type="checkbox"/><sub>99</sub> Unknown  <input type="checkbox"/><sub>1</sub> Somewhat/sometimes a problem  <input type="checkbox"/><sub>2</sub> Very much/often a problem</p>
<p><b>14. Child has other medical problems or disabilities</b> (e.g., Chronic or recurrent condition that affects the child's ability to function)</p>	<p><input type="checkbox"/><sub>0</sub> Not a problem <input type="checkbox"/><sub>99</sub> Unknown  <input type="checkbox"/><sub>1</sub> Somewhat/sometimes a problem  <input type="checkbox"/><sub>2</sub> Very much/often a problem</p>

<b>Services Received</b>	
<b>BASELINE INSTRUCTIONS: Has the child received any of these services or been placed in any of the following (excluding today's visit) within the past month (within the past 30 days). These may include services provided by your Center as well as services provided by any other clinician, setting or sector.</b>	
<b>1. Inpatient psychiatric unit or a hospital for mental health problems</b>	<input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes <input type="checkbox"/> 99 Unknown
<b>2. Residential treatment center</b> (A self-contained treatment facility where the child lives and goes to school)	<input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes <input type="checkbox"/> 99 Unknown
<b>3. Detention center, training school, jail, or prison</b>	<input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes <input type="checkbox"/> 99 Unknown
<b>4. Group home</b> (A group residence in a community setting)	<input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes <input type="checkbox"/> 99 Unknown
<b>5. Treatment foster care</b> (Placement with foster parents who receive special training and supervision to help children with problems)	<input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes <input type="checkbox"/> 99 Unknown
<b>6. Probation officer or court counselor</b>	<input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes <input type="checkbox"/> 99 Unknown
<b>7. Day treatment program</b> (A day program that includes a focus on therapy and may also provide education while the child is there)	<input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes <input type="checkbox"/> 99 Unknown
<b>8. Case management or care coordination</b> (Someone who helps the child get the kinds of services he/she needs)	<input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes <input type="checkbox"/> 99 Unknown
<b>9. In-home counseling</b> (Services, therapy, or treatment provided in the child's home)	<input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes <input type="checkbox"/> 99 Unknown
<b>10. Outpatient therapy</b> (From psychologist, social worker, therapist, or other counselor)	<input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes <input type="checkbox"/> 99 Unknown
<b>11. Outpatient treatment from a psychiatrist</b>	<input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes <input type="checkbox"/> 99 Unknown
<b>12. Primary care physician/pediatrician for symptoms related to trauma or emotional/behavioral problems.</b> (Excluding emergency room)	<input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes <input type="checkbox"/> 99 Unknown
<b>13. School counselor, school psychologist, or school social worker</b> (For behavioral or emotional problems)	<input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes <input type="checkbox"/> 99 Unknown
<b>14. Special class or special school</b> (For all or part of the day)	<input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes <input type="checkbox"/> 99 Unknown
<b>15. Child Welfare or Department of Social Services</b> (Include any types of contact)	<input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes <input type="checkbox"/> 99 Unknown
<b>16. Foster care</b> (Placement in kinship or non-relative foster care)	<input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes <input type="checkbox"/> 99 Unknown
<b>17. Therapeutic recreation services or mentor</b>	<input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes <input type="checkbox"/> 99 Unknown

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<b>Services Received (continued)</b>	
<b>18. Hospital emergency room</b> (For problems related to trauma or emotional or behavioral problems)	<input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes <input type="checkbox"/> 99 Unknown
<b>19. Self-help groups</b> (e.g., AA, NA)	<input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes <input type="checkbox"/> 99 Unknown

<b>Clinical Evaluation</b>	
Based on your clinical evaluation, for questions 1-21 please check each problem/symptom/disorder currently displayed by the child. For question 22 please indicate the <i>primary</i> problems/symptom/disorder currently displayed by the child.	
<b>Clinical Problems, Symptoms, &amp; Disorders</b>	<b>Child has/exhibits this problem?</b> (Answer all that apply)
1. Acute stress disorder	<input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>1</sub> Probable <input type="checkbox"/> <sub>2</sub> Definite
2. Post traumatic stress disorder	<input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>1</sub> Probable <input type="checkbox"/> <sub>2</sub> Definite
3. Traumatic/complicated grief	<input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>1</sub> Probable <input type="checkbox"/> <sub>2</sub> Definite
4. Dissociation	<input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>1</sub> Probable <input type="checkbox"/> <sub>2</sub> Definite
5. Somatization	<input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>1</sub> Probable <input type="checkbox"/> <sub>2</sub> Definite
6. Generalized anxiety	<input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>1</sub> Probable <input type="checkbox"/> <sub>2</sub> Definite
7. Separation disorder	<input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>1</sub> Probable <input type="checkbox"/> <sub>2</sub> Definite
8. Panic disorder	<input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>1</sub> Probable <input type="checkbox"/> <sub>2</sub> Definite
9. Phobic disorder	<input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>1</sub> Probable <input type="checkbox"/> <sub>2</sub> Definite
10. Obsessive compulsive disorder	<input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>1</sub> Probable <input type="checkbox"/> <sub>2</sub> Definite
11. Depression	<input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>1</sub> Probable <input type="checkbox"/> <sub>2</sub> Definite
12. Attachment problems	<input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>1</sub> Probable <input type="checkbox"/> <sub>2</sub> Definite
13. Sexual behavioral problems	<input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>1</sub> Probable <input type="checkbox"/> <sub>2</sub> Definite
14. Oppositional defiant disorder	<input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>1</sub> Probable <input type="checkbox"/> <sub>2</sub> Definite
15. Conduct disorder	<input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>1</sub> Probable <input type="checkbox"/> <sub>2</sub> Definite
16. General behavioral problems	<input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>1</sub> Probable <input type="checkbox"/> <sub>2</sub> Definite
17. Attention deficit hyperactivity disorder	<input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>1</sub> Probable <input type="checkbox"/> <sub>2</sub> Definite
18. Suicidality	<input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>1</sub> Probable <input type="checkbox"/> <sub>2</sub> Definite
19. Substance abuse	<input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>1</sub> Probable <input type="checkbox"/> <sub>2</sub> Definite
20. Sleep disorder	<input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>1</sub> Probable <input type="checkbox"/> <sub>2</sub> Definite
21. Are there any other additional problems currently displayed by this child?	Specify: _____

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**Clinical Evaluation (Continued)**

**22. Please indicate the *primary* problem/symptom/disorder currently displayed by this child. (Select only one)**

- 1 Acute stress disorder
- 2 Post traumatic stress disorder
- 3 Traumatic/complicated grief
- 4 Dissociation
- 5 Somatization
- 6 Generalized anxiety
- 7 Separation disorder
- 8 Panic disorder
- 9 Phobic disorder
- 10 Obsessive compulsive disorder
- 11 Depression
- 12 Attachment problems
- 13 Sexual behavioral problems
- 14 Oppositional defiant disorder
- 15 Conduct disorder
- 16 General behavioral problems
- 17 Attention deficit hyperactivity disorder
- 18 Suicidality
- 19 Substance abuse
- 20 Sleep disorder
- 21 Other

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**Follow-up Information**

**Follow-Up Assessment(s) should be completed in each of the following conditions:**

1. Near the end of planned treatment (e.g., approaching the last session for a planned discharge, at the time of termination for children who indicate they are dropping out, or at the last session before transferring to an out-of NCTSN provider)
  2. Every three months (as long as the child remains in treatment) except if the child is enrolled in the Cross-Site Evaluation, follow up assessments will be conducted every 3 months for 12 months even if services/treatment ends
  3. When a child returns to treatment for a new episode of care
- Every child must have a Follow-up Assessment completed with an "End of Treatment status. Some follow-up data is expected to be reported for all cases except those "Lost to follow-up".

1. **Date of follow-up:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

2. **Which type of follow-up is being performed?**

- 1 Follow-up for ongoing treatment
- 2 End of treatment → **If "End of Treatment",** please indicate the status of the child at the completion of follow-up:
  - 1 Treatment is completed as planned.
  - 2 Case was transferred to another clinic or program.
  - 3 Child dropped out prior to end of planned treatment (for any reason)
  - 4 Case is lost, no follow-up assessments performed
  - 98 Other, Specify: \_\_\_\_\_
- 3 Re-opening case for new episode of care
- 4 Post treatment (Use only for children participating in the Cross-Site Evaluation)
- 98 Other, Specify: \_\_\_\_\_

3. **Has any new trauma been experienced since last interview?**

- 0 No
- 1 Yes → (please update the General Trauma Information form)
- 99 Unknown

4. **Has any previously experienced trauma been revealed since last interview?**

- 0 No
- 1 Yes → (please update the General Trauma information form)
- 99 Unknown

**Note: For a child identified as 'Case is lost, no follow-up assessments performed', questions 5 and 6 are not required.**

5. **From whom are you collecting information for this form?** (Check all that apply)

- Parent
- Other adult relative
- Foster parent
- Agency staff
- Child/Adolescent/Self
- Other, Specify: \_\_\_\_\_

6. **Who is currently the legal guardian for this child?** (Check only one)

- 1 Parent
- 2 Other adult relative
- 3 State
- 4 Emancipated minor (self)
- 98 Other, Specify: \_\_\_\_\_
- 99 Unknown

7. **Is this child currently participating in the Cross-Site Evaluation?**

- 0 No → **If No: Indicate reason:** (Check only one)
  - 1 Parent/guardian/child refuse to participate
  - 98 Other, Specify: \_\_\_\_\_
- 1 Yes → **Which data point is being collected?** (Check only one)
  - 1 3 Month
  - 2 6 Month
  - 3 9 Month
  - 4 12 Month
  - 98 Other, Specify: \_\_\_\_\_

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**Follow-up Information (Continued)**

8. If Yes was selected in response to question #7 (Is this child currently participating in the Cross-Site Evaluation), were all of the standard assessments (CBCL, PTSD-RI &/or TSCC-A) completed within the timeframe allowed by the Cross-Site Evaluation (2 weeks/14 business days before or after the visit date specified for question 1 above)?

<sub>0</sub> No → If No: Please provide visit date(s) the standard assessments were administered.

Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Assessment: \_\_\_\_\_  
Month Day Year

Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Assessment: \_\_\_\_\_  
Month Day Year

Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Assessment: \_\_\_\_\_  
Month Day Year

**NOTE: Provide the date an assessment was completed if it was administered over multiple dates.**

<sub>1</sub> Yes

9. Please provide an identifier for the health care provider currently caring for this child. \_\_\_\_\_

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**Brief Intervention Services Information**

Brief Intervention refers to the number of sessions that a child may receive. If a child is receiving 3 – 6 sessions, then complete the following.

1. Is this child/family receiving brief intervention services?  
 No  
 Yes → **If Yes: Please press the Add Entry button and complete the requested information for EACH episode of care where the child/family receives brief intervention services. A new entry is required for each type of treatment and each different set of start/stop dates.**

1. What treatment component(s) is the child/family receiving for this brief episode of care? (Check all that apply)

- Screening
- Assessment
- Case Consultation
- Case Management
- Child and Family Traumatic Stress Intervention (CFTSI)
- Crisis Management
- Referral Services
- Psycho-education
- Safety Planning
- Individual Therapy
- Family Therapy
- Group Therapy
- Support Group
- Other, Specify: \_\_\_\_\_

2. Date this brief episode of care began: \_\_/\_\_/\_\_\_\_

**NOTE: Answer question 3 after the child/family has completed the selected treatment component(s).**

3. Did this child/family complete the treatment component(s) offered during this brief episode of care?  
 No, left treatment before completing → **If No: Date left treatment: \_\_/\_\_/\_\_\_\_**  
 Yes, completed treatment → **If Yes: Date completed treatment: \_\_/\_\_/\_\_\_\_**

**NCTSN Breakthrough Series/Learning Collaboratives**

Complete the following.

1. Is this child/family receiving a treatment from a therapist participating in a breakthrough series or learning collaborative for that treatment?

