



CLIENT INTAKE FORM

AGES 5 - 11

CLIENT INFORMATION				
How did you hear about our office?				
Full Name:		Preferred Name:		
DOB:	Age:	Sex:	Gender:	Pronouns:
Address:				
Race:	Ethnicity:		Religion:	
Guardian Name:		Guardian Phone:		
Guardian Email:				
Primary Care Doctor:	Phone:		Last visit:	
Therapist:	Phone:		Last visit:	
RESPONSIBLE PARTY INFORMATION				
Father's name:	DOB:	Phone:		
Physical address:				
Mother's name:	DOB:	Phone:		
Physical address:				
Primary insurance company:	ID#:			
Policy Holder's name:	DOB:			
Secondary insurance company:	ID#:			
Policy Holder's name:	DOB:			
EMERGENCY CONTACT INFORMATION (IF DIFFERENT THAN PARENT/GUARDIAN LISTED ABOVE)				
Name:	Phone:			
Relationship to client:				
Name:	Phone:			
Relationship to client:				
PRESENTING PROBLEM				
Describe what problem(s) you are seeking treatment for at this time:				



When did this/these problem(s) begin?

What do you think may have caused these problems?

Why are you seeking treatment today?

What have you tried in the past?

What goals do you hope to achieve with treatment?

List current mental health treatment:

Current medications:	Dose:	Response:

DEVELOPMENTAL HISTORY

Birth Hospital:	Any problems at/after birth..... Yes No		
Any complications:			
Delivery type: Normal Forceps C-Section			
Full term Pre-term delivered at _____ weeks			

Developmental delays:

CHILDHOOD

During childhood/adolescent years, did you experience:

Mood problems	Legal problems	Poor grades
Anxiety	Running away	Problems w/math
Hyperactivity	Were you shy	Problems w/reading
Poor attention	Difficulty in school	Problems w/writing
Behavior problems	Alcohol/drugs	Eating disorder
Family problems	Skipping school	

**PAST MENTAL HEALTH HISTORY**

List any past treatment/counseling:

Past mental health medications :	Response/side effects :

Have you ever attempted suicide?
If so, describe methods and dates:

Yes No

Have you had thoughts of hurting others?

Yes No

Have you had past psychiatric hospital stays or drug/alcohol abuse treatment?
If yes, location and dates:

Yes No

Have you ever used...

Tobacco / Nicotine	Diet pills	Laxatives
Smoke	Herbal Supplements	Others
Chew	OTC Medications	Ecstasy
Vape	Caffeine	Sedatives/downers
How many a day?	Cocaine	Inhalants
Alcohol	Opiates/oxycontin	
Heroin	Meth	
Marijuana		

FAMILY HISTORY

Mother's name: Living Yes No

Father's name: Living Yes No

Sibling(s) + Age(s):

Relationship Good Fair Poor

Has any blood relative had any of the following conditions

Depression	Seizures	Suicide
Anxiety	Schizophrenia	Alcohol/drug abuse
OCD	Bipolar disorder	Autism
Developmental Disabilities	Dementia	ADD/ADHD

**SOCIAL HISTORY**

Who do you live with?		What grade are you in?		
Where were you raised?		Are you adopted? Yes No <i>if so, at what age?</i>		
Are your parents divorced? Yes No <i>if so, what age were you?</i>	Have you been abused? Yes No <i>if so, what age were you?</i>			
	Type of Abuse	Physical	Sexual	Verbal Neglect
Any Significant Trauma? <i>if so, what was the trauma and how old were you?</i>				Yes No

LEGAL HISTORY

Do you have any current or past legal history?				Yes	No	Pending court date?
Arrest	Conviction	Probation	Parole	<i>Please explain:</i>		
DUI	Assault	Other _____				

MEDICAL HISTORY

Any Allergies to Medication? <i>if so, what medication?</i>			Yes	No
Are you sexually active? Yes No, but I have been in the past Never been sexually active	Females Only : Menstrual Cycle Regular Cycle Irregular Cycle Pelvic Pain PMS	Currently Pregnant? Yes No	Any Current Health Concerns? <i>If so, what?</i>	
Partners are... Male Female Both		Weeks:	Chronic Pain?	Yes No
Do you use birth control?			Any Surgeries? <i>If so, what surgeries?</i>	Yes No

Please check what applies to you.

