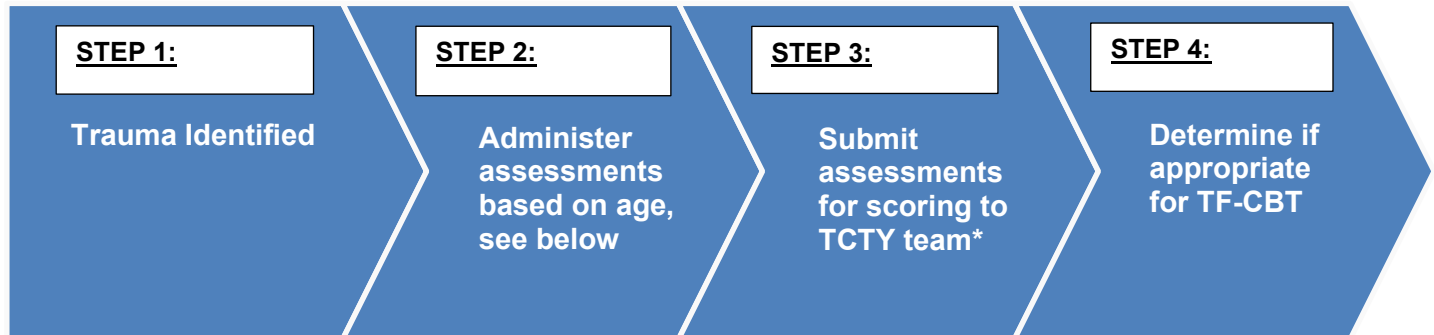
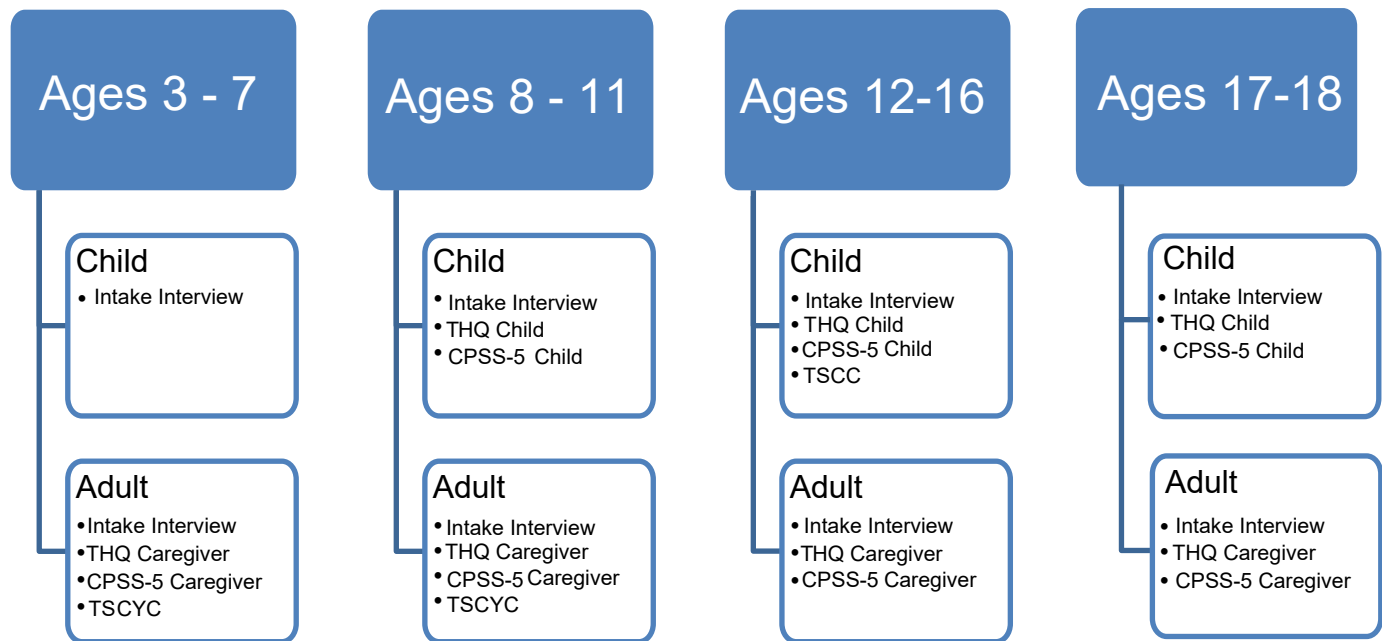


ASSESSMENTS

Clinicians will screen for trauma exposure in their own agency's clinical interview (if it is not known prior to intake there is trauma) and then do follow-up assessment. If trauma exposure is identified, follow this process:



TCTY Required Assessments:



Trauma History Questionnaire (THQ)

Completed By: Child (7+) and Caregiver (2-18) **Administration Time:** 10-20 Minutes

Administration Information and Guidelines

- Free Assessment
- Administer the THQ in a quiet, private location
- Caregiver can complete the THQ independently or with the provider
- Children complete the measure with the provider
- If caregivers don't know children's histories, they should not complete the THQ

Verbal Instructions

Introduce Measure

1. CAREGIVER: I'm going to ask you about different experiences your child may have had. Please think about things that may have happened to your child *in addition to* the experience that brought you here today.
2. CHILD: I'm going to ask you about different experiences you may have had. Please think about things that may have happened to you *in addition to* the experience that brought you here today
3. Caregivers and children will answer "yes" or "no." If they indicate "yes" ask for the age the event(s) occurred.
4. If it is unknown whether the experience occurred, do not select "yes" or "no" and write "unknown" next to the item.
5. At the end ask, "which experience would you say is the most distressing or worst for you/your child?"