<sub>0</sub> No

<sub>1</sub> Yes → **If Yes: Please press the Add Entry button and complete the requested information for each treatment the child/family is receiving through a breakthrough series or learning collaborative. A new entry is required for each type of treatment and each different set of start/stop dates.**

1. What treatment is this child/family receiving through a therapist participating in a breakthrough series or other learning collaborative? (Check only one)

- <sub>1</sub> Trauma-Focused Cognitive Behavior Therapy (TF-CBT)
- <sub>2</sub> Life Skills/Life Stories
- <sub>3</sub> Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)
- <sub>4</sub> Trauma Adaptive Recovery Group Education and Therapy (TARGET)
- <sub>5</sub> Trauma Systems Therapy (TST)
- <sub>6</sub> Child Parent Psychotherapy (CPP)
- <sub>7</sub> Cognitive-Behavioral Intervention for Trauma in Schools (CBITS)
- <sub>98</sub> Other, Specify name of treatment: \_\_\_\_\_

2. Date this treatment began: \_\_/\_\_/\_\_\_\_

**NOTE: Complete question 3 after the child/family has terminated this treatment.**

3. Did this child/family complete this treatment?

<sub>0</sub> No, left this treatment before completing → If No: Date left this treatment: \_\_/\_\_/\_\_\_\_

<sub>1</sub> Yes, completed treatment → If Yes: Date completed this treatment: \_\_/\_\_/\_\_\_\_

**Insurance Information and Domestic Environment**

**Insurance Information**

1. Is the child currently covered by any type of public or private health insurance?

- <sub>0</sub> No
- <sub>1</sub> Yes → If Yes: Specify type
- <sub>99</sub> Unknown

2. Type of public or private health insurance currently covering the child (Check all that apply)

- Public:
  - Medicare
  - Medicaid
  - Indian health service
  - Children's health insurance program (CHIP)
  - Other public, Specify: \_\_\_\_\_
- Private:
  - HMO
  - PPO
  - Fee-for-service
  - Other private, Specify: \_\_\_\_\_

3. Is the child's parent/guardian covered by any type of insurance?

- <sub>0</sub> No
- <sub>1</sub> Yes → If Yes: Specify type
- <sub>99</sub> Unknown

4. Type of public or private health insurance currently covering the child's parent/guardian (Check all that apply)

- Public:
  - Medicare
  - Medicaid
  - Indian health service
  - Children's health insurance program (CHIP)
  - Other public, Specify: \_\_\_\_\_
- Private:
  - HMO
  - PPO
  - Fee-for-service
  - Other private, Specify: \_\_\_\_\_

**Domestic Environment**

5. Where is the child's current primary residence? (Check only one)

- <sub>1</sub> Independent (alone or with peers)
- <sub>2</sub> Home (With parent(s))
- <sub>3</sub> With relatives or other family
- <sub>4</sub> Regular foster care
- <sub>5</sub> Treatment foster care
- <sub>6</sub> Residential treatment center
- <sub>7</sub> Correctional facility
- <sub>8</sub> Homeless
- <sub>99</sub> Unknown
- <sub>98</sub> Other, Specify: \_\_\_\_\_

6. How many months has the child been living in above setting?

\_\_\_\_\_(Enter number of months or "0" if less than one month)

- OR <sub>1</sub> Entire life
- OR <sub>99</sub> Unknown

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**Domestic Environment Details**

**If 'Home with parent(s) or 'With relatives or other family' is selected for primary residence on the Insurance Information and Domestic Environment form at Baseline complete the following questions.**

**1. What types of adults live in the home with the child? (Check all that apply)**

- Mother (Biological or adopted)
- Father (Biological or adopted)
- Parent's partner/significant other
- Grandparent
- Other adult relative
- Other adult non-relative
- Unknown
- Other, Specify: \_\_\_\_\_

**2. Total number of adults (18 years of age or older) living in child's home: \_\_\_\_\_**

**OR** <sub>99</sub> Unknown

**3. Total number of children younger than 18 years of age (including client) living in child's home: \_\_\_\_\_**

**OR** <sub>99</sub> Unknown

**4. Please specify zip code of child's current residence: \_\_\_\_\_ (5 digit zip code)**

**OR** <sub>99</sub> Unknown

**5. Primary language spoken at home: (Check only one)**

- <sub>1</sub> English
- <sub>2</sub> Spanish
- <sub>3</sub> French
- <sub>4</sub> Mandarin
- <sub>5</sub> Cantonese
- <sub>6</sub> Navaho
- <sub>7</sub> Japanese
- <sub>8</sub> Korean
- <sub>9</sub> Russian
- <sub>99</sub> Unknown
- <sub>98</sub> Other, Specify: \_\_\_\_\_

**6. What is the total income for the child's household for the past year, before taxes and including all sources:**

\$ \_\_\_\_\_ (US\$)

**OR** <sub>99</sub> Unknown

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<b>Indicators of Severity of Problems</b>	
<b>This section relates to the types of problems and experiences 'child' might have displayed. Indicate if the child experienced these types of problems during the past month (within the past 30 days). Please answer each question.</b>	
All responses should be the Indicator of Severity for problems experienced <b>within the past month.</b>	
<b>1. Academic problems</b> (e.g., Problems with school work or grades)	<input type="checkbox"/> <sub>0</sub> Not a problem <input type="checkbox"/> <sub>99</sub> Unknown <input type="checkbox"/> <sub>1</sub> Somewhat/sometimes a problem <input type="checkbox"/> <sub>2</sub> Very much/often a problem
<b>2. Behavior problems in school or daycare</b> (e.g., Getting into trouble, detention, suspension, expulsion)	<input type="checkbox"/> <sub>0</sub> Not a problem <input type="checkbox"/> <sub>99</sub> Unknown <input type="checkbox"/> <sub>1</sub> Somewhat/sometimes a problem <input type="checkbox"/> <sub>2</sub> Very much/often a problem
<b>3. Problems with skipping school or daycare</b> (e.g., Where he /she skipped at least 4 days in the past month, or skipped parts of the day on at least half of the school days)	<input type="checkbox"/> <sub>0</sub> Not a problem <input type="checkbox"/> <sub>99</sub> Unknown <input type="checkbox"/> <sub>1</sub> Somewhat/sometimes a problem <input type="checkbox"/> <sub>2</sub> Very much/often a problem
<b>4. Behavior problems at home or community</b> (e.g., Violent or aggressive behavior; breaking rules, fighting, destroying property, or other dangerous or illegal behavior)	<input type="checkbox"/> <sub>0</sub> Not a problem <input type="checkbox"/> <sub>99</sub> Unknown <input type="checkbox"/> <sub>1</sub> Somewhat/sometimes a problem <input type="checkbox"/> <sub>2</sub> Very much/often a problem
<b>5. Suicidality</b> (e.g., Thinking about killing himself/herself or attempting to do so)	<input type="checkbox"/> <sub>0</sub> Not a problem <input type="checkbox"/> <sub>99</sub> Unknown <input type="checkbox"/> <sub>1</sub> Somewhat/sometimes a problem <input type="checkbox"/> <sub>2</sub> Very much/often a problem
<b>6. Other self-injurious behaviors</b> (e.g., Cutting him/herself, pulling out his/her own hair)	<input type="checkbox"/> <sub>0</sub> Not a problem <input type="checkbox"/> <sub>99</sub> Unknown <input type="checkbox"/> <sub>1</sub> Somewhat/sometimes a problem <input type="checkbox"/> <sub>2</sub> Very much/often a problem
<b>7. Developmentally inappropriate sexualized behaviors</b> (e.g., Saying or doing things about sex that children his/her age do not usually know)	<input type="checkbox"/> <sub>0</sub> Not a problem <input type="checkbox"/> <sub>99</sub> Unknown <input type="checkbox"/> <sub>1</sub> Somewhat/sometimes a problem <input type="checkbox"/> <sub>2</sub> Very much/often a problem
<b>8. Alcohol use</b> (e.g., Use of alcohol)	<input type="checkbox"/> <sub>0</sub> Not a problem <input type="checkbox"/> <sub>99</sub> Unknown <input type="checkbox"/> <sub>1</sub> Somewhat/sometimes a problem <input type="checkbox"/> <sub>2</sub> Very much/often a problem
<b>9. Substance use</b> (e.g., Use of any illicit drugs, or misuse of prescription medication)	<input type="checkbox"/> <sub>0</sub> Not a problem <input type="checkbox"/> <sub>99</sub> Unknown <input type="checkbox"/> <sub>1</sub> Somewhat/sometimes a problem <input type="checkbox"/> <sub>2</sub> Very much/often a problem
<b>10. Attachment problems</b> (e.g., Difficulty forming and maintaining trusting relationships with other people)	<input type="checkbox"/> <sub>0</sub> Not a problem <input type="checkbox"/> <sub>99</sub> Unknown <input type="checkbox"/> <sub>1</sub> Somewhat/sometimes a problem <input type="checkbox"/> <sub>2</sub> Very much/often a problem
<b>11. Criminal activity</b> (e.g., Activities that have resulted in being stopped by the police or arrested)	<input type="checkbox"/> <sub>0</sub> Not a problem <input type="checkbox"/> <sub>99</sub> Unknown <input type="checkbox"/> <sub>1</sub> Somewhat/sometimes a problem <input type="checkbox"/> <sub>2</sub> Very much/often a problem
<b>12. Running away from home</b> (e.g., Staying away for at least one night)	<input type="checkbox"/> <sub>0</sub> Not a problem <input type="checkbox"/> <sub>99</sub> Unknown <input type="checkbox"/> <sub>1</sub> Somewhat/sometimes a problem <input type="checkbox"/> <sub>2</sub> Very much/often a problem
<b>13. Prostitution</b> (e.g., Exchanging sex for money, drugs or other resources)	<input type="checkbox"/> <sub>0</sub> Not a problem <input type="checkbox"/> <sub>99</sub> Unknown <input type="checkbox"/> <sub>1</sub> Somewhat/sometimes a problem <input type="checkbox"/> <sub>2</sub> Very much/often a problem
<b>14. Child has other medical problems or disabilities</b> (e.g., Chronic or recurrent condition that affects the child's ability to function)	<input type="checkbox"/> <sub>0</sub> Not a problem <input type="checkbox"/> <sub>99</sub> Unknown <input type="checkbox"/> <sub>1</sub> Somewhat/sometimes a problem <input type="checkbox"/> <sub>2</sub> Very much/often a problem

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<b>Services Received</b>	
<b>FOLLOW UP INSTRUCTIONS:</b> Has the child received any of these services or been placed in any of the following (excluding today's visit) since the last NCTSN Core Dataset collection. These may include services provided by your Center as well as services provided by any other clinician, setting or sector.	
<b>1. Inpatient psychiatric unit or a hospital for mental health problems</b>	<input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes <input type="checkbox"/> 99 Unknown
<b>2. Residential treatment center</b> (A self-contained treatment facility where the child lives and goes to school)	<input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes <input type="checkbox"/> 99 Unknown
<b>3. Detention center, training school, jail, or prison</b>	<input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes <input type="checkbox"/> 99 Unknown
<b>4. Group home</b> (A group residence in a community setting)	<input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes <input type="checkbox"/> 99 Unknown
<b>5. Treatment foster care</b> (Placement with foster parents who receive special training and supervision to help children with problems)	<input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes <input type="checkbox"/> 99 Unknown
<b>6. Probation officer or court counselor</b>	<input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes <input type="checkbox"/> 99 Unknown
<b>7. Day treatment program</b> (A day program that includes a focus on therapy and may also provide education while the child is there)	<input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes <input type="checkbox"/> 99 Unknown
<b>8. Case management or care coordination</b> (Someone who helps the child get the kinds of services he/she needs)	<input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes <input type="checkbox"/> 99 Unknown
<b>9. In-home counseling</b> (Services, therapy, or treatment provided in the child's home)	<input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes <input type="checkbox"/> 99 Unknown
<b>10. Outpatient therapy other than at this clinic</b> (From psychologist, social worker, therapist, or other counselor)	<input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes <input type="checkbox"/> 99 Unknown
<b>11. Outpatient treatment from a psychiatrist</b>	<input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes <input type="checkbox"/> 99 Unknown
<b>12. Primary care physician/pediatrician for symptoms related to trauma or emotional/behavioral problems</b> (Excluding emergency room)	<input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes <input type="checkbox"/> 99 Unknown
<b>13. School counselor, school psychologist, or school social worker</b> (For behavioral or emotional problems)	<input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes <input type="checkbox"/> 99 Unknown
<b>14. Special class or special school</b> (For all or part of the day)	<input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes <input type="checkbox"/> 99 Unknown
<b>15. Child welfare or departments of social services</b> (Include any types of contact)	<input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes <input type="checkbox"/> 99 Unknown
<b>16. Foster care</b> (Placement in kinship or non-relative foster care)	<input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes <input type="checkbox"/> 99 Unknown
<b>17. Therapeutic recreation services or mentor</b>	<input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes <input type="checkbox"/> 99 Unknown

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<b>Services Received (continued)</b>	
<b>18. Hospital emergency room</b> (For problems related to trauma or emotional or behavioral problems)	<input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>99</sub> Unknown
<b>19. Self-help groups</b> (e.g., AA, NA)	<input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>99</sub> Unknown

**Treatment by NCTSN Center**

Thinking about the period since the last assessment, please complete the following about services and treatment that your agency has provided for this child.