Acid Reflux	Head Injury	Lupus
Anemia	Headaches	Nausea/Vomitting
Asthma	Heart Disease	Other _____
Bone Fractures	Heart Rhythm Problems	Seizures
Cancer	Hepatitis	Serious Injuries
Chronic Fatigue Syndrome	High Blood Pressure	Sexual Dysfunction
Colitis/Irritable Bowel	High Cholesterol	Sinus Infections
Constipation	Kidney Disease	Thyroid Problems
Diabetes	Kidney Stones	Ulcers
Fibromyalgia	Loss of consciousness	



Columbia Depression Scale

AGES 5-11
Parent Form

Child's name: _____ Parent's name: _____

In the last four weeks...

1. Has he/she often seemed sad or depressed?	Yes	No
2. Has it seemed like nothing was fun for him/her and he/she just wasn't interested in anything?	Yes	No
3. Has he/she often been grouchy or irritable and often in a bad mood, when even little things would make him/her mad?	Yes	No
4. Has he/she lost weight, more than just a few pounds?	Yes	No
5. Has it seemed like he/she lost his/her appetite or ate a lot less than usual?	Yes	No
6. Has he/she gained a lot of weight, more than just a few pounds?	Yes	No
7. Has it seemed like he/she felt much hungrier than usual or ate a lot more than usual?	Yes	No
8. Has he/she had trouble sleeping-- that is, trouble falling asleep, staying asleep, or waking up too early?	Yes	No
9. Has he/she slept more during the day than he/she usually does?	Yes	No
10. Has he/she seemed to do things like walking or talking much more slowly than usual?	Yes	No
11. Has he/she often seemed restless-- like he/she just had to keep walking around?	Yes	No
12. Has he/she seemed to have less energy than he/she usually does?	Yes	No
13. Has doing even little things seemed to make him/her feel really tired?	Yes	No
14. Has he/she often blamed himself/herself for bad things that happened?	Yes	No
15. Has he/she said he/she couldn't do anything well or that he/she wasn't as good looking or as smart as other people?	Yes	No
16. Has it seemed like he/she couldn't think as clearly and as fast as usual?	Yes	No
17. Has he/she often seemed to have trouble keeping his/her mind on his/her schoolwork/work or other things?	Yes	No



Brighter Minds Health

Smarter Medication Management for Brighter Days

18. Has it often seemed hard for him/her to make up his/her mind or to make decisions?	Yes	No
19. Has he/she said he/she often thought about death or about people who had died or about being dead himself/herself?	Yes	No
20. Has he/she ever talked seriously about killing himself/herself?	Yes	No
21. Has he/she EVER, in his/her WHOLE LIFE, tried to kill himself/herself or made a suicide attempt?	Yes	No
22. Has he/she tried to kill himself/herself in the last four weeks?	Yes	No

Screen for Child Anxiety Related Disorders (SCARED)
AGES 5-11
Parent Form

Directions:

Below is a list of sentences that describe how people feel. Read each phrase and decide if it is "Not True or Hardly Ever True" or "Somewhat True or Sometimes True" or Very True or Often True" for your child. Choose the responses that describes your child for the **LAST 3 MONTHS**.

- 0-- Not True/Hardly Ever True
- 1-- Somewhat True/Sometimes True
- 2-- Very True/Often True

1. (PN) When my child feels frightened, it is hard for him/her to breathe.....	0	1	2
2. (SH) My child gets headaches when he/she is at school.....	0	1	2
3. (SC) My child doesn't like to be with people he/she doesn't know well.....	0	1	2
4. (SP) My child gets scared if he/she sleeps away from home.....	0	1	2
5. (GD) My child worries about other people liking him/her.....	0	1	2
6. (PN) When my child gets frightened, he/she feels like passing out.....	0	1	2
7. (GD) My child is nervous.....	0	1	2
8. (SP) My child follows me wherever I go.....	0	1	2
9. (PN) People tell me my child looks nervous.....	0	1	2
10. (SC) My child feels nervous with people he/she doesn't know well.....	0	1	2
11. (SH) My child gets stomach aches at school.....	0	1	2
12. (PN) When my child gets frightened, he/she feels like he/she is going crazy.....	0	1	2
13. (SP) My child worries about sleeping alone.....	0	1	2
14. (GD) My child worries about being as good as other kids.....	0	1	2
15. (PN) When my child gets frightened, he/she feels like things are not real.....	0	1	2