Check Understanding, Ask:

- "Does that make sense to you?"
- "Do you have any questions before we get started?"

Trauma History Questionnaire (THQ)

Scales and Interpretation

| Scale | Description/Scoring | Interpretation Notes |
|------------------------------------|---|--|
| Total Experiences | The sum of items children and caregivers indicated as a “yes.” | Higher numbers indicate more experienced traumatic events. Items involving caregivers and early age of exposure indicate complex trauma. |
| Most Distressing Experience | Children and caregivers will indicate which experience they find most distressing. | Indicate the item children and caregivers endorse as most distressing. |
| ACEs | The total number of experiences children and caregivers indicate as a “yes” for the following items: 6 (if by divorce), 7 (if a parent), 8, 11, 13, 14, 16, 17, (18 or 19), 22 | Four or more experiences indicates high risk. |
| Trafficking Screen | The total number of experiences children indicate as a “yes” for the following items: 8, 13, 14, 16, 24, 25 | Higher scores indicate higher risk for trafficking and exploitation |
| Historical Trauma Screening | Caregiver Item 26 | Indicates possible need to explore historical or generational trauma |

Trauma History Questionnaire (THQ) CHILD *(Developed at the Yale Childhood Violent Trauma Center)*

Instructions: I'm going to ask you about different experiences you may have had. Please think about things that may have happened to you in addition to the experience that brought you here today.

| | | |
|--|------------------------------|-----------------------------|
| 1. Have you ever been in or seen a serious accident? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Has someone close to you ever been very sick or very hurt or injured? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Have you ever experienced a severe illness or injury? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Have you ever experienced a painful or scary medical treatment when you were injured or sick? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Have you ever experienced the death of someone close to you? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Have you ever been unexpectedly separated from someone who takes care of you? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Has someone close to you ever harmed themselves or attempted or completed suicide? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. Have you ever been physically hurt (e.g., hit, kicked, punched) or threatened to be hurt? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9. Has someone ever robbed from you? Or have you ever witnessed this? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 10. Have you ever been attacked by a dog or other animal? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 11. Have you ever seen or heard a family member(s) physically fighting, attacking (e.g., pushing, hitting, punching, or using weapons) or beating each other up or threatening to hurt one another? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 12. Have you ever seen or heard someone in your neighborhood or school attacking each other or beating each other up (e.g., pushing, hitting, punching, or using weapons) or threatening to hurt one another? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 13. Has someone ever made you watch or do something sexual (e.g., such as touching you in a sexual way, touching your private parts, making you touch their private parts, or made you watch someone else touch themselves in a sexual way?) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 14. Has someone important to you ever repeatedly told you that you were no good, repeatedly yelled at you in a scary way, or had someone threaten to abandon you, leave you, or send you away? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 15. Has a peer ever bullied you on the internet or in person (e.g., called you names, teased you, made up stories about you, repeatedly told you that you were no good, excluded you or threatened to hurt you)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 16. Have you ever had a time when you did not have enough food or a place to live? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 17. Has there ever been a time in your life when an adult wasn't taking care of you? (e.g., when you didn't get fed, didn't have clothes to wear or when you weren't taken to school or to the doctor when you needed to go?) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 18. Have you ever seen anyone in your home using drugs like smoking drugs (other than cigarettes) or using needles? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 19. Have you ever seen anyone in your home drink too much (get drunk)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 20. Have you ever been exposed to a natural disaster (e.g., been in a really bad storm like a hurricane or tornado or in a fire, flood or earthquake)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 21. Have you ever experienced a man-made disaster (e.g., bombings, or another situation where somebody did something that hurt or killed a lot of people at the same time) or exposure to war? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 22. Have you ever witnessed a family member who was arrested, or had a family member in jail? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 23. Have there been other very scary or upsetting things that have happened to you? If so, what? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 24. Has someone ever made you do sexual things for food, money, or housing? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 25. Has someone ever taken sexual pictures of you or made you take sexual photos? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 26. Have you experienced discrimination or harassment based on your race or ethnic background? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 27. Have you experienced discrimination or harassment based on your actual or perceived gender identity or sexual orientation? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 28. Which item in this questionnaire is the most traumatic for you? | | |

Developed at the Yale Childhood Violent Trauma Center

DATE OF ASSESSMENT: _____

TOTAL: _____

____ PRE TREATMENT ____ POST TREATMENT

TCTY ID: _____

Trauma History Questionnaire (THQ) CAREGIVER *(Developed at the Yale Childhood Violent Trauma Center)*

Instructions: I'm going to ask you about different experiences your child may have had. Please think about things that may have happened to your child in addition to the experience that brought you here today.

| | | |
|--|------------------------------|-----------------------------|
| 1. Has your child ever been in or seen a serious accident? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Has someone close to your child ever been very sick or very hurt or injured? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Has your child ever experienced a severe illness or injury? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Has your child ever experienced a painful or scary medical treatment either when they were injured or sick? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Has your child ever experienced the death of someone close to him/her? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Has your child ever been unexpectedly separated from you (caregiver) or another person significant in the child's life | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Has someone close to your child ever attempted or committed suicide or harmed him/herself? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. Has your child ever been physically hurt (e.g., hit, kicked, punched) or threatened to be hurt? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9. Has someone ever robbed from your child? Or has your child ever witnessed this? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 10. Has your child ever been attacked by a dog or other animal? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 11. Has your child ever seen or heard a family member(s) physically fighting, attacking (e.g., pushing, hitting, punching, or using weapons) or beating each other up or threatening to hurt one another? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 12. Has your child ever seen or heard someone in your neighborhood or school attacking each other or beating each other up (e.g., pushing, hitting, punching, or using weapons) or threatening to hurt one another? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 13. Has someone ever made your child watch or do something sexual (e.g., such as touching your child in a sexual way, touching your child's private parts, making your child touch their private parts, or made your child watch someone else touch themselves in a sexual way?) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 14. Has someone important to your child ever repeatedly told your child that s/he was no good, repeatedly yelled at your child in a scary way, or had someone threaten to abandon your child, leave your child, or send them away? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 15. Has a peer ever bullied your child on the internet or in person (e.g., called him/her names, teased him/her, made up stories about him/her, repeatedly told him/her they were no good, excluded them or threatened to hurt him/her)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 16. Has your child ever had a time when s/he did not have enough food or a place to live? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 17. Has there ever been a time in your child's life when an adult wasn't taking care of him/her? (e.g., when s/he didn't get fed, didn't have clothes to wear or when s/he weren't taken to school or to the doctor when s/he needed to go?) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 18. Has your child ever seen anyone in your home using drugs like smoking drugs (other than cigarettes) or using needles? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 19. Has your child ever seen anyone in your home drink too much (get drunk)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 20. Has your child ever been exposed to a natural disaster (e.g., been in a really bad storm like a hurricane or tornado or in a fire, flood or earthquake)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 21. Has your child ever experienced man-made disaster (e.g., bombings, or another situation where somebody did something that hurt or killed a lot of people at the same time) or exposure to war? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 22. Has your child ever witnessed a family member who was arrested, or had a family member in jail? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 23. Have there been other very scary or upsetting things that have happened to your child? If so, what? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 24. Has someone ever made your child do sexual things for food, money, or housing? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 25. Has someone ever taken sexual pictures of your child or made them take sexual photos? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 26. Is the child's family part of a specific culture, racial or ethnic group that experienced trauma/oppression in the past? (e.g., Colonization of Native Americans, Forces Migration, Refugee, Holocaust) If so, What? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 27. Has your child experienced discrimination or harassment based on their race or ethnic background? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 28. Has your child experience discrimination or harassment based on their actual or perceived gender identity or sexual orientation? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 29. Which item in this questionnaire is the most traumatic for your child? | | |

Developed at the Yale Childhood Violent Trauma Center

TOTAL: _____

DATE OF ASSESSMENT: _____

____ PRE TREATMENT ____ POST TREATMENT

TCTY ID: _____

Child Post Traumatic Stress Scale 5 (CPSS-5 - Child)

Age: 8-18

Completed By: Child

Administration Time: 10-20 Minutes

Administration Guidelines

- Free assessment
- Paper measure
- Attempt to administer in a quiet, private location
- Read child the questions, provide them with the rating scale

Verbal Instructions

➤ Introduce Measure

1. Now let's talk about how you have been feeling about the event since the event happened (if less than a month) OR in the last month
2. If event occurred longer than a month say the following:
 - A month ago (or when the event happened) would have been (insert date).
 - Can you remember anything special or different that happened around that time? It could be a birthday, a party, a trip, or something else that happened at school or at home
 - This will help us to remember what has been happening just in the past month as I ask you these questions.
3. I'm going to be asking you how you have been feeling just about (name the event). I'll be sure to mention the amount of time and the event in my questions just so we don't forget.
4. I will read each item. You can tell me the number that best describes how often each one has bothered you since the event happened/in the past month.
5. Choose the number (0-4) that best describes how often the symptom has bothered your child in the LAST 2 WEEKS
6. If it has occurred: Give the rating scale and point to the scale (Almost Always 4, A Lot 3, Somewhat 2, A little 1, Not at all 0, Don't Know)

➤ Check Understanding

1. Does it make sense to you?
2. Do you have any questions before we get started?"

➤ Respond to Questions

1. Encourage them to answer all of the questions. If they ask what something means, tell them to give it their best guess. Make a note in the margin.