**1. Has the child received any inpatient or residential treatment?**

- <sub>0</sub> No
- <sub>1</sub> Yes → **If Yes: Specify type** (Check all that apply):
- |   |                              |
|---|------------------------------|
| <input type="checkbox"/> Hospital   | Specify number of days _____ |
| <input type="checkbox"/> Residential treatment center                             | Specify number of days _____ |
| <input type="checkbox"/> Group home or other community- based treatment placement | Specify number of days _____ |
| <input type="checkbox"/> Other, Specify _____                                     | Specify number of days _____ |

**2. Has the child received any outpatient therapy?**

- <sub>0</sub> No
- <sub>1</sub> Yes → **If Yes: Specify type** (Check all that apply):
- |   |                                |
|---|--------------------------------|
| <input type="checkbox"/> Individual therapy for child   | Specify number of visits _____ |
| <input type="checkbox"/> Individual therapy for parent  | Specify number of visits _____ |
| <input type="checkbox"/> Family or Dyadic therapy       | Specify number of visits _____ |
| <input type="checkbox"/> Group therapy with other youth | Specify number of visits _____ |
| <input type="checkbox"/> Multi-family group therapy     | Specify number of visits _____ |
| <input type="checkbox"/> Other, Specify _____           | Specify number of visits _____ |

**3. In what setting(s) has your agency provided services for this child and/or family? (Check all that apply)**

- Clinic
- Home
- School
- Day treatment/partial hospitalization
- Other, Specify \_\_\_\_\_

**Treatment by NCTSN Center (continued)**

Thinking about the period since the last assessment, please complete the following about services and treatment that your agency has provided for this child.

**4. Please indicate all general modalities of treatment provided.** (Check all that apply)

- Attachment-based therapy
- Behavioral therapy
- Cognitive therapy
- Cognitive behavioral therapy
- Day treatment or partial hospitalization
- Expressive therapies (Drawing, movement, theater)
- Family therapy
- Intensive in-home services
- Narrative therapy
- Parent training
- Peer therapy
- Pharmacotherapy/medication
- Phase-oriented trauma treatment
- Play therapy
- Psychoanalysis
- Psychodynamic psychotherapy
- School-based treatment
- Social skills training
- Solution-focused therapy
- Stress management/relaxation training
- Supportive therapy
- 'Wrap around' services
- Other, Specify \_\_\_\_\_

**Treatment by NCTSN Center (continued)**

Thinking about the period since the last assessment, please complete the following about services and treatment that your agency has provided for this child.

**5. Please indicate the *primary* general modality of treatment provided. (Check only one)**

- <sub>1</sub> Attachment-based therapy
- <sub>2</sub> Behavioral therapy
- <sub>3</sub> Cognitive therapy
- <sub>4</sub> Cognitive behavioral therapy
- <sub>5</sub> Day treatment or partial hospitalization
- <sub>6</sub> Expressive therapies (Drawing, movement, theater)
- <sub>7</sub> Family therapy
- <sub>8</sub> Intensive in-home services
- <sub>9</sub> Narrative therapy
- <sub>10</sub> Parent training
- <sub>11</sub> Peer therapy
- <sub>12</sub> Pharmacotherapy/medication
- <sub>13</sub> Phase-oriented trauma treatment
- <sub>14</sub> Play therapy
- <sub>15</sub> Psychoanalysis
- <sub>16</sub> Psychodynamic psychotherapy
- <sub>17</sub> School-based treatment
- <sub>18</sub> Social skills training
- <sub>19</sub> Solution-focused therapy
- <sub>20</sub> Stress management/relaxation training
- <sub>21</sub> Supportive therapy
- <sub>22</sub> 'Wrap around' services
- <sub>98</sub> Other, Specified in question 4

**Treatment by NCTSN Center Continued**

Thinking about the period since the last assessment, please complete the following about services and treatment that your agency has provided for this child.

1. Please indicate *all specific intervention protocols provided, if any. Items should ONLY be checked if treating clinician has been formally trained in the specific intervention protocol.* (Check all that apply)

- None
- Abuse-Focused Cognitive Behavioral Therapy for Child Physical Abuse (AF-CBT)
- Adapted Dialectical Behavior Therapy for Special Populations (DBT-SP)
- Attachment, Self-Regulation, and Competence (ARC): A Comprehensive Framework for Intervention with Complexly Traumatized Youth
- Child-Parent Psychotherapy (CPP)
- Cognitive-Behavioral Intervention for Trauma in Schools (CBITS)
- Combined Parent Child Cognitive-Behavioral Approach for Children & Families At-Risk for Child Physical Abuse
- Combined Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and Selective Serotonin Reuptake Inhibitors (SSRI) Treatment
- Culturally Modified Trauma-Focused Treatment (CM-TFT)
- Eye Movement Desensitization and Reprocessing (EMDR)
- Group Treatment for Children Affected by Domestic Violence
- Integrative Treatment of Complex Trauma (ITCT)
- Life Skills/Life Stories
- Multimodality Trauma Treatment Trauma-Focused Coping (MMTT)
- Multisystemic Treatment (MST)
- Parent-Child Interaction Therapy (PCIT)
- Real Life Heroes (RLH)
- Safety, Mentoring, Advocacy, Recovery, and Treatment (SMART)
- Sanctuary Model
- Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)
- Trauma Affect Regulation: Guidelines for Education and Therapy for Adolescents and Pre-Adolescents (TARGET-A)
- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
- Trauma-Focused Cognitive Behavioral Therapy for Childhood Traumatic Grief (TG-CBT)
- Trauma-Informed Brief Intervention Services
- Trauma System Therapy (TST)
- UCLA Trauma/Grief Program for Adolescents: Component Therapy for Trauma and Grief (CTTG)
- Youth Dialectical Behavioral Therapy
- Other, Specify: \_\_\_\_\_

**Treatment by NCTSN Center Continued (continued)**

Thinking about the period since the last assessment, please complete the following about services and treatment that your agency has provided for this child.

2. Please indicate the *primary* specific intervention protocol provided, if any. Items should ONLY be checked if treating clinician has been formally trained in the specific intervention protocol. (Check only one).

- <sub>1</sub> None
- <sub>2</sub> Abuse-Focused Cognitive Behavioral Therapy for Child Physical Abuse (AF-CBT)
- <sub>3</sub> Adapted Dialectical Behavior Therapy for Special Populations (DBT-SP)
- <sub>4</sub> Attachment, Self-Regulation, and Competence (ARC): A Comprehensive Framework for Intervention with Complexly Traumatized Youth
- <sub>5</sub> Child-Parent Psychotherapy (CPP)
- <sub>6</sub> Cognitive-Behavioral Intervention for Trauma in Schools (CBITS)
- <sub>7</sub> Combined Parent Child Cognitive-Behavioral Approach for Children & Families At-Risk for Child Physical Abuse
- <sub>8</sub> Combined Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and Selective Serotonin Reuptake Inhibitors (SSRI) Treatment
- <sub>9</sub> Culturally Modified Trauma-Focused Treatment (CM-TFT)
- <sub>10</sub> Eye Movement Desensitization and Reprocessing (EMDR)
- <sub>11</sub> Group Treatment for Children Affected by Domestic Violence
- <sub>12</sub> Integrative Treatment of Complex Trauma (ITCT)
- <sub>13</sub> Life Skills/Life Stories
- <sub>14</sub> Multimodality Trauma Treatment Trauma-Focused Coping (MMTT)
- <sub>15</sub> Multisystemic Treatment (MST)
- <sub>16</sub> Parent-Child Interaction Therapy (PCIT)
- <sub>17</sub> Real Life Heroes (RLH)
- <sub>18</sub> Safety, Mentoring, Advocacy, Recovery, and Treatment (SMART)
- <sub>19</sub> Sanctuary Model
- <sub>20</sub> Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)
- <sub>21</sub> Trauma Affect Regulation: Guidelines for Education and Therapy for Adolescents and Pre-Adolescents (TARGET-A)
- <sub>22</sub> Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
- <sub>23</sub> Trauma-Focused Cognitive Behavioral Therapy for Childhood Traumatic Grief (TG-CBT)
- <sub>24</sub> Trauma-Informed Brief Intervention Services
- <sub>25</sub> Trauma System Therapy (TST)
- <sub>26</sub> UCLA Trauma/Grief Program for Adolescents: Component Therapy for Trauma and Grief (CTTG)
- <sub>27</sub> Youth Dialectical Behavioral Therapy
- <sub>98</sub> Other, Specified in question 1

**Treatment by NCTSN Center Continued (continued)**

Thinking about the period since the last assessment, please complete the following about services and treatment that your agency has provided for this child.

**3. Please indicate *all* other psychosocial intervention, brief treatment, crisis stabilization, educational services, auxiliary services or prevention modalities provided. (Check all that apply)**

- Acupuncture
- Advocacy activities
- Assessment-Based Treatment for Traumatized Children: Trauma Assessment Pathway (TAP)
- Case management/case coordination
- Child Adult Relationship Enhancement (CARE)
- Child Development-Community Policing Program (CDCP)
- Community Outreach Program-Esperanza (COPE)
- Competence based auxiliary services
- Debriefing
- Honoring Children, Making Relatives (HC-MR)
- Honoring Children, Mending the Circle (HC-MC)
- Honoring Children, Respectful Ways (HC-RW)
- International Family Adult and Child Enhancement Services (IFACES)
- Meditation/Yoga
- Mentoring
- Posttraumatic Stress Management (PTSM)
- Psycho-education
- Psychological First Aid (PFA)
- Safe Harbor Program
- Self-Management/Coaching
- Support groups
- Streetwork Project
- Therapeutic recreational activities including summer camp
- Other, Specify: \_\_\_\_\_

**4. Please indicate ALL the types of clinicians/providers from your agency who have worked with this child. (Check all that apply)**

- Psychologist (Master's or Ph.D.)
- School psychologist (Not recorded above)
- Psychology trainee/intern
- Social worker (MSW, LCSW)
- School social worker
- Social worker trainee/intern
- Psychiatrist
- Other physician not psychiatrist
- Physician extender: (NP, PA), Advanced practice nurse (MSN, CNS)
- Nurse (RN, LPN)
- Therapist/counselor (Not recorded above)
- Occupational therapist/physical therapist
- Paraprofessional
- Translator/interpreter
- Other, Specify: \_\_\_\_\_

**Treatment by NCTSN Center Continued (continued)**

Thinking about the period since the last assessment, please complete the following about services and treatment that your agency has provided for this child.

5. Please indicate the *primary* lead clinician/provider from your agency who worked with this child. (Check only one)

- <sub>1</sub> Psychologist (Master's or Ph.D.)
- <sub>2</sub> School psychologist (Not recorded above)
- <sub>3</sub> Psychology trainee/intern
- <sub>4</sub> Social worker (MSW, LCSW)
- <sub>5</sub> School social worker
- <sub>6</sub> Social worker trainee/intern
- <sub>7</sub> Psychiatrist
- <sub>8</sub> Other physician not psychiatrist
- <sub>9</sub> Physician extender: (NP, PA), Advanced practice nurse (MSN, CNS)
- <sub>10</sub> Nurse (RN, LPN)
- <sub>11</sub> Therapist/counselor (Not recorded above)
- <sub>12</sub> Occupational therapist/physical therapist
- <sub>13</sub> Paraprofessional
- <sub>14</sub> Translator/interpreter
- <sub>15</sub> Other, Specified in question 4

This form completed only for clients remaining in treatment.

**Clinical Evaluation**

Based on your clinical evaluation, for questions 1-21 please check each problem/symptom/disorder currently displayed by the child. For question 22 please indicate the *primary* problems/symptom/disorder currently displayed by the child.