16. (SP) My child has nightmares about something bad happening to his/her parents.....	0	1	2
17. (SH) My child worries about going to school.....	0	1	2
18. (PN) When my child gets frightened, his/her heart beats fast.....	0	1	2
19. (PN) My child gets shaky.....	0	1	2
20. (SP) My child has nightmares about something bad happening to him/her.....	0	1	2
21. (GD) My child worries about things working out for him/her.....	0	1	2
22. (PN) When my child gets frightened, he/she sweats a lot.....	0	1	2
23. (GD) My child is a worrier.....	0	1	2
24. (PN) My child gets really frightened for no reason at all.....	0	1	2
25. (SP) My child is afraid to be alone in the house.....	0	1	2
26. (SC) It is hard for my child to talk with people he/she doesn't know well.....	0	1	2
27. (PN) When my child gets frightened, he/she feels like he/she is choking.....	0	1	2
28. (GD) People tell me that my child worries too much.....	0	1	2
29. (SP) My child doesn't like to be away from his/her family.....	0	1	2
30. (PN) My child is afraid of having anxiety (or panic) attacks.....	0	1	2
31. (SP) My child worries that something bad might happen to his/her parents.....	0	1	2
32. (SC) My child feels shy with people he/she doesn't know well.....	0	1	2
33. (GD) My child worries about what is going to happen in the future.....	0	1	2
34. (PN) When my child gets frightened, he/she feels like throwing up.....	0	1	2
35. (GD) My child worries about how well he/she does things.....	0	1	2



Brighter Minds Health

Smarter Medication Management for Brighter Days

36. (SH) My child is scared to go to school..... 0 1 2

37. (GD) My child worries about things that have already happened..... 0 1 2

38. (PN) When my child gets frightened, he/she feels dizzy..... 0 1 2

39. (SC) My child feels nervous when he/she is with other children or adults and he/she has to do something while they watch him/her (for example: read aloud, speak, play a game, play a sport)..... 0 1 2

40. (SC) My child feels nervous when he/she is going to parties, dances, or any place where there will be people he/she doesn't know well..... 0 1 2

41. (SC) My child is shy..... 0 1 2

NICQH Vanderbilt Assessment Scale

AGES 5-11

Parent Form

Directions: Each rating should be considered in the context of what is appropriate for the age of your child. When completing this form, please think about your child's behaviors in the **PAST 6 MONTHS**.

0-- Never 1-- Occasionally 2-- Often 3-- Very Often

1. Does not pay attention to details or makes careless mistakes, for example, homework

0 - Never 1 - Occasionally 2 - Often 3 - Very Often

2. Has difficulty keeping attention to what needs to be done

0 - Never 1 - Occasionally 2 - Often 3 - Very Often

3. Does not seem to listen when spoken to directly

0 - Never 1 - Occasionally 2 - Often 3 - Very Often

4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)

0 - Never 1 - Occasionally 2 - Often 3 - Very Often

5. Has difficulty organizing tasks and activities

0 - Never 1 - Occasionally 2 - Often 3 - Very Often

6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort

0 - Never 1 - Occasionally 2 - Often 3 - Very Often

7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)

0 - Never 1 - Occasionally 2 - Often 3 - Very Often

8. Is easily distracted by noises or other stimuli

0 - Never 1 - Occasionally 2 - Often 3 - Very Often

9. Is forgetful in daily activities

0 - Never 1 - Occasionally 2 - Often 3 - Very Often

10. Fidgets with hands or feet or squirms in seat.

0 - Never 1 - Occasionally 2 - Often 3 - Very Often

11. Leaves seat when remaining seated is expected

0 - Never 1 - Occasionally 2 - Often 3 - Very Often

12. Runs about or climbs too much when remaining seated is expected

0 - Never 1 - Occasionally 2 - Often 3 - Very Often



13. Has difficulty playing or beginning quiet play activities
0 - Never 1 - Occasionally 2 - Often 3 - Very Often

14. Is "on the go" or often acts as if "driven by a motor"
0 - Never 1 - Occasionally 2 - Often 3 - Very Often

15. Talks too much
0 - Never 1 - Occasionally 2 - Often 3 - Very Often

16. Blurts out answers before questions have been completed
0 - Never 1 - Occasionally 2 - Often 3 - Very Often

17. Has difficulty waiting his or her turn
0 - Never 1 - Occasionally 2 - Often 3 - Very Often

18. Interrupts or intrudes in on others' conversations and/or activities
0 - Never 1 - Occasionally 2 - Often 3 - Very Often