Scoring

| | |
|-----------------------|---------------------------------|
| Total Trauma | Add ratings for questions 1-20 |
| Functional Impairment | Add ratings for questions 21-27 |

Child Post Traumatic Stress Scale 5 (CPSS-5 - Child)

Scales and Interpretation

| SCALE | DESCRIPTION | INTERPRETATION NOTES |
|---|--|---|
| Re- Experiencing Symptoms | Symptoms are related to instances in which the client relives the traumatic event they experienced | Items 1-5 |
| Avoidance Symptoms | Symptoms are related to the client avoiding reminders of the traumatic event, | Items 6-7 |
| Negative Emotions & Cognitions | Symptoms are related to feeling distant from others, losing interest in activities they used to enjoy, or having trouble experiencing positive feelings | Items 8-14 |
| Hyperarousal Symptoms | Symptoms are related to the client experiencing an increased heartrate, sweating, difficulty breathing, difficulty sleeping, outbursts of anger, irritability, difficulty relaxing, and/or difficulty concentrating in relation to the traumatic event | Items 15-20 |
| Functional Impairment | Symptoms are related to the client experiencing a loss of functional capacity to meet responsibilities in their daily lives | Items 21-27 |
| Total Symptoms | The sum of aforementioned symptoms the client presents with | 0-4= Minimal Symptoms 5-10= Mild Symptoms 11-22= Moderate Symptoms 23-42= Severe Symptoms 43-80= Very Severe Symptoms |

The Child PTSD Symptom Scale (CPSS)—5 Interviewer Version

Pre-Treatment

CHILD

Now let's talk about how you have been feeling about the event IN THE LAST MONTH (or since it happened, if less than a month ago).

A month ago (or when the event happened) would have been (insert date).

Can you remember anything special or different that happened around that time? It could be a birthday, a party, a trip, or something else that happened at school or at home (use a calendar if necessary to illustrate the amount of time).

This will help us to remember what has been happening just in the past month (or since the event happened) as I ask you these questions.

I'm going to be asking you how you have been feeling just about (name the event). I'll be sure to mention the amount of time and the event in my questions just so we don't forget.

Show the CPSS Pictorial Rating Sheet.

I will read each item. You can tell me the number that best describes how often each one has bothered you IN THE LAST MONTH.

| Question | Not at All (0) | A Little (1) | Somewhat (2) | A Lot (3) | Almost Always (4) |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. Did you have upsetting thoughts or pictures about the experience come into your head when you did not want them to? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Did you have bad dreams or nightmares? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Did you act or feel like the experience was happening again? (Flashback) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Did you feel upset when you were reminded of what happened? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Did you have feelings in your body when you were reminded of what happened (e.g., stomach aches, headaches, chills, shaking, etc.)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Did you try not to think about, talk about, or have feelings about the experience? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Did you try to avoid activities, people, or places that reminded you of what happened? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Did you have trouble remembering important parts of the experience? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Did you have bad thoughts about yourself other people or the world? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Did you feel like what happened was your fault? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| Question | Not at All (0) | A Little (1) | Somewhat (2) | A Lot (3) | Almost Always (4) |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 11. Did you have strong upsetting feelings like guilt, anger, fear, or shame? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Did you have much less interest in doing things you used to like? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Did you have trouble feeling close to people? Did you feel like you didn't want to be around other people? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Did you have trouble having any good feelings like happiness or love? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Did you get angry easily? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Did you do anything that might hurt you (e.g., cutting, taking drugs, etc.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Were you very careful or on the lookout (for example, checking to see who is around you and what is around you)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Were you jumpy or easily frightened? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Did you have trouble paying attention because the bad event was on your mind? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Did you have trouble falling asleep or staying asleep? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

TOTAL: _____

Functional Impairment

| Question | Yes | No |
|---|--------------------------|--------------------------|
| 21. Did your symptoms interfere with you doing your prayers? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Did your symptoms interfere with your chores and duties at home? | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Did your symptoms interfere with your relationships with friends? | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Did your symptoms interfere with your fun and hobby activities? | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Did your symptoms interfere with your schoolwork? | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Did your symptoms interfere with your relationships with your family? | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Did your symptoms interfere with your overall happiness with your life? | <input type="checkbox"/> | <input type="checkbox"/> |

Created by the Yale Child Study Center

DATE OF ASSESSMENT: _____

____ PRE TREATMENT ____ POST TREATMENT

TCTY ID: _____

Child Post Traumatic Stress Scale 5 (CPSS-5 - Caregiver)

Age: 7-18

Completed By: Caregiver

Administration Time: 10-20 Minutes

Administration Guidelines

- Free assessment
- Paper measure
- Attempt to administer in a quiet, private location
- Caregiver completes on their own or the questions can be read to the caregiver
- Caregiver should have known the child for at least two weeks

Verbal Instructions

➤ Introduce Measure

1. This measure is about your perception of how your child is doing since the significant. Now let's talk about how your child has been feeling about the event since the event happened (if less than a month) OR in the last month
2. If event occurred longer than a month say the following:
 - A month ago (or when the event happened) would have been (insert date).
 - Can you remember anything special or different that happened around that time? It could be a birthday, a party, a trip, or something else that happened at school or at home
 - This will help us to remember what has been happening just in the past month as I ask you these questions.
3. I'm going to be asking you how your child has been feeling just about (name the event). I'll be sure to mention the amount of time and the event in my questions just so we don't forget.
4. I will read each item. You can tell me the number that best describes how often each one has bothered your child IN THE LAST MONTH. You can also answer "I Don't Know."
5. If it occurred: Give the rating scale and point to the scale (Almost Always 4, A Lot 3, Somewhat 2, A little 1, Not at all 0, Don't Know)

➤ Check Understanding

1. Does it make sense to you?
2. Do you have any question before we get started?

➤ Respond to Questions

1. Encourage them to answer all of the questions. If they ask what something means, tell them to give it their best guess. Make a note in the margin.