Clinical Problems, Symptoms, Disorders	Child has/exhibits this problem? (Answer all that apply)
1. Acute stress disorder	<input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>1</sub> Probable <input type="checkbox"/> <sub>2</sub> Definite
2. Post traumatic stress disorder	<input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>1</sub> Probable <input type="checkbox"/> <sub>2</sub> Definite
3. Traumatic/complicated grief	<input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>1</sub> Probable <input type="checkbox"/> <sub>2</sub> Definite
4. Dissociation	<input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>1</sub> Probable <input type="checkbox"/> <sub>2</sub> Definite
5. Somatization	<input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>1</sub> Probable <input type="checkbox"/> <sub>2</sub> Definite
6. Generalized anxiety	<input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>1</sub> Probable <input type="checkbox"/> <sub>2</sub> Definite
7. Separation disorder	<input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>1</sub> Probable <input type="checkbox"/> <sub>2</sub> Definite
8. Panic disorder	<input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>1</sub> Probable <input type="checkbox"/> <sub>2</sub> Definite
9. Phobic disorder	<input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>1</sub> Probable <input type="checkbox"/> <sub>2</sub> Definite
10. Obsessive compulsive disorder	<input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>1</sub> Probable <input type="checkbox"/> <sub>2</sub> Definite
11. Depression	<input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>1</sub> Probable <input type="checkbox"/> <sub>2</sub> Definite
12. Attachment problems	<input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>1</sub> Probable <input type="checkbox"/> <sub>2</sub> Definite
13. Sexual behavioral problems	<input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>1</sub> Probable <input type="checkbox"/> <sub>2</sub> Definite
14. Oppositional defiant disorder	<input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>1</sub> Probable <input type="checkbox"/> <sub>2</sub> Definite
15. Conduct disorder	<input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>1</sub> Probable <input type="checkbox"/> <sub>2</sub> Definite
16. General behavioral problems	<input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>1</sub> Probable <input type="checkbox"/> <sub>2</sub> Definite
17. Attention deficit hyperactivity disorder	<input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>1</sub> Probable <input type="checkbox"/> <sub>2</sub> Definite
18. Suicidality	<input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>1</sub> Probable <input type="checkbox"/> <sub>2</sub> Definite
19. Substance abuse	<input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>1</sub> Probable <input type="checkbox"/> <sub>2</sub> Definite
20. Sleep disorder	<input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>1</sub> Probable <input type="checkbox"/> <sub>2</sub> Definite
21. Are there any other additional problems currently displayed by this child?	Specify: _____

Form ID Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Child's Initials: \_\_\_\_\_  
Center ID Subcenter ID Child ID First Middle Last

This form completed only for clients remaining in treatment

**Clinical Evaluation (Continued)**

22. Please indicate the *primary* problem/symptom/disorder currently displayed by this child.

- <sub>1</sub> Acute stress disorder
- <sub>2</sub> Post traumatic stress disorder
- <sub>3</sub> Traumatic/complicated grief
- <sub>4</sub> Dissociation
- <sub>5</sub> Somatization
- <sub>6</sub> Generalized anxiety
- <sub>7</sub> Separation disorder
- <sub>8</sub> Panic disorder
- <sub>9</sub> Phobic disorder
- <sub>10</sub> Obsessive compulsive disorder
- <sub>11</sub> Depression
- <sub>12</sub> Attachment problems
- <sub>13</sub> Sexual behavior problems
- <sub>14</sub> Oppositional defiant disorder
- <sub>15</sub> Conduct disorder
- <sub>16</sub> General behavioral problems
- <sub>17</sub> Attention deficit hyperactivity disorder
- <sub>18</sub> Suicidality
- <sub>19</sub> Substance abuse
- <sub>20</sub> Sleep disorder
- <sub>21</sub> Other

## Core Clinical Characteristics (General Trauma Information Form)

Form ID Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Child's Initials: \_\_\_\_\_  
Center ID Subcenter ID Child ID First Middle Last

<b>General Trauma Information</b>																					
Please complete the following based on the clients trauma history. This information should be maintained during treatment if trauma is experienced or new trauma is revealed.																					
Trauma Type	Has child experienced this trauma? (Answer all Trauma Types)	When was this type of trauma experienced?																			
		Age in years: (Check all ages that apply)																			
		0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	Unknown
<b>1. Sexual maltreatment/abuse:</b> <small>(Actual or attempted sexual molestation, exploitation, or coercion by a caregiver)</small>	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Suspected <input type="checkbox"/> Unknown																				
<b>2. Sexual assault/rape:</b> <small>(Actual or attempted sexual molestation, exploitation, or coercion not by a caregiver and not recorded as sexual abuse)</small>	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Suspected <input type="checkbox"/> Unknown																				
<b>3. Physical maltreatment/abuse:</b> <small>(Actual or attempted infliction of physical pain or bodily injury by a caregiver)</small>	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Suspected <input type="checkbox"/> Unknown																				
<b>4. Physical assault:</b> <small>(Actual or attempted infliction of physical pain or bodily injury not by a caregiver and not recorded as physical abuse )</small>	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Suspected <input type="checkbox"/> Unknown																				
<b>5. Emotional abuse/Psychological Maltreatment:</b> <small>(Emotional abuse, verbal abuse, excessive demands, emotional neglect)</small>	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Suspected <input type="checkbox"/> Unknown																				
<b>6. Neglect:</b> <small>(Physical, medical, or educational neglect)</small>	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Suspected <input type="checkbox"/> Unknown																				
<b>7. Domestic Violence:</b> <small>(Exposure to physical, sexual, and/or emotional abuse directed at adult caregiver(s) in the home)</small>	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Suspected <input type="checkbox"/> Unknown																				

## Core Clinical Characteristics (General Trauma Information Form)

Form ID Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Child's Initials: \_\_\_\_\_  
Center ID Subcenter ID Child ID First Middle Last

<b>General Trauma Information</b>																					
Please complete the following based on the clients trauma history. This information should be maintained during treatment if trauma is experienced or new trauma is revealed.																					
Trauma Type	Has child experienced this trauma? (Check all that apply)	When was this type of trauma experienced? Age in years: (Check all ages that apply)																			
		0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	Unknown
		<b>8. War/Terrorism/Political violence inside the U.S.:</b> (Exposure to any of these events <b>inside</b> the U.S.)	<input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> Suspected <input type="checkbox"/> <sub>99</sub> Unknown																		
<b>9. War/Terrorism/Political violence outside the U.S.:</b> (Exposure to any of these events <b>outside</b> of the U.S.)	<input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> Suspected <input type="checkbox"/> <sub>99</sub> Unknown																				
<b>10. Illness/Medical Trauma:</b> (Life threatening or extremely painful illness or medical procedure)	<input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> Suspected <input type="checkbox"/> <sub>99</sub> Unknown																				
<b>11. Serious injury/Accident:</b> (Unintentional accident or injury)	<input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> Suspected <input type="checkbox"/> <sub>99</sub> Unknown																				
<b>12. Natural disaster:</b> (Major accident or disaster that is the result of a natural event)	<input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> Suspected <input type="checkbox"/> <sub>99</sub> Unknown																				
<b>13. Kidnapping:</b> (Unlawful seizure or detention against the child's will)	<input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> Suspected <input type="checkbox"/> <sub>99</sub> Unknown																				
<b>14. Traumatic loss or bereavement:</b> (Death or separation of a primary caregiver or sibling; the unexpected, or premature death of a close relative or close friend):	<input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> Suspected <input type="checkbox"/> <sub>99</sub> Unknown																				

## Core Clinical Characteristics (General Trauma Information Form)

Form ID Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Child's Initials: \_\_\_\_\_  
Center ID Subcenter ID Child ID First Middle Last

<b>General Trauma Information</b>																				
<b>Please complete the following based on the clients trauma history. This information should be maintained during treatment if trauma is experienced or new trauma is revealed.</b>																				
	<b>Has child experienced this trauma?</b> (Check all that apply)	<b>When was this type of trauma experienced?</b> Age in years: (Check all ages that apply)																		
		0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
<b>15. Forced displacement:</b> (Forced relocation due to political reasons)	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Suspected <input type="checkbox"/> Unknown																			
<b>16. Impaired Caregiver:</b> (History of exposure to caretaker depression, other medical illness, or alcohol/drug abuse)	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Suspected <input type="checkbox"/> Unknown																			
<b>17. Extreme interpersonal violence (not reported elsewhere):</b> (e.g., Homicide/suicide)	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Suspected <input type="checkbox"/> Unknown																			
<b>18. Community violence (not reported elsewhere):</b> (e.g., Gang-related violence, neighborhood violence)	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Suspected <input type="checkbox"/> Unknown																			
<b>19. School violence (not reported elsewhere):</b> (e.g., School shooting, bullying, classmate suicide)	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Suspected <input type="checkbox"/> Unknown																			
<b>20. Other Trauma (not reported elsewhere)?</b> Please Specify: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Suspected <input type="checkbox"/> Unknown																			

General Trauma Information	
<b>21. Primary focus of current treatment? (Select only one)</b>	
<input type="checkbox"/>	1 Sexual maltreatment/abuse
<input type="checkbox"/>	2 Sexual assault/ rape
<input type="checkbox"/>	3 Physical maltreatment/abuse
<input type="checkbox"/>	4 Physical assault
<input type="checkbox"/>	5 Emotional abuse/Psychological Maltreatment
<input type="checkbox"/>	6 Neglect
<input type="checkbox"/>	7 Domestic Violence
<input type="checkbox"/>	8 War/Terrorism/Political violence inside the U.S.
<input type="checkbox"/>	9 War/Terrorism /Political violence outside the U.S
<input type="checkbox"/>	10 Illness/Medical Trauma
<input type="checkbox"/>	11 Serious injury/Accident
<input type="checkbox"/>	12 Natural Disaster
<input type="checkbox"/>	13 Kidnapping
<input type="checkbox"/>	14 Traumatic loss or bereavement
<input type="checkbox"/>	15 Forced Displacement
<input type="checkbox"/>	16 Impaired Caregiver
<input type="checkbox"/>	17 Extreme interpersonal violence (not reported elsewhere)
<input type="checkbox"/>	18 Community Violence (not reported elsewhere)
<input type="checkbox"/>	19 School Violence (not reported elsewhere)
<input type="checkbox"/>	20 Other Trauma (not reported elsewhere)

Form ID Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Child's Initials: \_\_\_\_\_  
Center ID Subcenter ID Child ID First Middle Last

**Trauma Detail, Sexual Maltreatment/Abuse**

Complete the following if experience of this trauma type is indicated on the General Trauma Information Form.

1. When was this trauma revealed/known (to the clinician)?
  - Baseline
  - Other, please provide date: \_\_/\_\_/\_\_\_\_
  
2. Please describe the frequency of the experience. (Check only one)
  - <sub>1</sub> One-time event
  - <sub>2</sub> Repeated exposure
  - <sub>99</sub> Unknown
  
3. Please describe the type(s) of experience. (Check all that apply)
  - Experienced
  - Witnessed
  - Vicarious
  - Unknown
  
4. Please indicate the setting(s) of the experience. (Check all that apply)
  - Home
  - School
  - Community
  - Other, Specify: \_\_\_\_\_
  - Unknown
  
5. Please identify the perpetrator(s). (Check all that apply)
  - Parent
  - Other adult relative
  - Unrelated (but identifiable) adult
  - Sibling
  - Other youth
  - Stranger
  - Unknown
  
6. Was serious injury inflicted?
  - <sub>0</sub> No
  - <sub>1</sub> Yes → If YES, to whom:
    - Child
    - (Check all that apply)  Parent
    - Other adult relative
    - Unrelated (but identifiable) adult
    - Sibling
    - Other youth
    - Other, Specify: \_\_\_\_\_
  - <sub>99</sub> Unknown
  
7. Was a report filed ? (e.g. Police, Child Protective Services)
  - <sub>0</sub> No
  - <sub>1</sub> Yes
  - <sub>99</sub> Unknown
  
8. Did this maltreatment/abuse ever involve oral, vaginal, or anal penetration?
  - <sub>0</sub> No
  - <sub>1</sub> Yes
  - <sub>99</sub> Unknown

Form ID Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Child's Initials: \_\_\_\_\_  
Center ID Subcenter ID Child ID First Middle Last

**Trauma Detail, Sexual Assault/Rape**

Complete the following if experience of this trauma type is indicated on the General Trauma Information Form.

1. When was this trauma revealed/ known (to the clinician)?
  - Baseline
  - Other, please provide date: \_\_/\_\_/\_\_\_\_
  
2. Please describe the frequency of the experience. (Check only one)
  - <sub>1</sub> One-time event
  - <sub>2</sub> Repeated exposure
  - <sub>99</sub> Unknown
  
3. Please describe the type(s) of experience. (Check all that apply)
  - Experienced
  - Witnessed
  - Vicarious
  - Unknown
  
4. Please indicate the setting(s) of the experience. (Check all that apply)
  - Home
  - School
  - Community
  - Other, Specify: \_\_\_\_\_
  - Unknown
  
5. Please identify the perpetrator(s). (Check all that apply)
  - Parent
  - Other adult relative
  - Unrelated (but identifiable) adult
  - Sibling
  - Other youth
  - Stranger
  - Unknown
  
6. Was serious injury inflicted?
  - <sub>0</sub> No
  - <sub>1</sub> Yes → If YES, to whom:
    - Child
    - Parent
    - Other adult relative
    - Unrelated (but identifiable) adult
    - Sibling
    - Other youth
    - Other, Specify: \_\_\_\_\_
  - <sub>99</sub> Unknown
  
7. Was a weapon used?
  - <sub>0</sub> No
  - <sub>1</sub> Yes
  - <sub>99</sub> Unknown
  
8. Was a report filed? (e.g. Police, Child Protective Services)
  - <sub>0</sub> No
  - <sub>1</sub> Yes
  - <sub>99</sub> Unknown
  
9. Did this assault/rape ever involve oral, vaginal, or anal penetration?
  - <sub>0</sub> No
  - <sub>1</sub> Yes
  - <sub>99</sub> Unknown

Form ID Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Child's Initials: \_\_\_\_\_  
Center ID Subcenter ID Child ID First Middle Last

**Trauma Detail, Physical Maltreatment/Abuse**

Complete the following if experience of this trauma type is indicated on the General Trauma Information Form.

1. When was this trauma revealed/known (to the clinician)?
  - Baseline
  - Other, please provide date: \_\_/\_\_/\_\_\_\_
  
2. Please describe the frequency of the experience. (Check only one)
  - <sub>1</sub> One-time event
  - <sub>2</sub> Repeated exposure
  - <sub>99</sub> Unknown
  
3. Please describe the type(s) of experience. (Check all that apply)
  - Experienced
  - Witnessed
  - Vicarious
  - Unknown
  
4. Please indicate the setting(s) of the experience. (Check all that apply)
  - Home
  - School
  - Community
  - Other, Specify: \_\_\_\_\_
  - Unknown
  
5. Please identify the perpetrator(s). (Check all that apply)
  - Parent
  - Other adult relative
  - Unrelated (but identifiable) adult
  - Sibling
  - Other youth
  - Stranger
  - Unknown
  
6. Was serious injury inflicted?
  - <sub>0</sub> No
  - <sub>1</sub> Yes → **If YES, to whom:**
    - Child
    - Parent
    - Other adult relative
    - Unrelated (but identifiable) adult
    - Sibling
    - Other youth
    - Other, Specify: \_\_\_\_\_
  - <sub>99</sub> Unknown
  
7. Was a weapon used?
  - <sub>0</sub> No
  - <sub>1</sub> Yes
  - <sub>99</sub> Unknown
  
8. Was a report filed? (e.g. Police, Child Protective Services)
  - <sub>0</sub> No
  - <sub>1</sub> Yes
  - <sub>99</sub> Unknown

Form ID Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Child's Initials: \_\_\_\_\_  
Center ID Subcenter ID Child ID First Middle Last

**Trauma Detail, Physical Assault**

Complete the following if experience of this trauma type is indicated on the General Trauma Information Form.

1. When was this trauma revealed/known (to the clinician)?
  - Baseline
  - Other, please provide date: \_\_/\_\_/\_\_
  
2. Please describe the frequency of the experience. (Check only one)
  - <sub>1</sub> One-time event
  - <sub>2</sub> Repeated exposure
  - <sub>99</sub> Unknown
  
3. Please describe the type(s) of experience. (Check all that apply)
  - Experienced
  - Witnessed
  - Vicarious
  - Unknown
  
4. Please indicate the setting(s) of the experience. (Check all that apply)
  - Home
  - School
  - Community
  - Other, Specify: \_\_\_\_\_
  - Unknown
  
5. Please identify the perpetrator(s). (Check all that apply)
  - Parent
  - Other adult relative
  - Unrelated (but identifiable) adult
  - Sibling
  - Other youth
  - Stranger
  - Unknown
  
6. Was serious injury inflicted?
  - <sub>0</sub> No
  - <sub>1</sub> Yes → **If YES, to whom:**
    - Child
    - Parent
    - Other adult relative
    - Unrelated (but identifiable) adult
    - Sibling
    - Other youth
    - Other, Specify: \_\_\_\_\_
  - <sub>99</sub> Unknown
  
7. Was a weapon used?
  - <sub>0</sub> No
  - <sub>1</sub> Yes
  - <sub>99</sub> Unknown
  
8. Was a report filed? (e.g. Police, Child Protective Services)
  - <sub>0</sub> No
  - <sub>1</sub> Yes
  - <sub>99</sub> Unknown

Form ID Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Child's Initials: \_\_\_\_\_  
Center ID Subcenter ID Child ID First Middle Last

**Trauma Detail, Emotional Abuse/Psychological Maltreatment**

Complete the following if experience of this trauma type is indicated on the General Trauma Information Form.

1. When was this trauma revealed/known (to the clinician)?
  - Baseline
  - Other, please provide date: \_\_/\_\_/\_\_\_\_
  
2. Please describe the frequency of the experience. (Check only one)
  - 1 One-time event
  - 2 Repeated exposure
  - 99 Unknown
  
3. Please describe the type(s) of experience. (Check all that apply)
  - Experienced
  - Witnessed
  - Vicarious
  - Unknown
  
4. Please indicate the setting(s) of the experience. (Check all that apply)
  - Home
  - School
  - Community
  - Other, Specify: \_\_\_\_\_
  - Unknown
  
5. Please identify the perpetrator(s). (Check all that apply)
  - Parent
  - Other adult relative
  - Unrelated (but identifiable) adult
  - Sibling
  - Other youth
  - Stranger
  - Unknown
  
6. Please identify the type of maltreatment involved. (Check all that apply)
  - Emotional abuse
  - Emotional neglect
  - Verbal abuse
  - Excessive demands
  - Other, Specify \_\_\_\_\_
  - Unknown

Form ID Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Child's Initials: \_\_\_\_\_  
Center ID Subcenter ID Child ID First Middle Last

**Trauma Detail, Neglect**

Complete the following if experience of this trauma type is indicated on the General Trauma Information Form.

1. When was this trauma revealed/known (to the clinician)?
  - Baseline
  - Other, please provide date: \_\_/\_\_/\_\_\_\_
  
2. Please describe the frequency of the experience. (Check only one)
  - <sub>1</sub> One-time event
  - <sub>2</sub> Repeated exposure
  - <sub>99</sub> Unknown
  
3. Please describe the type(s) of experience. (Check all that apply)
  - Experienced
  - Witnessed
  - Vicarious
  - Unknown
  
4. Please indicate the setting(s) of the experience. (Check all that apply)
  - Home
  - School
  - Community
  - Other, Specify: \_\_\_\_\_
  - Unknown
  
5. Please identify the perpetrator(s). (Check all that apply)
  - Parent
  - Other adult relative
  - Unrelated (but identifiable) adult
  - Sibling
  - Other youth
  - Stranger
  - Unknown
  
6. Please identify the type of neglect involved. (Check all that apply)
  - Physical
  - Medical
  - Educational
  - Other, Specify \_\_\_\_\_
  - Unknown

Form ID Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Child's Initials: \_\_\_\_\_  
Center ID Subcenter ID Child ID First Middle Last

**Trauma Detail, Domestic Violence**

Complete the following if experience of this trauma type is indicated on the General Trauma Information Form.

1. When was this trauma revealed/known (to the clinician)?
  - Baseline
  - Other, please provide date: \_\_/\_\_/\_\_\_\_
  
2. Please describe the frequency of the experience. (Check only one)
  - <sub>1</sub> One-time event
  - <sub>2</sub> Repeated exposure
  - <sub>99</sub> Unknown
  
3. Please describe the type(s) of experience. (Check all that apply)
  - Experienced
  - Witnessed
  - Vicarious
  - Unknown
  
4. Please indicate the setting(s) of the experience. (Check all that apply)
  - Home
  - Other, Specify: \_\_\_\_\_
  - Unknown
  
5. Please identify the perpetrator(s). (Check all that apply)
  - Parent
  - Other adult relative
  - Unrelated (but identifiable) adult
  - Sibling
  - Other youth
  - Stranger
  - Unknown
  
6. Was a weapon used?
  - <sub>0</sub> No
  - <sub>1</sub> Yes
  - <sub>99</sub> Unknown
  
7. Was serious injury inflicted?
  - <sub>0</sub> No
  - <sub>1</sub> Yes → **If YES, to whom:**
    - Child
    - Parent
    - Other adult relative
    - Unrelated (but identifiable) adult
    - Sibling
    - Other youth
    - Other, Specify: \_\_\_\_\_
  - <sub>99</sub> Unknown
  
8. Was a report filed ? (e.g. Police, Child Protective Services)
  - <sub>0</sub> No
  - <sub>1</sub> Yes
  - <sub>99</sub> Unknown

Form ID Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Child's Initials: \_\_\_\_\_  
Center ID Subcenter ID Child ID First Middle Last

**Trauma Detail, War/Terrorism/Political Violence *inside* U.S.**

Complete the following if experience of this trauma type is indicated on the General Trauma Information Form.

1. When was this trauma revealed/known (to the clinician)?
  - Baseline
  - Other, please provide date: \_\_/\_\_/\_\_\_\_
  
2. Please describe the frequency of the experience. (Check only one)
  - <sub>1</sub> One-time event
  - <sub>2</sub> Repeated exposure
  - <sub>99</sub> Unknown
  
3. Please describe the type(s) of experience. (Check all that apply)
  - Experienced
  - Witnessed
  - Vicarious
  - Unknown
  
4. Please indicate the type of weapons used. (Check all that apply)
  - Conventional (e.g. shootings, bombings, 9/11, Oklahoma City)
  - Chemical
  - Radiological
  - Biological
  - Unknown
  
5. Was anyone that the child knew seriously injured or killed?
  - <sub>0</sub> No
  - <sub>1</sub> Yes → **If YES, to whom:**
    - Child
    - Parent
    - Other adult relative
    - Unrelated (but identifiable) adult
    - Sibling
    - Other youth
    - Other, Specify: \_\_\_\_\_
  - <sub>99</sub> Unknown

Form ID Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Child's Initials: \_\_\_\_\_  
Center ID Subcenter ID Child ID First Middle Last

**Trauma Detail, War/Terrorism/Political Violence *outside* U.S.**

Complete the following if experience of this trauma type is indicated on the General Trauma Information Form.

1. When was this trauma revealed/known (to the clinician)?
  - Baseline
  - Other, please provide date: \_\_/\_\_/\_\_\_\_
  
2. Please describe the frequency of the experience. (Check only one)
  - <sub>1</sub> One-time event
  - <sub>2</sub> Repeated exposure
  - <sub>99</sub> Unknown
  
3. Please describe the type(s) of experience. (Check all that apply)
  - Experienced
  - Witnessed
  - Vicarious
  - Unknown
  
4. Was anyone that the child knew seriously injured or killed?
  - <sub>0</sub> No
  - <sub>1</sub> Yes → **If YES, to whom:**
    - Child
    - Parent
    - Other adult relative
    - Unrelated (but identifiable) adult
    - Sibling
    - Other youth
    - Other, Specify: \_\_\_\_\_
  - <sub>99</sub> Unknown

Form ID Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Child's Initials: \_\_\_\_\_  
Center ID Subcenter ID Child ID First Middle Last

**Trauma Detail, Illness/Medical**

Complete the following if experience of this trauma type is indicated on the General Trauma Information Form.

1. When was this trauma revealed/known (to the clinician)?
  - Baseline
  - Other, please provide date: \_\_/\_\_/\_\_\_\_
  
2. Please describe the frequency of the experience. (Check only one)
  - <sub>1</sub> One-time event
  - <sub>2</sub> Repeated exposure
  - <sub>99</sub> Unknown
  
3. Please describe the type(s) of experience. (Check all that apply)
  - Experienced
  - Witnessed
  - Vicarious
  - Unknown
  
4. Please indicate the setting(s) of the experience. (Check all that apply)
  - Home
  - Hospital
  - Extended care facility
  - Other, Specify: \_\_\_\_\_
  - Unknown
  
5. Was the child's condition life-threatening?
  - <sub>0</sub> No
  - <sub>1</sub> Yes
  - <sub>99</sub> Unknown

Form ID Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Child's Initials: \_\_\_\_\_  
Center ID Subcenter ID Child ID First Middle Last

**Trauma Detail, Serious injury/accident**

Complete the following if experience of this trauma type is indicated on the General Trauma Information Form.

1. When was this trauma revealed/known (to the clinician)?
  - Baseline
  - Other, please provide date: \_\_/\_\_/\_\_\_\_
  
2. Please describe the frequency of the experience. (Check only one)
  - <sub>1</sub> One-time event
  - <sub>2</sub> Repeated exposure
  - <sub>99</sub> Unknown
  
3. Please describe the type(s) of experience. (Check all that apply)
  - Experienced
  - Witnessed
  - Vicarious
  - Unknown
  
4. Please indicate the setting(s) of the experience. (Check all that apply)
  - Home
  - School
  - Community
  - Other, Specify: \_\_\_\_\_
  - Unknown
  
5. Please specify type of accident/injury(s): (Check all that apply)
  - Motor vehicle
  - Dog bite
  - Near drowning
  - Accidental shooting
  - Other, Specify: \_\_\_\_\_
  - Unknown
  
6. Was permanent disability/death inflicted?
  - <sub>0</sub> No
  - <sub>1</sub> Yes → **If YES, to whom:**
    - Child
    - Parent
    - Other adult relative
    - Unrelated (but identifiable) adult
    - Sibling
    - Other youth
    - Other, Specify: \_\_\_\_\_
  - <sub>99</sub> Unknown

Form ID Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Child's Initials: \_\_\_\_\_  
Center ID Subcenter ID Child ID First Middle Last

**Trauma Detail, Natural Disasters**

Complete the following if experience of this trauma type is indicated on the General Trauma Information Form.

1. When was this trauma revealed/known (to the clinician)?
  - Baseline
  - Other, please provide date: \_\_/\_\_/\_\_\_\_
  
2. Please describe the frequency of the experience. (Check only one)
  - <sub>1</sub> One-time event
  - <sub>2</sub> Repeated exposure
  - <sub>99</sub> Unknown
  
3. Please describe the type(s) of experience. (Check all that apply)
  - Experienced
  - Witnessed
  - Vicarious
  - Unknown
  
4. Please specify type of disaster(s) involved. (Check all that apply)
  - Earthquake
  - Hurricane
  - Flood
  - Tornado
  - Fire
  - Industrial
  - Other, Specify: \_\_\_\_\_
  - Unknown
  
5. Was serious injury inflicted?
  - <sub>0</sub> No
  - <sub>1</sub> Yes → **If YES, to whom:**
    - Child
    - Parent
    - Other adult relative
    - Unrelated (but identifiable) adult
    - Sibling
    - Other youth
    - Other, Specify: \_\_\_\_\_
  - <sub>99</sub> Unknown
  
6. Did the child/family evacuate their home?
  - <sub>0</sub> No
  - <sub>1</sub> Yes
  - <sub>99</sub> Unknown
  
7. Was the child's home severely damaged or destroyed?
  - <sub>0</sub> No
  - <sub>1</sub> Yes
  - <sub>99</sub> Unknown

Form ID Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Child's Initials: \_\_\_\_\_  
Center ID Subcenter ID Child ID First Middle Last

**Trauma Detail, Kidnapping/Abduction**

Complete the following if experience of this trauma type is indicated on the General Trauma Information Form.

1. When was this trauma revealed/known (to the clinician)?
  - Baseline
  - Other, please provide date: \_\_/\_\_/\_\_
  
2. Please describe the frequency of the experience. (Check only one)
  - <sub>1</sub> One-time event
  - <sub>2</sub> Repeated exposure
  - <sub>99</sub> Unknown
  
3. Please describe the type(s) of experience. (Check all that apply)
  - Experienced
  - Witnessed
  - Vicarious
  - Unknown
  
4. Please identify the perpetrator(s). (Check all that apply)
  - Parent
  - Other adult relative
  - Unrelated (but identifiable) adult
  - Sibling
  - Other youth
  - Stranger
  - Unknown
  
5. Was a weapon used?
  - <sub>0</sub> No
  - <sub>1</sub> Yes
  - <sub>99</sub> Unknown

Form ID Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Child's Initials: \_\_\_\_\_  
Center ID Subcenter ID Child ID First Middle Last

**Trauma Detail, Traumatic Loss or Bereavement**

Complete the following if experience of this trauma type is indicated on the General Trauma Information Form.

1. When was this trauma revealed/known (to the clinician)?
  - Baseline
  - Other, please provide date: \_\_/\_\_/\_\_\_\_
  
2. Please describe the frequency of the experience. (Check only one)
  - <sub>1</sub> One-time event
  - <sub>2</sub> Repeated exposure
  - <sub>99</sub> Unknown
  
3. Please describe the type(s) of experience. (Check all that apply)
  - Experienced
  - Witnessed
  - Vicarious
  - Unknown
  
4. Please identify the people lost. (Check all that apply)
  - Parent
  - Other adult relative
  - Unrelated (but identifiable) adult
  - Sibling
  - Other youth
  - Stranger
  - Unknown
  
5. Was the loss/bereavement due to death?
  - <sub>0</sub> No
  - <sub>1</sub> Yes
  - <sub>99</sub> Unknown
  
6. If loss was due to death, please specify cause(s) of death. (Check all that apply)
  - Natural causes/illness
  - Violence
  - Accident
  - Disaster
  - Terrorism, War, Political violence
  - Other, Specify \_\_\_\_\_
  
7. If loss is not due to death, was caregiver removed from home?
  - <sub>0</sub> No
  - <sub>1</sub> Yes
  - <sub>99</sub> Unknown
  
8. If caregiver(s) was removed from home, please specify reason(s). (Check all that apply)
  - Divorce
  - Incarceration
  - Hospitalization (medical or psychiatric)
  - Other, Specify \_\_\_\_\_
  
9. Was child removed from the home? (e.g., Foster care, other out-of home)
  - <sub>0</sub> No
  - <sub>1</sub> Yes
  - <sub>99</sub> Unknown

Form ID Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Child's Initials: \_\_\_\_\_  
Center ID Subcenter ID Child ID First Middle Last

**Trauma Detail, Forced Displacement**

Complete the following if experience of this trauma type is indicated on the General Trauma Information Form.

- 1. When was this trauma revealed/ known (to the clinician)?  
 Baseline  
 Other, please provide date: \_\_/\_\_/\_\_\_\_
  
- 2. Please describe the frequency of the experience. (Check only one)  
 1 One-time event  
 2 Repeated exposure  
 99 Unknown
  
- 3. Please describe the type(s) of experience. (Check all that apply)  
 Experienced  
 Witnessed  
 Vicarious  
 Unknown

Form ID Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Child's Initials: \_\_\_\_\_  
Center ID Subcenter ID Child ID First Middle Last

**Trauma Detail, Impaired Caregiver**

Complete the following if experience of this trauma type is indicated on the General Trauma Information Form.

1. When was this trauma revealed/known (to the clinician)?
  - Baseline
  - Other, please provide date: \_\_/\_\_/\_\_
  
2. Please describe the frequency of the experience. (Check only one)
  - <sub>1</sub> One-time event
  - <sub>2</sub> Repeated exposure
  - <sub>99</sub> Unknown
  
3. Please describe the type(s) of experience. (Check all that apply)
  - Experienced
  - Witnessed
  - Vicarious
  - Unknown
  
4. Please identify the impaired caregiver(s). (Check all that apply)
  - Parent
  - Other adult relative
  - Unrelated (but identifiable) adult
  - Sibling
  - Other youth
  - Stranger
  - Other, Specify: \_\_\_\_\_
  - Unknown
  
5. The impairment was due to? (Check all that apply)
  - Drug use/abuse/addiction
  - Caregiver mental health impairment/disorder
  - Caregiver medical illness
  - Other
  - Unknown

Form ID Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Child's Initials: \_\_\_\_\_  
Center ID Subcenter ID Child ID First Middle Last

**Trauma Detail, Extreme Interpersonal Violence (Not reported elsewhere)**

Complete the following if experience of this trauma type is indicated on the General Trauma Information Form.

1. When was this trauma revealed/known (to the clinician)?
  - Baseline
  - Other, please provide date: \_\_/\_\_/\_\_\_\_
  
2. Please describe the frequency of the experience. (Check only one)
  - <sub>1</sub> One-time event
  - <sub>2</sub> Repeated exposure
  - <sub>99</sub> Unknown
  
3. Please describe the type(s) of experience. (Check all that apply)
  - Experienced
  - Witnessed
  - Vicarious
  - Unknown
  
4. Please indicate the setting(s) of the experience. (Check all that apply)
  - Home
  - School
  - Community
  - Other, Specify: \_\_\_\_\_
  - Unknown
  
5. Please identify the perpetrator(s). (Check all that apply)
  - Parent
  - Other adult relative
  - Unrelated (but identifiable) adult
  - Sibling
  - Other youth
  - Stranger
  - Unknown
  
6. Please indicate the type(s) of violence. (Check all that apply)
  - Robbery
  - Assault
  - Homicide
  - Suicide
  - Other, Specify: \_\_\_\_\_
  - Unknown
  
7. Was a weapon used?
  - <sub>0</sub> No
  - <sub>1</sub> Yes
  - <sub>99</sub> Unknown
  
8. Was serious injury inflicted?
  - <sub>0</sub> No
  - <sub>1</sub> Yes → **If YES, to whom:**
    - Child
    - Parent
    - Other adult relative
    - Unrelated (but identifiable) adult
    - Sibling
    - Other youth
    - Other, Specify: \_\_\_\_\_
  - <sub>99</sub> Unknown

Form ID Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Child's Initials: \_\_\_\_\_  
Center ID Subcenter ID Child ID First Middle Last

**Trauma Detail, Community Violence (Not reported elsewhere)**

Complete the following if experience of this trauma type is indicated on the General Trauma Information Form.

1. When was this trauma revealed/known (to the clinician)?
  - Baseline
  - Other, please provide date: \_\_/\_\_/\_\_\_\_
  
2. Please describe the frequency of the experience. (Check only one)
  - <sub>1</sub> One-time event
  - <sub>2</sub> Repeated exposure
  - <sub>99</sub> Unknown
  
3. Please describe the type(s) of experience. (Check all that apply)
  - Experienced
  - Witnessed
  - Vicarious
  - Unknown
  
4. Please indicate the setting(s) of the experience. (Check all that apply)
  - School
  - Community
  - Other, Specify: \_\_\_\_\_
  - Unknown
  
5. Was anyone seriously injured or killed?
  - <sub>0</sub> No
  - <sub>1</sub> Yes → **If YES, to whom:**
    - Child
    - Parent
    - Other adult relative
    - Unrelated (but identifiable) adult
    - Sibling
    - Other youth
    - Other, Specify: \_\_\_\_\_
  - <sub>99</sub> Unknown
  
6. Was the violence gang-related?
  - <sub>0</sub> No
  - <sub>1</sub> Yes
  - <sub>99</sub> Unknown

Form ID Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Child's Initials: \_\_\_\_\_  
Center ID Subcenter ID Child ID First Middle Last

**Trauma Detail, School Violence (Not reported elsewhere)**

Complete the following if experience of this trauma type is indicated on the General Trauma Information Form.

1. When was this trauma revealed/known (to the clinician)?
  - Baseline
  - Other, please provide date: \_\_/\_\_/\_\_\_\_
  
2. Please describe the frequency of the experience. (Check only one)
  - <sub>1</sub> One-time event
  - <sub>2</sub> Repeated exposure
  - <sub>99</sub> Unknown
  
3. Please describe the type(s) of experience. (Check all that apply)
  - Experienced
  - Witnessed
  - Vicarious
  - Unknown
  
4. Please identify the type(s) of violence. (Check all that apply)
  - School shooting
  - Bullying
  - Classmate suicide
  - Other, Specify \_\_\_\_\_
  - Unknown
  
5. Was serious injury inflicted?
  - <sub>0</sub> No
  - <sub>1</sub> Yes → **If YES, to whom:**
    - Child
    - Teacher/staff
    - Sibling
    - Other youth
    - Other, Specify: \_\_\_\_\_
  - <sub>99</sub> Unknown

Was this assessment administered on [ derive date of visit from Followupinfo.doc]?  
 \_\_\_ No If no, Please specify the date this assessment was administered. DD/MMM/YYYY  
 \_\_\_ Yes

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	Never	Some- times	Lots of times	Almost all of the time
1. Bad dreams or nightmares.....	0	1	2	3
2. Feeling afraid something bad might happen.....	0	1	2	3
3. Scary ideas or pictures just pop into my head.....	0	1	2	3
4. Pretending I am someone else.....	0	1	2	3
5. Arguing too much.....	0	1	2	3
6. Feeling lonely.....	0	1	2	3
7. Feeling sad or unhappy.....	0	1	2	3
8. Remembering things that happened that I didn't like.....	0	1	2	3
9. Going away in my mind, trying not think.....	0	1	2	3
10. Remembering scary things.....	0	1	2	3
11. Wanting to yell and break things.....	0	1	2	3
12. Crying.....	0	1	2	3
13. Getting scared all of a sudden and don't know why.....	0	1	2	3
14. Getting mad and can't calm down.....	0	1	2	3
15. Feeling dizzy.....	0	1	2	3
16. Wanting to yell at people.....	0	1	2	3
17. Wanting to hurt myself.....	0	1	2	3
18. Wanting to hurt other people.....	0	1	2	3
19. Feeling scared of men.....	0	1	2	3
20. Feeling scared of women.....	0	1	2	3
21. Washing myself because I feel dirty on the inside.....	0	1	2	3
22. Feeling stupid or bad.....	0	1	2	3
23. Feeling like I did something wrong.....	0	1	2	3
24. Feeling like things aren't real.....	0	1	2	3
25. Forgetting things, can't remember things.....	0	1	2	3
26. Feeling like I'm not in my body.....	0	1	2	3
27. Feeling nervous or jumpy inside.....	0	1	2	3
28. Feeling afraid.....	0	1	2	3
29. Can't stop thinking about something bad that happened to me...	0	1	2	3
30. Getting into fights.....	0	1	2	3
31. Feeling mean.....	0	1	2	3
32. Pretending I'm somewhere else.....	0	1	2	3
33. Being afraid of the dark.....	0	1	2	3
34. Worrying about things.....	0	1	2	3
35. Feeling like nobody likes me.....	0	1	2	3
36. Remembering things I don't want to remember.....	0	1	2	3
37. My mind going empty or blank.....	0	1	2	3
38. Feeling like I hate people.....	0	1	2	3
39. Trying not to have any feelings.....	0	1	2	3
40. Feeling mad.....	0	1	2	3
41. Feeling afraid somebody will kill me.....	0	1	2	3
42. Wishing bad things had never happened.....	0	1	2	3
43. Wanting to kill myself.....	0	1	2	3
44. Daydreaming.....				

0 = Never  
 1 = Sometimes  
 2 = Lots of times  
 3 = Almost all of the time

0 = Never  
 1 = Sometimes  
 2 = Lots of times  
 3 = Almost all of the time



Was this assessment administered on [ derive date of visit from Followupinfo.dov]?  
 \_\_\_ No If no, Specify the date this assessment was administered. DD/MMM/YYYY  
 \_\_\_ Yes

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Please print

# CHILD BEHAVIOR CHECKLIST FOR AGES 6-18

For office use only  
ID # \_\_\_\_\_

CHILD'S FULL NAME  
 First Middle Last

CHILD'S GENDER  
 Boy  Girl

CHILD'S AGE \_\_\_\_\_

CHILD'S ETHNIC GROUP OR RACE \_\_\_\_\_

TODAY'S DATE  
 Mo. \_\_\_\_\_ Date \_\_\_\_\_ Yr. \_\_\_\_\_

CHILD'S BIRTHDATE  
 Mo. \_\_\_\_\_ Date \_\_\_\_\_ Yr. \_\_\_\_\_

GRADE IN SCHOOL \_\_\_\_\_

NOT ATTENDING SCHOOL

Please fill out this form to reflect *your* view of the child's behavior even if other people might not agree. Feel free to print additional comments beside each item and in the space provided on page 2. **Be sure to answer all items.**

PARENTS' USUAL TYPE OF WORK, even if not working now. (Please be specific — for example, auto mechanic, high school teacher, homemaker, laborer, lathe operator, shoe salesman, army sergeant.)

FATHER'S TYPE OF WORK \_\_\_\_\_

MOTHER'S TYPE OF WORK \_\_\_\_\_

**Include only the information inclosed in ORANGE boxes on the EDC screens. This information is found on page 1, 3, 4.**

THIS FORM FILLED OUT BY: (print your full name)

Your gender:  Male  Female

Your relation to the child:

Biological Parent  Step Parent  Grandparent

Adoptive Parent  Foster Parent  Other (specify) \_\_\_\_\_

**I. Please list the sports your child most likes to take part in.** For example: swimming, baseball, skating, skate boarding, bike riding, fishing, etc.

None

- a. \_\_\_\_\_
- b. \_\_\_\_\_
- c. \_\_\_\_\_

Compared to others of the same age, about how much time does he/she spend in each?

Less Than Average    Average    More Than Average    Don't Know

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Compared to others of the same age, how well does he/she do each one?

Below Average    Average    Above Average    Don't Know

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**II. Please list your child's favorite hobbies, activities, and games, other than sports.** For example: stamps, dolls, books, piano, crafts, cars, computers, singing, etc. (Do *not* include listening to radio or TV.)

None

- a. \_\_\_\_\_
- b. \_\_\_\_\_
- c. \_\_\_\_\_

Compared to others of the same age, about how much time does he/she spend in each?

Less Than Average    Average    More Than Average    Don't Know

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Compared to others of the same age, how well does he/she do each one?

Below Average    Average    Above Average    Don't Know

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**III. Please list any organizations, clubs, teams, or groups your child belongs to.**

None

- a. \_\_\_\_\_
- b. \_\_\_\_\_
- c. \_\_\_\_\_

Compared to others of the same age, how active is he/she in each?

Less Active    Average    More Active    Don't Know

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**IV. Please list any jobs or chores your child has.** For example: paper route, babysitting, making bed, working in store, etc. (Include both paid and unpaid jobs and chores.)

None

- a. \_\_\_\_\_
- b. \_\_\_\_\_
- c. \_\_\_\_\_

Compared to others of the same age, how well does he/she carry them out?

Below Average    Average    Above Average    Don't Know

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Be sure you answered all items. Then see other side.**

V. 1. About how many close friends does your child have? (Do not include brothers & sisters)

NO INFORMATION FROM THIS PAGE on the EDC screens. [ ] None [ ] 1 [ ] 2 or 3 [ ] 4 or more

2. About how many times a week does your child do things with any friends outside of regular school hours?

(Do not include brothers & sisters) [ ] Less than 1 [ ] 1 or 2 [ ] 3 or more

VI. Compared to others of his/her age, how well does your child:

Worse Average Better [ ] Has no brothers or sisters
a. Get along with his/her brothers & sisters? [ ] [ ] [ ]
b. Get along with other kids? [ ] [ ] [ ]
c. Behave with his/her parents? [ ] [ ] [ ]
d. Play and work alone? [ ] [ ] [ ]

VII. 1. Performance in academic subjects.

[ ] Does not attend school because \_\_\_\_\_

Check a box for each subject that child takes

Other academic subjects—for example: computer courses, foreign language, business. Do not include gym, shop, driver's ed., or other nonacademic subjects.

Table with 5 columns: Failing, Below Average, Average, Above Average. Rows a-g for various subjects.

2. Does your child receive special education or remedial services or attend a special class or special school?

[ ] No [ ] Yes—kind of services, class, or school:

3. Has your child repeated any grades? [ ] No [ ] Yes—grades and reasons:

4. Has your child had any academic or other problems in school? [ ] No [ ] Yes—please describe:

When did these problems start? \_\_\_\_\_

Have these problems ended? [ ] No [ ] Yes—when?

Does your child have any illness or disability (either physical or mental)? [ ] No [ ] Yes—please describe:

What concerns you most about your child?

Please describe the best things about your child.

NO INFORMATION ON THIS PAGE for EDC screens
PAGE 2

Be sure you answered all items.

Below is a list of items that describe children and youths. For each item that describes your child **now or within the past 6 months**, please circle the **2** if the item is **very true or often true** of your child. Circle the **1** if the item is **somewhat or sometimes true** of your child. If the item is **not true** of your child, circle the **0**. Please answer all items as well as you can, even if some do not seem to apply to your child.

0 = Not True (as far as you know)			1 = Somewhat or Sometimes True			2 = Very True or Often True		
0	1	2	1. Acts too young for his/her age	0	1	2	32. Feels he/she has to be perfect	
0	1	2	2. Drinks alcohol without parents' approval (describe): _____	0	1	2	33. Feels or complains that no one loves him/her	
0	1	2	3. Argues a lot	0	1	2	34. Feels others are out to get him/her	
0	1	2	4. Fails to finish things he/she starts	0	1	2	35. Feels worthless or inferior	
0	1	2	5. There is very little he/she enjoys	0	1	2	36. Gets hurt a lot, accident-prone	
0	1	2	6. Bowel movements outside toilet	0	1	2	37. Gets in many fights	
0	1	2	7. Bragging, boasting	0	1	2	38. Gets teased a lot	
0	1	2	8. Can't concentrate, can't pay attention for long	0	1	2	39. Hangs around with others who get in trouble	
0	1	2	9. Can't get his/her mind off certain thoughts; obsessions (describe): _____	0	1	2	40. Hears sounds or voices that aren't there (describe): _____	
0	1	2	10. Can't sit still, restless, or hyperactive	0	1	2	41. Impulsive or acts without thinking	
0	1	2	11. Clings to adults or too dependent	0	1	2	42. Would rather be alone than with others	
0	1	2	12. Complains of loneliness	0	1	2	43. Lying or cheating	
0	1	2	13. Confused or seems to be in a fog	0	1	2	44. Bites fingernails	
0	1	2	14. Cries a lot	0	1	2	45. Nervous, highstrung, or tense	
0	1	2	15. Cruel to animals	0	1	2	46. Nervous movements or twitching (describe): _____	
0	1	2	16. Cruelty, bullying, or meanness to others	0	1	2	47. Nightmares	
0	1	2	17. Daydreams or gets lost in his/her thoughts	0	1	2	48. Not liked by other kids	
0	1	2	18. Deliberately harms self or attempts suicide	0	1	2	49. Constipated, doesn't move bowels	
0	1	2	19. Demands a lot of attention	0	1	2	50. Too fearful or anxious	
0	1	2	20. Destroys his/her own things	0	1	2	51. Feels dizzy or lightheaded	
0	1	2	21. Destroys things belonging to his/her family or others	0	1	2	52. Feels too guilty	
0	1	2	22. Disobedient at home	0	1	2	53. Overeating	
0	1	2	23. Disobedient at school	0	1	2	54. Overtired without good reason	
0	1	2	24. Doesn't eat well	0	1	2	55. Overweight	
0	1	2	25. Doesn't get along with other kids	56. Physical problems <b>without known medical cause:</b>				
0	1	2	26. Doesn't seem to feel guilty after misbehaving	0	1	2	a. Aches or pains ( <b>not</b> stomach or headaches)	
0	1	2	27. Easily jealous	0	1	2	b. Headaches	
0	1	2	28. Breaks rules at home, school, or elsewhere	0	1	2	c. Nausea, feels sick	
0	1	2	29. Fears certain animals, situations, or places, other than school (describe): _____	0	1	2	d. Problems with eyes ( <b>not</b> if corrected by glasses) (describe): _____	
0	1	2	30. Fears going to school	0	1	2	e. Rashes or other skin problems	
0	1	2	31. Fears he/she might think or do something bad	0	1	2	f. Stomachaches	
				0	1	2	g. Vomiting, throwing up	
				0	1	2	h. Other (describe): _____	

0 = Not True (as far as you know)

1 = Somewhat or Sometimes True

2 = Very True or Often True

- 0 1 2 57. Physically attacks people
- 0 1 2 58. Picks nose, skin, or other parts of body  
(describe): \_\_\_\_\_  
\_\_\_\_\_
- 0 1 2 59. Plays with own sex parts in public
- 0 1 2 60. Plays with own sex parts too much
- 0 1 2 61. Poor school work
- 0 1 2 62. Poorly coordinated or clumsy
- 0 1 2 63. Prefers being with older kids
- 0 1 2 64. Prefers being with younger kids
- 0 1 2 65. Refuses to talk
- 0 1 2 66. Repeats certain acts over and over;  
compulsions (describe): \_\_\_\_\_  
\_\_\_\_\_
- 0 1 2 67. Runs away from home
- 0 1 2 68. Screams a lot
- 0 1 2 69. Secretive, keeps things to self
- 0 1 2 70. Sees things that aren't there (describe): \_\_\_\_\_  
\_\_\_\_\_
- 0 1 2 71. Self-conscious or easily embarrassed
- 0 1 2 72. Sets fires
- 0 1 2 73. Sexual problems (describe): \_\_\_\_\_  
\_\_\_\_\_
- 0 1 2 74. Showing off or clowning
- 0 1 2 75. Too shy or timid
- 0 1 2 76. Sleeps less than most kids
- 0 1 2 77. Sleeps more than most kids during day and/or  
night (describe): \_\_\_\_\_  
\_\_\_\_\_
- 0 1 2 78. Inattentive or easily distracted
- 0 1 2 79. Speech problem (describe): \_\_\_\_\_  
\_\_\_\_\_
- 0 1 2 80. Stares blankly
- 0 1 2 81. Steals at home
- 0 1 2 82. Steals outside the home
- 0 1 2 83. Stores up too many things he/she doesn't need  
(describe): \_\_\_\_\_  
\_\_\_\_\_

- 0 1 2 84. Strange behavior (describe): \_\_\_\_\_  
\_\_\_\_\_
- 0 1 2 85. Strange ideas (describe): \_\_\_\_\_  
\_\_\_\_\_
- 0 1 2 86. Stubborn, sullen, or irritable
- 0 1 2 87. Sudden changes in mood or feelings
- 0 1 2 88. Sulks a lot
- 0 1 2 89. Suspicious
- 0 1 2 90. Swearing or obscene language
- 0 1 2 91. Talks about killing self
- 0 1 2 92. Talks or walks in sleep (describe): \_\_\_\_\_  
\_\_\_\_\_
- 0 1 2 93. Talks too much
- 0 1 2 94. Teases a lot
- 0 1 2 95. Temper tantrums or hot temper
- 0 1 2 96. Thinks about sex too much
- 0 1 2 97. Threatens people
- 0 1 2 98. Thumb-sucking
- 0 1 2 99. Smokes, chews, or sniffs tobacco
- 0 1 2 100. Trouble sleeping (describe): \_\_\_\_\_  
\_\_\_\_\_
- 0 1 2 101. Truancy, skips school
- 0 1 2 102. Underactive, slow moving, or lacks energy
- 0 1 2 103. Unhappy, sad, or depressed
- 0 1 2 104. Unusually loud
- 0 1 2 105. Uses drugs for nonmedical purposes (*don't*  
include alcohol or tobacco) (describe): \_\_\_\_\_  
\_\_\_\_\_
- 0 1 2 106. Vandalism
- 0 1 2 107. Wets self during the day
- 0 1 2 108. Wets the bed
- 0 1 2 109. Whining
- 0 1 2 110. Wishes to be of opposite sex
- 0 1 2 111. Withdrawn, doesn't get involved with others
- 0 1 2 112. Worries
- 113. Please write in any problems your child has that  
were not listed above:  
0 1 2 \_\_\_\_\_  
0 1 2 \_\_\_\_\_  
0 1 2 \_\_\_\_\_

Was this assessment administered on [ derive date of visit from Followupinfo.doc]?  
 No If no, Specify the date this assessment was administered. DD/MM/YY  
 Yes

Please print. Be sure to answer all items.

