Pediatric Traumatic Stress Screening Tool

6–10 years of age

Sometimes **violent** or **very scary** or **upsetting** things happen. This could be something that happened to your child or something your child saw. It can include being badly hurt, someone doing something harmful to your child or someone else, or a serious accident or serious illness.

Has something like this happened to your child **recently**? ❑ Yes ❑ No

If 'Yes,' what happened? _____

Has something like this happened to your child **in the past**? ❑ Yes ❑ No

If 'Yes,' what happened? _____

FREQUENCY RATING CALENDARS

Select how often your child had the problem below in the past month. Use the calendars on the right to help you decide how often.

	How much of the time during the past month...	None	Little	Some	Much	Most
1	My child has bad dreams about what happened or other bad dreams.	0	1	2	3	4
2	My child has trouble going to sleep, waking up often, or has trouble getting back to sleep.	0	1	2	3	4
3	My child has upsetting thoughts, pictures, or sounds of what happened come to mind when he/she doesn't want them to.	0	1	2	3	4
4	When something reminds my child of what happened, he/she has strong feelings in his/her body, like his/her heart beats fast, headaches, or stomach aches.	0	1	2	3	4
5	When something reminds my child of what happened, he/she gets very upset, afraid, or sad.	0	1	2	3	4
6	My child has trouble concentrating or paying attention.	0	1	2	3	4
7	My child gets upset easily or gets into arguments or physical fights.	0	1	2	3	4
8	My child tries to stay away from people, places, or things that remind him/her about what happened.	0	1	2	3	4
9	My child has trouble feeling happiness or love.	0	1	2	3	4
10	My child tries not to think about or have feelings about what happened.	0	1	2	3	4
11	My child has thoughts like "I will never be able to trust other people."	0	1	2	3	4
12	My child feels alone even when he/she is around other people.	0	1	2	3	4

13	*Over the last 2 weeks, how often has your child been bothered by thoughts that he/she would be better off dead or hurting him or herself in some way?	Not at all	Several days	More than half the days	Nearly every day

*Adapted from Patient Health Questionnaire (PHQ-C)

Clinicians, please indicate actions taken:

☐ **No Action Taken**

Referrals: (check all that apply)

- ☐ Child Protection (DCFS/CPS)
- ☐ Crisis Evaluation/Emergency Department
- ☐ Trauma Evidence-Based Treatment
- ☐ Mental Health Integration (MHI)

In-office Interventions: (check all that apply)

- ☐ Sleep Education
- ☐ Belly Breathing
- ☐ Guided Imagery
- ☐ Progressive Muscle Relaxation

Patient Name: _____ Patient DOB: _____ EMPI _____

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Based on the UCLA Brief Trauma Screen

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