Scoring

| | |
|-----------------------|---------------------------------|
| Total Trauma | Add ratings for questions 1-20 |
| Functional Impairment | Add ratings for questions 21-27 |

Child Post Traumatic Stress Scale 5 (CPSS-5 - Child)

Scales and Interpretation

| SCALE | DESCRIPTION | INTERPRETATION NOTES |
|---|--|---|
| Re- Experiencing Symptoms | Symptoms are related to instances in which the client relives the traumatic event they experienced | Items 1-5 |
| Avoidance Symptoms | Symptoms are related to the client avoiding reminders of the traumatic event, | Items 6-7 |
| Negative Emotions & Cognitions | Symptoms are related to feeling distant from others, losing interest in activities they used to enjoy, or having trouble experiencing positive feelings | Items 8-14 |
| Hyperarousal Symptoms | Symptoms are related to the client experiencing an increased heartrate, sweating, difficulty breathing, difficulty sleeping, outbursts of anger, irritability, difficulty relaxing, and/or difficulty concentrating in relation to the traumatic event | Items 15-20 |
| Functional Impairment | Symptoms are related to the client experiencing a loss of functional capacity to meet responsibilities in their daily lives | Items 21-27 |
| Total Symptoms | The sum of aforementioned symptoms the client presents with | 0-4= Minimal Symptoms 5-10= Mild Symptoms 11-22= Moderate Symptoms 23-42= Severe Symptoms 43-80= Very Severe Symptoms |

The Child PTSD Symptom Scale (CPSS)—5 Interviewer Version
Pre-Treatment
CAREGIVER

Now let's talk about how your child has been feeling about the event IN THE LAST MONTH (or since it happened, if less than a month ago).

A month ago (or when the event happened) would have been (insert date).

Can you remember anything special or different that happened around that time? It could be a birthday, a party, a trip, or something else that happened at school or at home (use a calendar if necessary to illustrate the amount of time).

This will help us to remember what has been happening just in the past month (or since the event happened) as I ask you these questions.

I'm going to be asking you how your child has been feeling just about (name the event). I'll be sure to mention the amount of time and the event in my questions just so we don't forget.

Show the CPSS Pictorial Rating Sheet.

I will read each item. You can tell me the number that best describes how often each one has bothered your child IN THE LAST MONTH. You can also answer "I Don't Know."

[illegible]

| Question | DK (0) | Not at All (0) | A Little (1) | Some- what (2) | A Lot (3) | Almost Always (4) |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 11. Did your child have strong upsetting feelings like guilt, anger, fear, or shame? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Did your child have much less interest in doing things they used to like? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Did your child have trouble feeling close to people? Did your child feel like they didn't want to be around other people? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Did your child have trouble having any good feelings like happiness or love? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Did your child get angry easily? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Did your child do anything that might hurt themselves (e.g., cutting, taking drugs, etc.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Was your child very careful or on the lookout (for example, checking to see who is around them and what is around them)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Was your child jumpy or easily frightened? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Did your child have trouble paying attention because the bad event was on their mind? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Did your child have trouble falling asleep or staying asleep? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

TOTAL: _____

Functional Impairment

| Question | Yes | No |
|---|--------------------------|--------------------------|
| 21. Did your child's symptoms interfere with them doing their prayers? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Did your child's symptoms interfere with their chores and duties at home? | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Did your child's symptoms interfere with their relationships with friends? | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Did your child's symptoms interfere with their fun and hobby activities? | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Did your child's symptoms interfere with their schoolwork? | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Did your child's symptoms interfere with their relationships with their family? | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Did your child's symptoms interfere with their overall happiness with their life? | <input type="checkbox"/> | <input type="checkbox"/> |

Created by the Yale Child Study Center

DATE OF ASSESSMENT: _____

____ PRE TREATMENT ____ POST TREATMENT

TCTY ID: _____

Trauma Symptom Checklist for Young Children (TSCYC)

Age: 3-11

Completed by: Caregiver

Administration Time: 15-20 minutes

Administration Guidelines

- The assessment administration and scoring fees are part of the learning collaborative during the duration of the consultation calls.
- After the learning collaborative each clinician/agency will be independently responsible for the assessment fees if you choose to continue to use it. More information can be found at www.parinc.com/sign-up or the link below for specific assessment information.
 - TSCYC: www.parinc.com/Products/Pkey/4521
- Paper measure or electronic
- Attempt to administer in a quiet, private location
- Upon completion, thank caregiver for their willingness to complete the screening

Verbal Instructions

- **Introduce Measure**
 1. Caregiver: Say the following: "These questions describe things that kids sometimes think, feel, or do and your answers will help us determine how best to help this child."
 2. Explain the ratings (1 = Never happens, 2 = Sometimes, 3 = Lots of times, 4 = Almost all the time)
- **Check Understanding**
 1. Do you have any questions before your start?
- **Respond to Questions**
 1. Encourage caregiver to answer all the questions. If they ask what something means, tell them to give it their best guess; if no idea, skip it

Trauma Symptom Checklist for Young Children (TSCYC)

