

Child and Adolescent Trauma Screen (CATS) - Youth Report

Name: _____

Date: _____

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 you. Mark No if it didn't happen to you.

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

Describe: _____

Which one is bothering you the most now? _____

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

Mark 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

1. Upsetting thoughts or pictures about what happened that pop into your head.	0	1	2	3
2. Bad dreams reminding you of what happened.	0	1	2	3
3. Feeling as if what happened is happening all over again.	0	1	2	3
4. Feeling very upset when you are reminded of what happened.	0	1	2	3
5. Strong feelings in your body when you are reminded of what happened (sweating, heart beating fast, upset stomach).	0	1	2	3
6. Trying not to think about or talk about what happened. Or to not have feelings about it.	0	1	2	3
7. Staying away from people, places, things, or situations that remind you of what happened.	0	1	2	3
8. Not being able to remember part of what happened.	0	1	2	3
9. Negative thoughts about yourself or others. Thoughts like I won't have a good life, no one can be trusted, the whole world is unsafe.	0	1	2	3
10. Blaming yourself for what happened, or blaming someone else when it isn't their fault.	0	1	2	3
11. Bad feelings (afraid, angry, guilty, ashamed) a lot of the time.	0	1	2	3
12. Not wanting to do things you used to do.	0	1	2	3
13. Not feeling close to people.	0	1	2	3
14. Not being able to have good or happy feelings.	0	1	2	3
15. Feeling mad. Having fits of anger and taking it out on others.	0	1	2	3
16. Doing unsafe things.	0	1	2	3
17. Being overly careful or on guard (checking to see who is around you).	0	1	2	3
18. Being jumpy.	0	1	2	3
19. Problems paying attention.	0	1	2	3
20. Trouble falling or staying asleep.	0	1	2	3

Total Score _____
Clinical = 15+

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

- | | | | | | |
|------------------------------|------------------------------|-----------------------------|-------------------------|------------------------------|-----------------------------|
| 1. Getting along with others | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 4. Family relationships | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Hobbies/Fun | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 5. General happiness | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. School or work | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |