

Therapist ID: \_\_\_\_\_

Date: \_\_\_\_\_

Client ID: \_\_\_\_\_

## Child and Adolescent Trauma Screen (CATS) – Page 1

### Caregiver Report – 7-17 Version

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

	Yes	No
1. Serious natural disaster like a flood, tornado, hurricane, earthquake, or fire.	<input type="checkbox"/>	<input type="checkbox"/>
2. Serious accident or injury like a car/bike crash, dog bite, or sports injury.	<input type="checkbox"/>	<input type="checkbox"/>
3. Robbed by threat, force, or weapon.	<input type="checkbox"/>	<input type="checkbox"/>
4. Slapped, punched, or beat up in the family.	<input type="checkbox"/>	<input type="checkbox"/>
5. Slapped, punched, or beat up by someone not in the family.	<input type="checkbox"/>	<input type="checkbox"/>
6. Seeing someone in the family slapped, punched, or beat up.	<input type="checkbox"/>	<input type="checkbox"/>
7. Seeing someone in the community slapped, punched, or beat up.	<input type="checkbox"/>	<input type="checkbox"/>
8. Someone older touching your child's private parts when they shouldn't.	<input type="checkbox"/>	<input type="checkbox"/>
9. Someone forcing or pressuring sex, or when your child couldn't say no.	<input type="checkbox"/>	<input type="checkbox"/>
10. Someone close to your child dying suddenly or violently.	<input type="checkbox"/>	<input type="checkbox"/>
11. Attacked, stabbed, shot at, or hurt badly.	<input type="checkbox"/>	<input type="checkbox"/>
12. Seeing someone attacked, stabbed, shot at, or hurt badly.	<input type="checkbox"/>	<input type="checkbox"/>
13. Stressful or scary medical procedure.	<input type="checkbox"/>	<input type="checkbox"/>
14. Being around war.	<input type="checkbox"/>	<input type="checkbox"/>
15. Other stressful or scary event? If yes, describe the event: _____	<input type="checkbox"/>	<input type="checkbox"/>
16. Which of the above events (#1-15) is bothering your child most now? # _____		

If you marked **YES** to any of the questions 1-15, continue to CATS Page 2.

If you marked **NO** to all questions 1-15, DO NOT complete CATS Page 2.

## Child and Adolescent Trauma Screen (CATS) – Page 2

### Caregiver Report – 7-17 Version

Mark **Never (0)**, **Once in a While (1)**, **Half the Time (2)**, or **Almost Always (3)** for how often the following things have bothered your child *in the last two weeks*:

	0	1	2	3
1. Upsetting thoughts or images about the stressful event. Or re-enacting a stressful event in play.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Bad dreams related to a stressful event.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Acting, playing or feeling as if a stressful event is happening right now.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Feeling very upset when reminded of a stressful event.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Strong physical reactions when reminded of a stressful event (sweating, heart beating fast, upset stomach).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Trying not to think about, talk about, or have feelings about a stressful event.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Avoiding activities, people, places, or things that are reminders of a stressful event.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Not being able to remember an important part of a stressful event.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Negative changes in how they think about themselves, others, or the world after a stressful event.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Thinking a stressful event happened because they or someone else did something wrong or did not do enough to stop it.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Having very negative emotional states (afraid, angry, guilty, and ashamed).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Losing interest in activities they enjoyed before a stressful event, including not playing as much.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Feeling distant or cut off from people around them.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Not showing or reduced positive feelings (being happy, having loving feelings).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Being irritable or having angry outbursts without a good reason and taking it out on others.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Risky behavior or behavior that could be harmful.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Being overly alert or on guard.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Being jumpy or easily startled.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Problems with concentration.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Trouble falling or staying asleep.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Please circle YES or NO if the problems you marked in questions 1-20 interfered with:**

21. Getting along with others	<b>Yes</b>	<b>No</b>	24. Family relationships	<b>Yes</b>	<b>No</b>
22. Hobbies/Fun	<b>Yes</b>	<b>No</b>	25. General Happiness	<b>Yes</b>	<b>No</b>
23. School or work	<b>Yes</b>	<b>No</b>			