TRAUMA SCREEN

Lots of kids have upsetting or scary experiences as they grow up. Today, I'm going to ask you about the most upsetting experience you've ever had and how you've been feeling about it lately. If I ask you a question that you don't understand, just tell me that you don't understand and I'll try my best to explain it so that it makes sense to you.

First, tell me about the most upsetting or scary experience you've ever had. It could be something that happened to you, something that you saw happen, or even something that happened to a friend or someone in your family. It might be something like a car accident, getting beaten up, living through an earthquake, being robbed, losing a parent, being touched in a way you didn't like, seeing your mother get hurt, or some other very upsetting event.

What is the most upsetting or scary experience you've ever had?

_____

_____

_____

_____

When did this happen? (How old were you? How long ago did it happen? What grade were you in?)

_____

(Interviewer use only)
Did this event included:

a. Actual or threatened death? Yes No
b. Actual or threatened serious injury? Yes No
c. Actual or threatened sexual violation Yes No

Name or ID#: _____ Date: _____

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Now let's talk about how you've been feeling about this experience IN THE LAST MONTH. A month ago 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 as I ask you these questions.

Let's also remember that I'm going to be asking you how you've been feeling just about (insert trauma). I'll be sure to mention the amount of time and the upsetting experience in my questions just so we don't forget.

0 Not at all	1 Once a week or less/a little	2 2 to 3 times a week/somewhat	3 4 to 5 times a week/a lot	4 6 or more times a week/almost always

1.	0	1	2	3	4	Did you have upsetting thoughts or pictures about the experience that came into your head when you didn't want them to?
2.	0	1	2	3	4	Did you have bad dreams or nightmares?
3.	0	1	2	3	4	Did you act or feel like the experience was happening again (seeing or hearing something and feeling as if you are there again)?
4.	0	1	2	3	4	Did you feel upset when you were reminded of what happened (for example, feeling scared, angry, sad, guilty, confused)?
5.	0	1	2	3	4	Did you have feelings in your body when you were reminded of what happened (for example, breaking out into a sweat, heart beating fast)?
6.	0	1	2	3	4	Did you try not to think about, talk about, or have feelings about the experience?
7.	0	1	2	3	4	Did you try to avoid activities, people, or places that reminded you of what happened?
8.	0	1	2	3	4	Did you have trouble remembering an important part of the experience?
9.	0	1	2	3	4	Did you have bad thoughts about yourself, other people, or the world (for example, "I can't do anything right", "All people are bad", "The world is a scary place")?
10.	0	1	2	3	4	Did you feel like what happened was your fault (for example, "I should have known better", "I shouldn't have done that")?

0 Not at all	1 Once a week or less/a little	2 2 to 3 times a week/somewhat	3 4 to 5 times a week/a lot	4 6 or more times a week/almost always

11.	0	1	2	3	4	Did you have strong upsetting feelings like fear, anger, guilt, or shame?
12.	0	1	2	3	4	Did you have much less interest in doing things you used to like?
13.	0	1	2	3	4	Did you have trouble feeling close to people? Did you feel like you didn't want to be around other people?
14.	0	1	2	3	4	Did you have trouble having any good feelings (like happiness or love)?
15.	0	1	2	3	4	Did you get angry easily (for example, yelling, hitting others, throwing things)?
16.	0	1	2	3	4	Did you do anything that might hurt yourself (for example, taking drugs, running away)?
17.	0	1	2	3	4	Were you very careful or on the lookout (for example, checking to see who is around you and what is around you)?
18.	0	1	2	3	4	Were you jumpy or easily frightened (for example, when someone walks up behind you, when you hear a loud noise)?
19.	0	1	2	3	4	Did you have trouble paying attention (for example, losing track of a story on TV, forgetting what you read, unable to pay attention in class)?
20.	0	1	2	3	4	Did you having trouble falling or staying asleep?

How much have these symptoms been interfering with your everyday life?

21	0	1	2	3	4	Doing your prayers
22.	0	1	2	3	4	Chores and duties at home
23.	0	1	2	3	4	Relationships with friends
24.	0	1	2	3	4	Fun and hobby activities
25.	0	1	2	3	4	Schoolwork
26.	0	1	2	3	4	Relationships with your family
27.	0	1	2	3	4	General happiness with your life