19. Argues with adults
0 - Never 1 - Occasionally 2 - Often 3 - Very Often

20. Loses temper
0 - Never 1 - Occasionally 2 - Often 3 - Very Often

21. Actively defies or refuses to go along with adults' requests or rules
0 - Never 1 - Occasionally 2 - Often 3 - Very Often

22. Deliberately annoys people
0 - Never 1 - Occasionally 2 - Often 3 - Very Often

23. Blames others for his or her mistakes or misbehaviors
0 - Never 1 - Occasionally 2 - Often 3 - Very Often

24. Is touchy or easily annoyed by others
0 - Never 1 - Occasionally 2 - Often 3 - Very Often

25. Is angry or resentful
0 - Never 1 - Occasionally 2 - Often 3 - Very Often

26. Is spiteful and wants to get even
0 - Never 1 - Occasionally 2 - Often 3 - Very Often

27. Bullies, threatens, or intimidates others
0 - Never 1 - Occasionally 2 - Often 3 - Very Often

28. Starts physical fights
0 - Never 1 - Occasionally 2 - Often 3 - Very Often



29. Lies to get out of trouble or to avoid obligations (ie, "cons" others)

0 - Never 1 - Occasionally 2 - Often 3 - Very Often

30. Is truant for school (skips school) without permission

0 - Never 1 - Occasionally 2 - Often 3 - Very Often

31. Is physically cruel to people

0 - Never 1 - Occasionally 2 - Often 3 - Very Often

32. Has stolen things that have value

0 - Never 1 - Occasionally 2 - Often 3 - Very Often

33. Deliberately destroys others' property

0 - Never 1 - Occasionally 2 - Often 3 - Very Often

34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)

0 - Never 1 - Occasionally 2 - Often 3 - Very Often

35. Is physically cruel to animals

0 - Never 1 - Occasionally 2 - Often 3 - Very Often

36. Has deliberately set fires to cause damage

0 - Never 1 - Occasionally 2 - Often 3 - Very Often

37. Has broken into someone else's home, business, or car

0 - Never 1 - Occasionally 2 - Often 3 - Very Often

38. Has stayed out at night without permission

0 - Never 1 - Occasionally 2 - Often 3 - Very Often

39. Has run away from home overnight

0 - Never 1 - Occasionally 2 - Often 3 - Very Often

40. Has forced someone into sexual activity

0 - Never 1 - Occasionally 2 - Often 3 - Very Often

41. Is fearful, anxious, or worried

0 - Never 1 - Occasionally 2 - Often 3 - Very Often

42. Is afraid to try new things for fear of making mistakes

0 - Never 1 - Occasionally 2 - Often 3 - Very Often

43. Feels worthless or inferior

0 - Never 1 - Occasionally 2 - Often 3 - Very Often



44. Blames self for problems, feels guilty

0 - Never 1 - Occasionally 2 - Often 3 - Very Often

45. Feels lonely, unwanted, or unloved: complains that "no one loves him or her"

0 - Never 1 - Occasionally 2 - Often 3 - Very Often

46. Is sad, unhappy, or depressed

0 - Never 1 - Occasionally 2 - Often 3 - Very Often

47. Is self-conscious or easily embarrassed

0 - Never 1 - Occasionally 2 - Often 3 - Very Often

PERFORMANCE

48. Overall school performance

Excellent (1) Above Average (2) Average (3) Somewhat of a problem (4) Problematic (5)

49. Reading

Excellent (1) Above Average (2) Average (3) Somewhat of a problem (4) Problematic (5)

50. Writing

Excellent (1) Above Average (2) Average (3) Somewhat of a problem (4) Problematic (5)

51. Mathematics

Excellent (1) Above Average (2) Average (3) Somewhat of a problem (4) Problematic (5)

52. Relationship with parents

Excellent (1) Above Average (2) Average (3) Somewhat of a problem (4) Problematic (5)

53. Relationship with siblings

Excellent (1) Above Average (2) Average (3) Somewhat of a problem (4) Problematic (5)

54. Relationship with peers

Excellent (1) Above Average (2) Average (3) Somewhat of a problem (4) Problematic (5)

55. Participation in organized activities (eg, teams)

Excellent (1) Above Average (2) Average (3) Somewhat of a problem (4) Problematic (5)

Young Mania Rating Scale

AGES 5-11

Parent Form

Directions: Please read each question below and mark the answer number which closely describes your child.

1. Mood- Is your child's mood higher (better) than usual?

- 0. No
- 1. Mildly or possibly increased
- 2. Definite elevation- more optimistic, self-confident; cheerful; appropriate to their conversation
- 3. Elevated but inappropriate to content; joking, mildly silly
- 4. Euphoric; inappropriate laughter; singing/making noises; very silly

2. Motor Activity/Energy- Does your child's energy level or motor activity appear to be greater than usual?

- 0. No
- 1. Mildly or possibly increased
- 2. More animated; increased gesturing
- 3. Energy is excessive; hyperactive at times; restless but can be calmed
- 4. Very excited; continuous hyperactivity; cannot be calmed

3. Sexual Interest- Is your child showing more than usual interest in sexual matters?

- 0. No
- 1. Mildly or possibly increased
- 2. Definite increase when the topic arises
- 3. Talks spontaneously about sexual matters; gives more detail than usual; more interested in girls/boys than usual
- 4. Has shown open sexual behavior- touching others or self inappropriately

4. Sleep- Has our child's sleep decreased lately?

- 0. No
- 1. Sleeping less than normal amount by up to one hour
- 2. Sleeping less than normal amount by more than one hour
- 3. Need for sleep appears decreased; less than four hours
- 4. Denies need for sleep; has stayed up one night or more

5. Irritability- Has your child appeared irritable?

- 0. No more than usual
- 1. More grouchy and crabby
- 2. Irritable openly several times throughout the day; recent episodes of anger with family, at school, or with friends
- 3. Frequently irritable to point of being rude or withdrawn
- 4. Hostile and uncooperative about all the time



6. Speech (rate and amount)- Is your child talking more quickly or more than usual?

- 0. No change
- 1. Seems more talkative
- 2. Talking faster or more to say at times
- 3. Talking more or faster to point he/she is difficult to interrupt
- 4. Continuous speech; unable to interrupt

7. Thoughts- Has your child shown changes in his/her thought patterns?

- 0. No
- 1. Thinking faster; some decrease in concentration; talking "around the issue"
- 2. Distractible; loses track of the point; changes topics frequently; thoughts racing
- 3. Difficult to follow; goes from one idea to the next; topics do not relate; makes rhymes or repeats words
- 4. Not understandable; he/she doesn't seem to make sense

8. Content- Is your child talking about different things than usual?

- 0. No
- 1. He/she has new interests and is making more plans
- 2. Making special projects; more religious or interested in God
- 3. Thinks more of him/herself; believes he/she has special powers; believes he/she is receiving special messages
- 4. Is hearing unreal noises/voices; detects odors no one else smells; feels unusual sensations; has unreal beliefs

9. Disruptive-Aggressive Behavior- Has your child been more disruptive or aggressive?

- 0. No; he/she is cooperative
- 1. Sarcastic; loud; defensive
- 2. More demanding; making threats
- 3. Has threatened a family member or teacher; shouting; knocking over possessions/furniture or hitting a wall
- 4. Has attacked family member, teacher, or peer; destroyed property; cannot be spoken to without violence.

10. Appearance- Has your child's interest in his/her appearance changed recently?

- 0. No
- 1. A little less or more interest in grooming than usual
- 2. Doesn't care about washing or changing clothes or is changing clothes more than three times a day
- 3. Very messy; needs to be supervised to finish dressing; applying makeup in overly-done or poor fashion
- 4. Refuses to dress appropriately; wearing bizarre styles

11. Insight- Does your child think he/she needs help at this time?

- 0. Yes; admits difficulties and wants treatment
- 1. Believes there might be something wrong
- 2. Admits to change in behavior but denies he/she needs help
- 3. Admits behavior might have changed but denies need for help
- 4. Denies there have been any changes in his/her behavior/thinking



1 : Stressful and Scary Events

1.1 Has your child ever been in a serious accident where someone could have been (or actually was) severely injured or died? (for example: serious car or bicycle accident, a fall, a fire, an incident where s/he was burned, an actual or near drowning, or a severe sports injury)

Yes No Unsure

If so, Identify the type of accident (s):

How old was your child?

