Trauma Checklist (Parent version)

To be completed by parents/caregivers of children and youth (ages 2-17)

CHILD'S NAME_________________________________**AGE**_____**SEX** _____ **DATE** __________

Parent / Caregiver Name: ____________________________________

Below is a list of scary, dangerous or violent situations or events that sometimes happen to kids. Please mark YES if, to the best of your knowledge, your child has experienced or witnessed any of the following events. Mark NO if, to the best of your knowledge this did not happen to your child.

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 your child ☐ 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, 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 child's private sexual body parts** when your child did not want it or anyone **forcing sex** on your child ☐ Yes ☐ No
11. Your child **hearing about the violent death** or **serious injury** of a loved one ☐ Yes ☐ No
12. Your child having **painful and scary medical treatment in a hospital** when the child was very badly sick or injured. ☐ Yes ☐ No
13. Of the question to which you answered YES, which was the worst. (Please list the questions #) ____________
14. Of the above questions, which one is the reason you are here? (Please list the question #) ____________

Please check YES or NO to answer, to the best of your knowledge, how your child felt about the event in question 14.

Was your child scared he or she would die? ☐ Yes ☐ No
Was your child scared he or she would be hurt badly? ☐ Yes ☐ No
Was your child hurt badly? ☐ Yes ☐ No
Was your child scared someone else would die? ☐ Yes ☐ No
Was your child scared that someone else would be hurt badly? ☐ Yes ☐ No
Was someone hurt badly? ☐ Yes ☐ No
Did someone die? ☐ Yes ☐ No

Trauma Checklist / Parent

Please rate as best as you can, on a scale from 0-3 how much or how often these following things have bothered your child 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. Your child having unwanted, upsetting thought or images about the traumatic event

__2. Your child having bad dreams or nightmares about the traumatic event

__3. Your child acting or feeling as if the event was happening again

__4. Your child feeling emotionally upset when s/he thinks about or hears about the event

__5. Your child having feelings in his/her body when he/she thinks about or hears about the event (Heart beating fast, upset stomach, breaking out in a sweat)

__6. Your child trying not to think about, talk about or have feeling about the event

__7. Your child trying to avoid activities or people, or places that remind your child of the traumatic event

__8. Your child not being able to remember an important part of the traumatic event

__9. Your child having much less interest in, or not doing the things she/he used to do

__10. Your child not feeling close to the people around him/her

__11. Your child not being able to have strong feelings (being able to cry or feel really happy)

__12. Your child feeling as if her/his future hope or plans will not come true

__13. Your child having trouble falling asleep or staying asleep

__14. Your child feeling irritable or having fits or anger

__15. Your child having trouble concentrating

__16. Your child being overly alert

__17. Your child being jumpy or easily startled

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

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