Age: 3-11 Completed by: Caregiver Administration Time: 15-20 minutes (90-items)

| SCALE | DESCRIPTION | INTERPRETATION NOTES |
|---|---|---|
| Response Level (RL) | Reflects a tendency to underreport even normal problems in the child, often due to generalized denial or a need to present the child as especially psychologically healthy or "good" | Score of $\geq 70T$ = Invalid; 65T-69T = viewed as underresponding |
| Atypical Response (ATR) | Reflects a general overresponse, a specific need to appear especially symptomatic, or a state of being overwhelmed by traumatic stress | Score of $\geq 90T$ = Invalid |
| Anxiety (ANX) | Generalized anxiety and worry, specific fears, being easily frightened; and a sense of impending danger | Scores of $\geq 70T$ = clinically significant; 65T-69T = subclinical |
| Depression (DEP) | Feelings of sadness, unhappiness, tearfulness, depressed appearance; depressive thinking such as self-blame and self-denigration; and self-injuriousness | Scores of $\geq 70T$ = clinically significant; 65T-69T = subclinical |
| Anger (ANG) | Angry feelings, and behaviors, including feeling mad, feeling mean, becoming easily angered yelling, hitting, fighting, and cruelty to animals | Scores of $\geq 70T$ = clinically significant; 65T-69T = subclinical |
| Posttraumatic Stress - Intrusion (PTS-I) | Nightmares, posttraumatic play, flashbacks, fear in response to trauma-reminiscent events, and being upset by traumatic memories | Scores of $\geq 70T$ = clinically significant; 65T-69T = subclinical |
| Posttraumatic Stress - Avoidance (PTS-AV) | Avoiding people, places, and situations reminiscent of a traumatic event, emotional numbing, unwillingness to speak about traumatic event, and difficulties fully remembering the trauma | Scores of $\geq 70T$ = clinically significant; 65T-69T = subclinical |
| Posttraumatic Stress - Arousal (PTS-AR) | Posttraumatic stress symptoms associated with autonomic arousal (i.e., fight-flight-freeze response), including jumpiness, tension, attention and concentration problems, and sleep problems | Scores of $\geq 70T$ = clinically significant; 65T-69T = subclinical |
| Posttraumatic Stress - Total (PTS-TOT) | Sum of all 3 posttraumatic scales. Reflects overall posttraumatic symptomatology experienced by the child. A <u>raw</u> score of ≥ 40 , in a child with trauma exposure, suggests a possible diagnosis of PTSD | Scores of $\geq 70T$ = severe posttraumatic stress; 65T-69T = mild to moderate posttraumatic stress |
| Dissociation (DIS) | Emotional disengagement; staring into space, living in a fantasy world, absent-mindedness, appearing to be in a trance, and reduced attention to environment | Scores of $\geq 70T$ = clinically significant; 65T-69T = subclinical |
| Sexual Concerns (SC) | Sexual knowledge, behaviors, feelings, or preoccupations that are atypical because they occur earlier than expected or with greater than normal frequency, and fearful responses to sexual stimuli | Scores of $\geq 70T$ = clinically significant; 65T-69T = subclinical |

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Age:

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TSCYC
TCTY

Date:

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| | | / | | | / | | | | |
|--|--|---|--|--|---|--|--|--|--|

Timepoint: ☐ Pre ☐ PostGender: ☐ Male ☐ Female

ID#:

Site

Name:

DIRECTIONS: The following items have to do with things the child does, feels, or experiences. Please indicate how often he or she has done, felt, or experienced each of the following things in the last month. Please choose only **ONE** answer for each item.

| | Not At All 1 | Sometimes 2 | Often 3 | Very Often 4 |
|--|-----------------------|-----------------------|-----------------------|-----------------------|
| 1. Temper Tantrums | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 2. Looking sad | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 3. Telling a lie | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 4. Bad dreams or nightmares | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 5. Living in a fantasy world | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 6. Seeming to know more about sex than he or she should | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 7. Being easily scared | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 8. Not wanting to go somewhere that reminded him or her of a bad thing from the past | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 9. Worrying that his or her food was poisoned | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 10. Flinching or jumping when someone moved quickly or there was a loud noise | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 11. Being bothered by memories of something that happened to him or her | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 12. Worrying that someone might be sexual with him or her | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 13. Not wanting to talk about something that happened to him or her | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 14. Not doing something he or she was supposed to do | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 15. Breaking things on purpose | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 16. Talking about sexual things | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 17. Having trouble concentrating | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 18. Blaming himself or herself for things that weren't his or her fault | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 19. Acting frightened when he or she was reminded of something that happened in the past | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 20. Pretending to have sex | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 21. Worrying that bad things would happen in the future | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 22. Arguing | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 23. Getting into physical fights | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 24. Drawing pictures about an upsetting thing that happened to him or her | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |



Please turn sheet over for questions on the other side

| | | | |
|----------------------|----------------------|----------------------|----------------------|
| Entered: | <input type="text"/> | ID# | <input type="text"/> |
| Date: | <input type="text"/> | Entered by: | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |

| | Not At All 1 | Sometimes 2 | Often 3 | Very Often 4 |
|--|-----------------------|-----------------------|-----------------------|-----------------------|
| 25. Not noticing what he or she was doing | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 26. Having trouble sitting still | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 27. Playing games about something bad that actually happened to him or her in the past | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 28. Seeming to be in a daze | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 29. Having trouble remembering an upsetting thing that happened in the past | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 30. Using drugs | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 31. Fear of the dark | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 32. Being afraid to be alone | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 33. Spacing out | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 34. Being too aggressive | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 35. Touching other children's or adults' private parts (under or over clothes) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 36. Suddenly seeing, feeling, or hearing something bad that happened in the past | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 37. Hearing voices telling him or her to hurt someone | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 38. Staring off into space | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 39. Changing the subject or not answering when he or she was asked about a bad thing that happened to him or her | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 40. Having a nervous breakdown | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 41. Not laughing or being happy like other children | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 42. Crying at night because he or she was frightened | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 43. Hitting adults (including parents) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 44. Being frightened of men | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 45. Not being able to pay attention | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 46. Seeming to be a million miles away | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 47. Being easily startled | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 48. Watching out everywhere for possible danger | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 49. No longer doing things that he or she used to enjoy | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 50. Becoming frightened or disturbed when something sexual was mentioned or seen | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 51. Not sleeping for two or more days | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 52. Not paying attention because he or she was in his or her own world | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 53. Making mistakes | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 54. Crying for no obvious reason | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

| | Not At All 1 | Sometimes 2 | Often 3 | Very Often 4 |
|--|-----------------------|-----------------------|-----------------------|-----------------------|
| 55. Not wanting to be around someone who did something bad to him or her or reminded him or her of something bad | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 56. Being tense | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 57. Worrying about other people's safety | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 58. Becoming very angry over a little thing | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 59. Drawing pictures of sexual things | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 60. Pulling his or her hair out | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 61. Calling himself or herself bad, stupid or ugly | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 62. Throwing things at friends or family members | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 63. Getting upset about something in the past | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 64. Temporary blindness or paralysis | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 65. Getting upset about something sexual | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 66. Not going to bed at night the first time he or she was asked | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 67. Fear that he or she would be killed by someone | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 68. Saying that nobody liked him or her | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 69. Crying when he or she was reminded of something from the past. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 70. Saying that something bad didn't happen to him or her even though it did happen | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 71. Saying he or she wanted to die or be killed | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 72. Acting as if he or she didn't have any feelings about something bad that happened to him or her | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 73. Whining | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 74. Not sleeping well | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 75. Worrying about sexual things | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 76. Being frightened by things that didn't used to scare him or her | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 77. Hallucinating | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 78. Acting like he or she was in a trance | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 79. Forgetting his or her own name | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 80. Getting upset when he or she was reminded of something bad that happened | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 81. Avoiding things that reminded him or her of a bad thing that had happened in the past | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 82. Acting jumpy | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 83. Making a mess | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 84. Acting sad or depressed | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |



Please turn sheet over for questions on the other side

| | Not At All 1 | Sometimes 2 | Often 3 | Very Often 4 |
|---|-----------------------|-----------------------|-----------------------|-----------------------|
| 85. Being so absent-minded that he or she didn't notice what was going on around him or her | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 86. Not wanting to eat certain foods | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 87. Yelling at family, friends, or teachers | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 88. Not playing because he or she was depressed | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 89. Being disobedient | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 90. Intentionally hurting other children or family members | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Trauma Symptom Checklist for Children (TSCC)

Age: 12-16

Completed By: Child

Administration Time: 15-20 Minutes

Administration Guidelines

- The assessment administration and scoring fees are part of the learning collaborative during the duration of the consultation calls.
- After the learning collaborative each clinician/agency will be independently responsible for the assessment fees if you choose to continue to use it. More information can be found at www.parinc.com/sign-up or the link below for specific assessment information.
 - TSCC: www.parinc.com/Products/Pkey/461
- Paper measure or electronic
- Attempt to administer in a quiet, private location
- If necessary, you may read screening items to child but avoid interpretation if possible
- Upon completion, praise child for their effort/willingness to answer the questions and allow them time to debrief afterwards if needed
- Be sure to check critical items and follow-up if necessary

Verbal Instructions

- **Introduce Measure**
 1. Child: Say the following: "These questions describe things that kids sometimes think, feel, or do and your answers will help us learn how to best help you."
 2. Explain the ratings (0 = Never happens, 1 = Sometimes, 2 = Lots of times, 3 = Almost all the time)
- **Check Understanding**
 1. Does it make sense to you?
 2. Do you have any questions before we get started?
- **Respond to Questions**
 1. Encourage child to answer all the questions. If they ask what something means, tell them to give it their best guess; if no idea, skip it