Did anyone die?

Yes No Unsure

Who was the victim to your child?

Was your child strongly affected by one or more of these experiences?

Yes No Unsure

1.2 Has your child ever seen a serious accident where someone could have been (or actually was) severely injured or died? (like a serious car or bicycle accident, a fire, an incident where someone was burned, an actual or near drowning, or a severe sports injury?)

Yes No Unsure

If so, Identify the type of accident (s):

How old was your child?

Did anyone die?

Yes No Unsure

Who was the victim to your child?

Was your child strongly affected by one or more of these experiences?

Yes No Unsure

1.3 Has your child ever been in a natural disaster where someone could have been (or actually was) severely injured or died, or where your family or people in your community lost or had to permanently leave their home (like a tornado, fire, hurricane, or earthquake)?

Yes No Unsure

If so, Identify the type of disaster(s):

How old was your child?

Did anyone die?

Yes No Unsure

Was your child strongly affected by one or more of these experiences?

Yes No Unsure



1.4a Has your child ever experienced the severe illness or injury to someone close to him/her?

Yes No Unsure

If so, what was the person's relationship to your child?

How old was your child?

Was your child strongly affected by one or more of these experiences?

Yes No Unsure

1.4b Has your child ever experienced the death of someone close to him/her?

Yes No Unsure

If so, what was the person's relationship to your child?

How old was your child?

Was your child strongly affected by one or more of these experiences?

Yes No Unsure

Was the death(s) due to (*check all that apply*):

Natural causes

Illness

Accident

Violence

Unknown

1.5 Has your child ever undergone any serious medical procedures or had a life threatening illness? Or been treated by a paramedic, seen in an emergency room, or hospitalized overnight for a medical procedure?

Yes No Unsure

If so, please describe.

How old was your child?

Was your child strongly affected by one or more of these experiences?

Yes No Unsure

1.6 Has your child ever been separated from you or another person who your child depends on for love or security for more than a few days OR under very stressful circumstances? For example, due to foster care, immigration, war, major illness, or hospitalization.

Yes No Unsure

If so, who was your child separated from?

How old was your child?

Was your child strongly affected by one or more of these experiences?

Yes No Unsure

1.7 Has someone close to your child ever attempted suicide or harmed him or herself?

Yes No Unsure

If so, what was the person's relationship to your child?

How old was your child?

Was your child strongly affected by one or more of these experiences?

Yes No Unsure



2 : Physical Violence Toward Your Child

2.1 Has someone ever physically assaulted your child, like hitting, pushing, choking, shaking, biting, or burning? Or punished your child and caused physical injury or bruises. Or attacked your child with a gun, knife, or other weapon? (This could be done by someone in the family or not).

Yes No Unsure

If so, what was the person's relationship to your child?

Was a weapon used?

Yes No Unsure

If so, what type?

How old was your child?

Was your child strongly affected by one or more of these experiences?

Yes No Unsure

2.2 Has someone ever directly threatened your child with serious physical harm?

Yes No Unsure

If so, what was the person's relationship to your child?

Was a weapon used?

Yes No Unsure

If so, what type?

How old was your child?

Was your child strongly affected by one or more of these experiences?

Yes No Unsure

2.3 Has someone ever mugged or tried to steal from your child? Or has your child been present when a family member, other caregiver, or friend was mugged?

Yes No Unsure

If so, who was mugged?

Was a weapon used?

Yes No Unsure

If so, what type of weapon?

How old was your child?

Was your child strongly affected by one or more of these experiences?

Yes No Unsure

2.4 Has anyone ever kidnapped your child? (Including a parent or relative) Or has anyone ever kidnapped someone close to your child?

Yes No Unsure

If someone else, who was kidnapped?

If your child, what was the kidnapper's relationship to your child?

How old was your child?

Was your child strongly affected by one or more of these experiences?

Yes No Unsure



2.5 Has your child ever been attacked by a dog or other animal?

Yes No Unsure

Was your child seriously physically hurt as a result of the attack?

How old was your child?

Was your child strongly affected by one or more of these experiences?

Yes No Unsure

3 : Physical Violence Within Family

3.1 Has your child ever seen, heard, or heard about people IN YOUR FAMILY physically fighting, hitting, slapping, kicking, or pushing each other. Or shooting with a gun or stabbing, or using any other kind of dangerous weapon?

Yes No Unsure

If so, what were these people's relationship to your child?

Did your child see what happened?

Yes No Unsure

Was a weapon used?

Yes No Unsure

If so, what type?

How old was your child?

Was your child strongly affected by one or more of these experiences?

Yes No Unsure

3.2 Has your child ever seen or heard people IN YOUR FAMILY threaten to seriously harm each other?

Yes No Unsure

If so, what were these people's relationship to your child?

Was your child present when the threat was made?

Yes No Unsure

Did they threaten to use a weapon?

Yes No Unsure

If so, what type of weapon?

How old was your child?

Was your child strongly affected by one or more of these experiences?

Yes No Unsure

3.3 Has your child ever known or seen that a family member was arrested, jailed, imprisoned, or taken away (like by police, soldiers, or other authorities)?

Yes No Unsure

If so, what were these people's relationship to your child?

Was your child there when the police came?

Yes No Unsure

How old was your child?

Was your child strongly affected by one or more of these experiences?

Yes No Unsure



4 : Physical Violence Outside of Home

4.1 Has your child ever seen or heard people OUTSIDE YOUR FAMILY fighting, hitting, pushing, or attacking each other? Or seen or heard about violence such as beatings, shootings, or muggings that occurred in settings that are important to your child, such as school, your neighborhood, or the neighborhood of someone important to your child?

Yes No Unsure

If so, what were these people's relationship to your child?

Did your child see what happened?

Yes No Unsure

Was a weapon used?

If so, what type?

Yes No Unsure

Where did this happen?

How old was your child?

Was your child strongly affected by one or more of these experiences?

Yes No Unsure

4.2 Has your child ever been directly exposed to war, armed conflict, or terrorism?

Yes No Unsure

How old was your child?

Was your child strongly affected by one or more of these experiences?

Yes No Unsure

4.3 Has your child ever seen or heard acts of war or terrorism on the television or radio?

Yes No Unsure

How old was your child?

Was your child strongly affected by one or more of these experiences?

Yes No Unsure

5 : Sexual Abuse

5.1 Has someone ever made your child see or do something sexual (like touching in a sexual way, exposing self or masturbating in front of the child, engaging in sexual intercourse)?

Yes No Unsure

If so, what were these people's relationship to your child?

Was there physical violence?

Yes No Unsure

Was a weapon used?

If so, what type?

Yes No Unsure

How old was your child?

Was your child strongly affected by one or more of these experiences?

Yes No Unsure



5.2 Has your child ever been present when someone was being forced to engage in any sort of sexual activity?

Yes No Unsure

If so, what were these people's relationship to your child?

Victim:

Aggressor:

Was there physical violence?

Yes No Unsure

Was a weapon used?

Yes No Unsure

If so, what type?

How old was your child?

Was your child strongly affected by one or more of these experiences?

Yes No Unsure

6 : Verbal Abuse and Neglect

6.1 Has your child ever repeatedly been told s/he was no good, yelled at in a scary way, or had someone threaten to abandon, leave or send him/her away?

Yes No Unsure

If so, what were these people's relationship to your child?

How old was your child?

Was your child strongly affected by one or more of these experiences?

Yes No Unsure

6.2 Has your child ever gone through a period when s/he lacked appropriate care (like not having enough to eat or drink, lacking shelter, being left alone when s/he was too young to care for herself/himself, or being left with a caregiver who was abusing drugs)?

Yes No Unsure

How old was your child?

Was your child strongly affected by one or more of these experiences?

Yes No Unsure

7 : Other Traumatic Events

7.1 Have there been other stressful things that have happened to your child?

Yes No Unsure

If so, briefly describe.

How old was your child?

Was your child strongly affected by one or more of these experiences?

Yes No Unsure