Child and adolescents Trauma Screening

Client Name: ______________________

(CATS)

Identifier: ______________________

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Date: ______________________

PTSD AVERAGE SCORE: ______

Caregiver's Name: ____

Clinician's Name: ____

CAREGIVER REPORT

Caregiver Score: ______

Trauma Exposure: ____

Criteria	**# of Symptoms** (Only count items rated 2 or 3)	**# Symptoms Required**	**DSM-5 Criteria Met?**	
Re-experiencing Items 1-5		1+	Yes: _____	No: _____
Avoidance Items 6-7		1+	Yes: _____	No: _____
Negative Mood/ Cognitions Items 8-15		2+	Yes: _____	No: _____
Arousal Items 16-20		2+	Yes: _____	No: _____
Functional Impairment Set of 1-5 Yes/No Questions		1+	Yes: _____	No: _____

CHILD REPORT

Child Score: ______

Trauma Exposure: ____

Criteria	**# of Symptoms** (Only count items rated 2 or 3)	**# Symptoms Required**	**DSM-5 Criteria Met?**	
Re-experiencing Items 1-5		1+	Yes: _____	No: _____
Avoidance Items 6-7		1+	Yes: _____	No: _____
Negative Mood/ Cognitions Items 8-15		2+	Yes: _____	No: _____
Arousal Items 16-20		2+	Yes: _____	No: _____
Functional Impairment Set of 1-5 Yes/No Questions		1+	Yes: _____	No: _____

Child and adolescents Trauma Screening (CATS)

CAREGIVER REPORT

Client Name: ______________________

Identifier: ______________________

Caregiver's Name: ____________________________________

Date: ______________________

Stressful or scary events happen to many children. Below is a list of stressful and scary events that sometimes happen. Mark YES if it happened to the child to the best of your knowledge. Mark NO if it didn't happen to the child.

1.	Serious natural disaster like a flood, tornado, hurricane, earthquake, or fire.	☐ Yes	☐ No
2.	Serious accident or injury like a car/bike wreck, dog bite, sports injury.	☐ Yes	☐ No
3.	Robbed by threat, force, or weapon.	☐ Yes	☐ No
4.	Slapped, punched, or beat up in the family.	☐ Yes	☐ No
5.	Slapped, punched, or beat up by someone not in the family.	☐ Yes	☐ No
6.	Seeing someone in the family get slapped, punched, or beat up.	☐ Yes	☐ No
7.	Someone older touching his/her private parts when they shouldn't.	☐ Yes	☐ No
8.	Someone forcing or pressuring sex, or when he/she couldn't say no.	☐ Yes	☐ No
9.	Someone close to the child dying suddenly or violently.	☐ Yes	☐ No
10.	Attacked, stabbed, shot at, or hurt badly.	☐ Yes	☐ No
11.	Seeing someone attacked, stabbed, shot at, hurt badly, or killed.	☐ Yes	☐ No
12.	Stressful or scary medical procedure.	☐ Yes	☐ No
13.	Being around war.	☐ Yes	☐ No
14.	Other stressful or scary event?	☐ Yes	☐ No

Describe: ____

Which one is currently bothering the child the most? _______

If you marked "YES" to any stressful or scary events for the child, then answer the questions on the next page.

Write 0, 1, 2, or 3 for how often the following things have bothered the child in the last two weeks:

0 NEVER/ 1 ONCE IN A WHILE / 2 HALF THE TIME/ 3 ALMOST ALWAYS

Client Name: ______________________

Identifier: ______________________

Date: ______________________

1. Upsetting thoughts or images about stressful event or re-enacting a stressful event in play. ______
2. Bad dreams related to a stressful event. ______
3. Acting, playing, or feeling as if a stressful event is happening right now. ______
4. Feeling very emotionally upset when reminded of a stressful event. ______
5. Strong physical reactions when reminded of a stressful event (sweating, heart beating fast). ______
6. Trying not to remember, talk about, or have feelings about a stressful event. ______
7. Avoiding activities, people, places, or things that are reminders of stressful events. ______
8. Not being able to remember an important part of a stressful event. ______
9. Negative changes in how he/she thinks about self, others, or the world after stressful event. ______
10. Thinking a stressful event happened because s/he or someone else did something wrong or did not do enough to stop it. ______
11. Having very negative emotional states (afraid, angry, guilty, ashamed). ______
12. Losing interest in activities s/he enjoys before stressful event, including not playing as much. ______
13. Feeling distant or cut off from the people around her/him. ______
14. Not showing or reducing positive feelings (being happy, having loving feelings). ______
15. Being irritable or having angry outbursts without a good reason and taking it out on others. or things. ______
16. Risky behavior or behavior that could be harmful. ______
17. Being overly alert or on guard. ______
18. Being jumpy or easily startled. ______
19. Problems with concentration. ______
20. Trouble falling or staying asleep ______

