Trauma Checklist (Youth and Child)

NAME_____AGE_____SEX_____DATE_____

Below is a list of scary, dangerous or violent situations or events that sometimes happen to kids. For each of the following questions, mark YES if the event happened to you and check NO if this did not happen to you.

1. Being in a **big earthquake** that badly damaged the building you were in. ☐ Yes ☐ No
2. Being in another kind of **disaster,** like a fire, tornado, flood or hurricane. ☐ Yes ☐ No
3. Being in a bad **accident**, like a **very serious** car accident ☐ Yes ☐ No
4. Being in a place where **war** was going on around you. ☐ Yes ☐ No
5. Being **hit, kicked or punched** very hard at home (DO NOT include ordinary fights with brothers or sisters) ☐ Yes ☐ No
6. Seeing a **family member being hit, punched or kicked** very hard at home (DO NOT include ordinary fights with brothers or sisters) ☐ Yes ☐ No
7. Being **beaten up, shot at or being threatened to be hurt** badly. ☐ Yes ☐ No
8. Seeing **someone** in real life **being beaten up, shot at, hurt badly, killed or almost killed** ☐ Yes ☐ No
9. Seeing a **dead body** in real life. (DO NOT include funerals) ☐ Yes ☐ No
10. Having an adult or someone much older **touch your private sexual body parts** when you did not want them to or anyone **forcing sex** on you ☐ Yes ☐ No
11. Hearing about the **violent death or serious injury** of a loved one ☐ Yes ☐ No
12. Having **painful and scary medical treatment in a hospital** when you were very badly sick or injured. ☐ Yes ☐ No
13. Of the questions you marked YES, which was the *worst. (*Please list the number) _____
14. Of the questions, which one is the reason you are here? (Please list the number) _____

Please check YES or NO to answer how you felt during the event in question 14.

1. Were you scared you would die? ☐ Yes ☐ No
2. Were you scared you would be hurt badly? ☐ Yes ☐ No
3. Were you hurt badly? ☐ Yes ☐ No
4. Were you scared someone else would die? ☐ Yes ☐ No
5. Were you scared that someone else would be hurt badly? ☐ Yes ☐ No
6. Was someone else hurt badly? ☐ Yes ☐ No
7. Did someone die? ☐ Yes ☐ No

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

0 Not at all
1 Once per week or less/ a little bit/ once in a while
2 2 to 4 times per week/ somewhat/ half the time
3 5 or more times per week/ very much/ almost always

__1. Having upsetting thoughts or images about the event that came into your head when you didn't want them to.
__2. Having bad dreams or nightmares.
__3. Acting or feeling as if the event was happening again.
__4. Feeling upset when you think about or hear about the event.
__5. Having feelings in your body when you think about or hear about the event. (Heart beating fast, upset stomach, breaking out in a sweat)
__6. Trying not to think about, talk about or have feelings about the event.
__7. Trying to avoid activities or people, or places that remind you of the event.
__8. Not being able to remember an important part of the upsetting event.
__9. Having much less interest or not doing the things you used to do
__10. Not feeling too close to the people around you
__11. Not being able to have strong feelings (being able to cry or feel really happy)
__12. Feeling as if your future hopes or plans will not come true
__13. Having trouble falling or staying asleep
__14. Feeling irritable of having fits or anger
__15. Having trouble concentrating
__16. Being overly careful (checking to see who is around you)
__17. Being jumpy or easily startled

Please mark YES or NO if the problems above interfered with the following:

1. Saying prayers □ Yes □ No
2. Doing chores □ Yes □ No
3. Friendships □ Yes □ No
4. Hobbies/Fun □ Yes □ No
5. Schoolwork □ Yes □ No
6. Family relationships □ Yes □ No
7. General happiness □ Yes □ No