Pediatric Traumatic Stress Screening Tool

11 years and older

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

Has something like this happened **recently**? ❑ Yes ❑ No

If 'Yes,' what happened? _____

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

If 'Yes,' what happened? _____

If you checked 'yes' on either question above, please continue below.

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

FREQUENCY RATING CALENDARS

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

13	*Over the last 2 weeks, how often have you been bothered by thoughts that you would be better off dead or hurting yourself in some way?	Not at all	Several days	More than half the days	Nearly every day

*Adapted from Patient Health Questionnaire (PHQ-A)

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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