# CHILD BEHAVIOR CHECKLIST FOR AGES 1½ - 5

For office use only  
ID # \_\_\_\_\_

CHILD'S FULL NAME	First <b>OMI</b>	Middle <b>contents of Blue Box from FDC</b>	Last <b>Screen</b>
CHILD'S GENDER <input type="checkbox"/> Boy <input type="checkbox"/> Girl	CHILD'S AGE	CHILD'S ETHNIC GROUP OR RACE	
TODAY'S DATE Mo. _____ Date _____ Yr. _____		CHILD'S BIRTHDATE Mo. _____ Date _____ Yr. _____	

PARENTS' USUAL TYPE OF WORK, even if not working now. Please be specific for example, auto mechanic, high school teacher, homemaker, laborer, lathe operator, shoe salesman, army sergeant.

FATHER'S TYPE OF WORK: \_\_\_\_\_  
 MOTHER'S TYPE OF WORK: \_\_\_\_\_

THIS FORM FILLED OUT BY: (print your full name)

Your relationship to child:

Mother  Father  Other (specify): \_\_\_\_\_

Please fill out this form to reflect *your* view of the child's behavior even if other people might not agree. Feel free to write additional comments beside each item and in the space provided on page 2. **Be sure to answer all items.**

Below is a list of items that describe children. For each item that describes the child *now or within the past 2 months*, please circle the **2** if the item is **very true** or **often true** of the child. Circle the **1** if the item is **somewhat or sometimes true** of the child. If the item is **not true** of the child, circle the **0**. Please answer all items as well as you can, even if some do not seem to apply to the child.

**0 = Not True (as far as you know)      1 = Somewhat or Sometimes True      2 = Very True or Often True**

- 0 1 2 1. Aches or pains (without medical cause; **do not** include stomach or headaches)
- 0 1 2 2. Acts too young for age
- 0 1 2 3. Afraid to try new things
- 0 1 2 4. Avoids looking others in the eye
- 0 1 2 5. Can't concentrate, can't pay attention for long
- 0 1 2 6. Can't sit still, restless, or hyperactive
- 0 1 2 7. Can't stand having things out of place
- 0 1 2 8. Can't stand waiting; wants everything now
- 0 1 2 9. Chews on things that aren't edible
- 0 1 2 10. Clings to adults or too dependent
- 0 1 2 11. Constantly seeks help
- 0 1 2 12. Constipated, doesn't move bowels (when not sick)
- 0 1 2 13. Cries a lot
- 0 1 2 14. Cruel to animals
- 0 1 2 15. Defiant
- 0 1 2 16. Demands must be met immediately
- 0 1 2 17. Destroys his/her own things
- 0 1 2 18. Destroys things belonging to his/her family or other children
- 0 1 2 19. Diarrhea or loose bowels (when not sick)
- 0 1 2 20. Disobedient
- 0 1 2 21. Disturbed by any change in routine
- 0 1 2 22. Doesn't want to sleep alone
- 0 1 2 23. Doesn't answer when people talk to him/her
- 0 1 2 24. Doesn't eat well (describe): \_\_\_\_\_
- 0 1 2 25. Doesn't get along with other children
- 0 1 2 26. Doesn't know how to have fun; acts like a little adult
- 0 1 2 27. Doesn't seem to feel guilty after misbehaving
- 0 1 2 28. Doesn't want to go out of home
- 0 1 2 29. Easily frustrated

- 0 1 2 30. Easily jealous
- 0 1 2 31. Eats or drinks things that are not food—**don't** include sweets (describe): \_\_\_\_\_
- 0 1 2 32. Fears certain animals, situations, or places (describe): \_\_\_\_\_
- 0 1 2 33. Feelings are easily hurt
- 0 1 2 34. Gets hurt a lot, accident-prone
- 0 1 2 35. Gets in many fights
- 0 1 2 36. Gets into everything
- 0 1 2 37. Gets too upset when separated from parents
- 0 1 2 38. Has trouble getting to sleep
- 0 1 2 39. Headaches (without medical cause)
- 0 1 2 40. Hits others
- 0 1 2 41. Holds his/her breath
- 0 1 2 42. Hurts animals or people without meaning to
- 0 1 2 43. Looks unhappy without good reason
- 0 1 2 44. Angry moods
- 0 1 2 45. Nausea, feels sick (without medical cause)
- 0 1 2 46. Nervous movements or twitching (describe): \_\_\_\_\_
- 0 1 2 47. Nervous, highstrung, or tense
- 0 1 2 48. Nightmares
- 0 1 2 49. Overeating
- 0 1 2 50. Overtired
- 0 1 2 51. Shows panic for no good reason
- 0 1 2 52. Painful bowel movements (without medical cause)
- 0 1 2 53. Physically attacks people
- 0 1 2 54. Picks nose, skin, or other parts of body (describe): \_\_\_\_\_

**Be sure you have answered all items. Then see other side.**

Please print your answers. Be sure to answer all items.

0 = Not True (as far as you know)

1 = Somewhat or Sometimes True

2 = Very True or Often True

- 0 1 2 55. Plays with own sex parts too much
- 0 1 2 56. Poorly coordinated or clumsy
- 0 1 2 57. Problems with eyes (without medical cause)  
(describe): \_\_\_\_\_
- 0 1 2 58. Punishment doesn't change his/her behavior
- 0 1 2 59. Quickly shifts from one activity to another
- 0 1 2 60. Rashes or other skin problems (without medical cause)
- 0 1 2 61. Refuses to eat
- 0 1 2 62. Refuses to play active games
- 0 1 2 63. Repeatedly rocks head or body
- 0 1 2 64. Resists going to bed at night
- 0 1 2 65. Resists toilet training (describe): \_\_\_\_\_
- 0 1 2 66. Screams a lot
- 0 1 2 67. Seems unresponsive to affection
- 0 1 2 68. Self-conscious or easily embarrassed
- 0 1 2 69. Selfish or won't share
- 0 1 2 70. Shows little affection toward people
- 0 1 2 71. Shows little interest in things around him/her
- 0 1 2 72. Shows too little fear of getting hurt
- 0 1 2 73. Too shy or timid
- 0 1 2 74. Sleeps less than most children during day and/or night (describe): \_\_\_\_\_
- 0 1 2 75. Smears or plays with bowel movements
- 0 1 2 76. Speech problem (describe): \_\_\_\_\_
- 0 1 2 77. Stares into space or seems preoccupied
- 0 1 2 78. Stomachaches or cramps (without medical cause)

- 0 1 2 79. Rapid shifts between sadness and excitement
- 0 1 2 80. Strange behavior (describe): \_\_\_\_\_
- 0 1 2 81. Stubborn, sullen, or irritable
- 0 1 2 82. Sudden changes in mood or feelings
- 0 1 2 83. Sulks a lot
- 0 1 2 84. Talks or cries out in sleep
- 0 1 2 85. Temper tantrums or hot temper
- 0 1 2 86. Too concerned with neatness or cleanliness
- 0 1 2 87. Too fearful or anxious
- 0 1 2 88. Uncooperative
- 0 1 2 89. Underactive, slow moving, or lacks energy
- 0 1 2 90. Unhappy, sad, or depressed
- 0 1 2 91. Unusually loud
- 0 1 2 92. Upset by new people or situations  
(describe): \_\_\_\_\_
- 0 1 2 93. Vomiting, throwing up (without medical cause)
- 0 1 2 94. Wakes up often at night
- 0 1 2 95. Wanders away
- 0 1 2 96. Wants a lot of attention
- 0 1 2 97. Whining
- 0 1 2 98. Withdrawn, doesn't get involved with others
- 0 1 2 99. Worries
- 100. Please write in any problems the child has that were not listed above.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please be sure you have answered all items.

Underline any you are concerned about.

Does the child have any illness or disability (either physical or mental)?  No  Yes—Please describe:

Omit this section from EDC Screens

What concerns you most about the child?

Please describe the best things about the child:

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Name \_\_\_\_\_; Center Number ; Subject I.D. Number ; Age ;  
Sex: Male Female; Today's Date (write month, day and year) //; Week of Treatment:

Here is a list of problems people sometimes have after very bad things happen. Please **THINK** about the bad thing that happened to you. Then, **READ** each problem on the list carefully. **CIRCLE ONE** of the numbers (0, 1, 2, 3 or 4) that tells how often the problem has happened to you **in the past month**. Use the **Rating Sheet** on Page 3 to help you decide how often the problem has happened in the past month.

**PLEASE BE SURE TO ANSWER ALL QUESTIONS**

HOW MUCH OF THE TIME DURING THE PAST MONTH	None	Little	Some	Much	Most
1 <sub>D4</sub> I watch out for danger or things that I am afraid of.	0	1	2	3	4
2 <sub>B4</sub> When something reminds me of what happened, I get very upset, afraid or sad.	0	1	2	3	4
3 <sub>B1</sub> I have upsetting thoughts, pictures, or sounds of what happened come into my mind when I do not want them to.	0	1	2	3	4
4 <sub>D2</sub> I feel grouchy, angry or mad.	0	1	2	3	4
5 <sub>B2</sub> I have dreams about what happened or other bad dreams.	0	1	2	3	4
6 <sub>B3</sub> I feel like I am back at the time when the bad thing happened, living through it again.	0	1	2	3	4
7 <sub>C4</sub> I feel like staying by myself and not being with my friends.	0	1	2	3	4
8 <sub>C5</sub> I feel alone inside and not close to other people.	0	1	2	3	4
9 <sub>C1</sub> I try not to talk about, think about, or have feelings about what happened.	0	1	2	3	4
10 <sub>C6</sub> I have trouble feeling happiness or love.	0	1	2	3	4

Was this assessment administered [derive date of visit from Followupinfo.dox]?  
 Yes \_\_\_\_\_  
 No If no, Specify the date this assessment was administered: DD/MM/YYYY \_\_\_\_\_

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HOW MUCH OF THE TIME DURING THE PAST MONTH	None	Little	Some	Much	Most
11 <sub>C6</sub> I have trouble feeling sadness or anger.	0	1	2	3	4
12 <sub>D5</sub> I feel jumpy or startle easily, like when I hear a loud noise or when something surprises me.	0	1	2	3	4
13 <sub>D1</sub> I have trouble going to sleep or I wake up often during the night.	0	1	2	3	4
14 <sub>AF</sub> I think that some part of what happened is my fault.	0	1	2	3	4
15 <sub>C3</sub> I have trouble remembering important parts of what happened.	0	1	2	3	4
16 <sub>D3</sub> I have trouble concentrating or paying attention.	0	1	2	3	4
17 <sub>C2</sub> I try to stay away from people, places, or things that make me remember what happened.	0	1	2	3	4
18 <sub>B5</sub> 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
19 <sub>C7</sub> I think that I will not live a long life.	0	1	2	3	4
20 <sub>D2</sub> I have arguments or physical fights.	0	1	2	3	4
21 <sub>C7</sub> I feel pessimistic or negative about my future.	0	1	2	3	4
22 <sub>AF</sub> I am afraid that the bad thing will happen again.	0	1	2	3	4

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Omit From EDC Screens

# FREQUENCY RATING SHEET

HOW OFTEN OR HOW MUCH OF THE TIME  
THE PAST MONTH, THAT IS SINCE \_\_\_\_\_,  
DOES THE PROBLEM HAPPEN?

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			

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 TIMES  
A MONTH

1-2 TIMES  
A WEEK

2-3 TIMES  
EACH WEEK

ALMOST  
EVERY DAY

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