Please mark “YES” OR “NO” if the problems you marked interfered with:

Getting along with others: ☐ Yes ☐ No

Family relationships: ☐ Yes ☐ No

Hobbies/fun: ☐ Yes ☐ No

General happiness: ☐ Yes ☐ No

School or work: ☐ Yes ☐ No

Child and adolescents Trauma Screening (CATS)

Client Name: ______________________

YOUTH REPORT

Identifier: ______________________

Date: ______________________

AGES 7-17

Stressful or scary events happen to many children. Below is a list of stressful and scary events that sometimes happen. Mark YES if it happened to you. Mark NO if it didn't happen to you.

1. Serious natural disaster like a flood, tornado, hurricane, earthquake, or fire.	☐ Yes	☐ No
2. Serious accident or injury like a car/bike wreck, dog bite, sports injury.	☐ Yes	☐ No
3. Robbed by threat, force, or weapon.	☐ Yes	☐ No
4. Slapped, punched, or beat up in your family.	☐ Yes	☐ No
5. Slapped, punched, or beat up by someone not in your family.	☐ Yes	☐ No
6. Seeing someone in your family get slapped, punched, or beat up.	☐ Yes	☐ No
7. Someone older touching your private parts when they shouldn't.	☐ Yes	☐ No
8. Someone forcing or pressuring sex, or when you couldn't say no.	☐ Yes	☐ No
9. Someone close to you dying suddenly or violently.	☐ Yes	☐ No
10. Attacked, stabbed, shot at, or hurt badly.	☐ Yes	☐ No
11. Seeing someone attacked, stabbed, shot at, hurt badly, or killed.	☐ Yes	☐ No
12. Stressful or scary medical procedure.	☐ Yes	☐ No
13. Being around war.	☐ Yes	☐ No
14. Other stressful or scary event?	☐ Yes	☐ No

Describe: ____

Which one is currently bothering you the most? _______

If you marked "YES" to any stressful or scary events, then answer the questions on the next page.

Write 0, 1, 2, or 3 for how often the following things have bothered you in the last two weeks:

0 NEVER/ 1 ONCE IN A WHILE / 2 HALF THE TIME/ 3 ALMOST ALWAYS

Client Name: ________________________

Identifier: ________________________

Date: ________________________

1. Upsetting thoughts or images about what happened that pop into your head. _______
2. Bad dreams reminding you of what happened. _______
3. Feeling as if what happened is happening all over again. _______
4. Feeling very emotionally upset when reminded of what happened. _______
5. Strong physical reactions when reminded of what happened (sweating, heart beating fast). _______
6. Trying not to remember, talk about, or have feelings about what happened. _______
7. Avoiding activities, people, places, or things that are reminders of what happened. _______
8. Not being able to remember part of what happened. _______
9. Negative thoughts about yourself or others. Thoughts that the whole world is unsafe. _______
10. Blaming yourself for what happened or blaming someone else when it isn't their fault. _______
11. Bad feelings (afraid, angry, guilty, ashamed) a lot of the time. _______
12. Not wanting to do things you used to do. _______
13. Not feeling close to people. _______
14. Not being able to have good or happy feelings. _______
15. Feeling mad. Having fits of anger and taking it out on someone else. _______
16. Doing unsafe things _______
17. Being overly careful or on guard (checking to see who is around). _______
18. Being jumpy or easily startled. _______
19. Problems with concentration. _______
20. Trouble falling or staying asleep _______

Please mark "YES" OR "NO" if the problems you marked interfered with:

Getting along with others: ☐ Yes ☐ No

Family relationships: ☐ Yes ☐ No

Hobbies/fun: ☐ Yes ☐ No

General happiness: ☐ Yes ☐ No

School or work: ☐ Yes ☐ No