| Trauma Symptom Checklist for Children (TSCC) | | | |
|---|---|--|---|
| Age: 12-16 | | Completed by: Child | Administration Time: 15-20 minutes (54-items) |
| SCALE | DESCRIPTION | INTERPRETATION NOTES | |
| Underresponse (UND) | Reflects a tendency toward denial, a general underendorsement response set, or a need to appear unusually symptom-free | Score of $\geq 70T$ = Invalid; 65T-75T = viewed as underresponding | |
| Hyperresponse (HYP) | Reflects a general overresponse, a specific need to appear especially symptomatic, or a state of being overwhelmed by traumatic stress | Score of $\geq 90T$ = Invalid; 75T-89T = viewed as potential overresponders | |
| Anxiety (ANX) | Generalized anxiety, hyperarousal, and worry; specific fears; episodes of free-floating anxiety; and a sense of impending danger | Scores of $\geq 65T$ = clinically significant; 60T-65T = subclinical | |
| Depression (DEP) | Feelings of sadness, unhappiness, and loneliness; episodes of tearfulness; depressive thinking such as guilt and self-denigration; and self-injuriousness and suicidality | Scores of $\geq 65T$ = clinically significant; 60T-65T = subclinical CRITICAL ITEMS: #20 (hurt self) and #52 (kill self) | |
| Anger (ANG) | Angry thoughts, feelings, and behaviors, including feeling mad, feeling mean, and hating others; having difficulty de-escalating anger; wanting to yell at or hurt people; arguing and fighting | Scores of $\geq 65T$ = clinically significant; 60T-65T = subclinical CRITICAL ITEM: #21 (hurt others) | |
| Posttraumatic Stress (PTS) | Posttraumatic symptoms including intrusive thoughts, sensations, and memories of painful past events; nightmares; fears; and cognitive avoidance of painful feelings | Scores of $\geq 65T$ = clinically significant; 60T-65T = subclinical | |
| Dissociation (DIS) DIS-O (Overt) DIS-F (Fantasy) | One's mind going blank; emotional numbing; pretending to be someone else or somewhere else; daydreaming; memory problems; and dissociative avoidance. Has two subscales: DIS-O (Overt Dissociation) and DIS-F (Fantasy) | Scores of $\geq 65T$ = clinically significant; 60T-65T = subclinical | |
| Sexual Concerns (SC) SC-P (Sexual Preoccupation) SC-D (Sexual Distress) | Sexual thoughts of feelings that are atypical when they occur earlier than expected or with greater than normal frequency; sexual conflicts; negative responses to sexual stimuli; and fear of being sexually exploited. Has two subscales: SC-P (Sexual Preoccupation) and SC-D (Sexual Distress) | Scores of $\geq 65T$ = clinically significant; 60T-65T = subclinical Scores of $\geq 70T$ = clinically significant; 65T-70T = subclinical | |

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Date:

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|--|--|---|--|--|---|--|--|--|--|
| | | / | | | / | | | | |
|--|--|---|--|--|---|--|--|--|--|

Timepoint: ☐ Pre ☐ PostGender: ☐ Male ☐ Female

ID#:

Site

Name:

DIRECTIONS: The items in this questionnaire describe things that kids sometimes think, feel, or do. Read each item, then mark how often it has happened to you in the past 30 days by filling in the circle under the correct answer. Please choose only ONE answer for each item.

| | Never 0 | Sometimes 1 | Lots of times 2 | Almost all of the time 3 |
|--|-----------------------|-----------------------|-----------------------|-----------------------------------|
| 1. Bad dreams or nightmares | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 2. Feeling afraid something bad might happen | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 3. Scary ideas or pictures just pop into my head | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 4. Wanting to say dirty words | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 5. Pretending I am someone else | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 6. Arguing too much | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 7. Feeling lonely | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 8. Touching my private parts too much | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 9. Feeling sad or unhappy | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 10. Remembering things that happened that I didn't like | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 11. Going away in my mind, trying not to think | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 12. Remembering scary things | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 13. Wanting to yell and break things | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 14. Crying | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 15. Getting scared all of a sudden and don't know why | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 16. Getting mad and can't calm down | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 17. Thinking about having sex | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 18. Feeling dizzy | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 19. Wanting to yell at people | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 20. Wanting to hurt myself | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 21. Wanting to hurt other people | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 22. Thinking about touching other people's private parts | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 23. Thinking about sex when I don't want to | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 24. Feeling scared of men | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |



Please turn sheet over for questions on the other side

| | | | | | |
|----------------------|----------------------|-------------|----------------------|----------------------|----------------------|
| Entered: | <input type="text"/> | ID# | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Date: | <input type="text"/> | Entered by: | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | / | <input type="text"/> | / | <input type="text"/> |

| | Never 0 | Sometimes 1 | Lots of times 2 | Almost all of the time 3 |
|---|-----------------------|-----------------------|-----------------------|-----------------------------------|
| 25. Feeling scared of women | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 26. Washing myself because I feel dirty on the inside | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 27. Feeling stupid or bad | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 28. Feeling like I did something wrong | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 29. Feeling like things aren't real | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 30. Forgetting things, can't remember things | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 31. Feeling like I'm not in my body | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 32. Feeling nervous or jumpy inside | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 33. Feeling afraid | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 34. Not trusting people because they might want sex | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 35. Can't stop thinking about something bad that happened to me | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 36. Getting into fights | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 37. Feeling mean | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 38. Pretending I'm somewhere else | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 39. Being afraid of the dark | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 40. Getting scared or upset when I think about sex | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 41. Worrying about things | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 42. Feeling like nobody likes me | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 43. Remembering things I don't want to remember | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 44. Having sex feelings in my body | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 45. My mind going empty or blank | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 46. Feeling like I hate people | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 47. Can't stop thinking about sex | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 48. Trying not to have any feelings | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 49. Feeling mad | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 50. Feeling afraid somebody will kill me | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 51. Wishing bad things had never happened | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 52. Wanting to kill myself | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 53. Daydreaming | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 54. Getting upset when people talk about sex | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |