SCREENER AGE 1

Screener ID:

Child Name:

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR COMMUNITY BASED SERVICES

SCREENER REPORT

Screener ID:

Case Number:

Original Individual ID:

Individual ID:

Child Name:

Child DOB:

Child Age at Time Screener Started:

Child's Gender

Case Manager Name:

Case Manager Region:

Case Manager County:

Date Screener Started:

Date Screener Finalized:

Screener ID:

Child Name:

YOUNG CHILD PTSD A CHECKLIST (0-6 YRS)

Below is a list of stressful or scary events. Select whether your child has experienced each below ***during the past 12 months and/or prenatal exposure.***

1. Accident or crash with automobile, plane or boat
   - ☐ YES
   - ☐ NO

2. Attacked by an animal
   - ☐ YES
   - ☐ NO

3. Man-made disasters (fire, war, etc.)
   - ☐ YES
   - ☐ NO

4. Natural Disasters (hurricane, tornado, flood)
   - ☐ YES
   - ☐ NO

5. Hospitalization or invasive medical procedures **(for example, extended stays related to premature birth, in utero exposure to drugs or alcohol)**
   - ☐ YES
   - ☐ NO

6. Physical abuse
   - ☐ YES
   - ☐ NO

7. Sexual abuse, sexual assault, or rape
   - ☐ YES
   - ☐ NO

8. Accidental burning
   - ☐ YES
   - ☐ NO

9. Near drowning
   - ☐ YES
   - ☐ NO

Screener ID:

Child Name:

10. Witnessed another person being beaten, raped, threatened with serious harm, shot at, seriously wounded, or killed **(for example, violence against any household members)**
    - ☐ YES
    - ☐ NO

11. Kidnapped
    - ☐ YES
    - ☐ NO

12. Not having basic needs met, such as food and shelter; or left alone repeatedly for more than a few minutes
    - ☐ YES
    - ☐ NO

13. ***Has this child experienced any other traumatic events that were NOT captured elsewhere on this screener? If yes, please add details below. If no, please leave text box blank.***
    - ☐ YES
    - ☐ NO

Screener ID:

Child Name:

YOUNG CHILD PTSD B CHECKLIST (1-6 YRS)

Below is a list of symptoms that children can have after life-threatening events. Please mark the box for the answer that best describes how often the symptom has bothered your child in the last month.

1. Does your child have intrusive memories of the trauma? Does s/he bring it up on his/her own?
   - ☐ Not at all
   - ☐ Once a week or less/once in a while
   - ☐ 2 to 4 times a week/half the time
   - ☐ 5 or more times a week/almost always
   - ☐ Everyday

2. Does your child re-enact the trauma in play with dolls or toys? This would be scenes that look just like the trauma. Or does s/he act it out by him/herself with other kids?
   - ☐ Not at all
   - ☐ Once a week or less/once in a while
   - ☐ 2 to 4 times a week/half the time
   - ☐ 5 or more times a week/almost always
   - ☐ Everyday

3. Is your child having more nightmares since the trauma(s) occurred?
   - ☐ Not at all
   - ☐ Once a week or less/once in a while
   - ☐ 2 to 4 times a week/half the time
   - ☐ 5 or more times a week/almost always
   - ☐ Everyday

4. Does your child act like the traumatic event is happening to him/her again, even when it isn't? This is where a child is acting like they are back in the traumatic event and aren't in touch with reality. This is a pretty obvious thing when it happens.
   - ☐ Not at all
   - ☐ Once a week or less/once in a while
   - ☐ 2 to 4 times a week/half the time
   - ☐ 5 or more times a week/almost always
   - ☐ Everyday

Screener ID:

Child Name:

5. Since the trauma(s) has s/he had episodes when s/he seems to freeze? You may have tried to snap him/her out of it but s/he was unresponsive.
   - ☐ Not at all
   - ☐ Once a week or less/once in a while
   - ☐ 2 to 4 times a week/half the time
   - ☐ 5 or more times a week/almost always
   - ☐ Everyday

6. Does s/he get upset when exposed to reminders of the event(s)? For example, a child who was in a car wreck might be nervous while riding in a car now. Or, a child who was in a hurricane might be nervous when it is raining. Or, a child who saw domestic violence might be nervous when other people argue. Or, a girl who was sexually abused might be nervous when someone touches her.
   - ☐ Not at all
   - ☐ Once a week or less/once in a while
   - ☐ 2 to 4 times a week/half the time
   - ☐ 5 or more times a week/almost always
   - ☐ Everyday

7. Does your child get physically distressed when exposed to reminders? Like heart racing, shaking hands, sweaty, short of breath, or sick to his/her stomach? Think of the same type of examples as in #6.
   - ☐ Not at all
   - ☐ Once a week or less/once in a while
   - ☐ 2 to 4 times a week/half the time
   - ☐ 5 or more times a week/almost always
   - ☐ Everyday

8. Does your child try to avoid conversations that might remind him/her of the trauma(s)? For example, if other people talk about what happened, does s/he walk away or change the topic?
   - ☐ Not at all
   - ☐ Once a week or less/once in a while
   - ☐ 2 to 4 times a week/half the time
   - ☐ 5 or more times a week/almost always
   - ☐ Everyday

Screener ID:

Child Name:

9. Does your child try to avoid things or places that remind him/her of the trauma(s)? For example, a child who was in a car wreck might try to avoid getting into a car. Or, a child who saw domestic violence might be nervous to go in the house where it occurred. Or, a girl who was sexually abused might be nervous about going to bed because that's where she was abused before.
    - ☐ Not at all
    - ☐ Once a week or less/once in a while
    - ☐ 2 to 4 times a week/half the time
    - ☐ 5 or more times a week/almost always
    - ☐ Everyday

10. Does your child have difficulty remembering the whole incident? Has s/he blocked out the entire event?
    - ☐ Not at all
    - ☐ Once a week or less/once in a while
    - ☐ 2 to 4 times a week/half the time
    - ☐ 5 or more times a week/almost always
    - ☐ Everyday

11. Has s/he lost interest in doing things that s/he used to like to do since the trauma(s)?
    - ☐ Not at all
    - ☐ Once a week or less/once in a while
    - ☐ 2 to 4 times a week/half the time
    - ☐ 5 or more times a week/almost always
    - ☐ Everyday

12. Since the trauma(s), does your child show a restricted range of emotions on his/her face compared to before?
    - ☐ Not at all
    - ☐ Once a week or less/once in a while
    - ☐ 2 to 4 times a week/half the time
    - ☐ 5 or more times a week/almost always
    - ☐ Everyday

13. Has your child lost hope for the future? For example, s/he believes will not have fun tomorrow, or will never be good at anything.
    - ☐ Not at all
    - ☐ Once a week or less/once in a while
    - ☐ 2 to 4 times a week/half the time
    - ☐ 5 or more times a week/almost always
    - ☐ Everyday

Screener ID:

Child Name:

14. Since the trauma(s) has your child become more distant and detached from family members, relatives, or friends?
    - ☐ Not at all
    - ☐ Once a week or less/once in a while
    - ☐ 2 to 4 times a week/half the time
    - ☐ 5 or more times a week/almost always
    - ☐ Everyday

15. Has s/he had a hard time falling asleep or staying asleep since the trauma(s)?
    - ☐ Not at all
    - ☐ Once a week or less/once in a while
    - ☐ 2 to 4 times a week/half the time
    - ☐ 5 or more times a week/almost always
    - ☐ Everyday

16. Has your child become more irritable, or had outbursts of anger, or developed extreme temper tantrums since the trauma(s)?
    - ☐ Not at all
    - ☐ Once a week or less/once in a while
    - ☐ 2 to 4 times a week/half the time
    - ☐ 5 or more times a week/almost always
    - ☐ Everyday

17. Has your child had more trouble concentrating since the trauma(s)?
    - ☐ Not at all
    - ☐ Once a week or less/once in a while
    - ☐ 2 to 4 times a week/half the time
    - ☐ 5 or more times a week/almost always
    - ☐ Everyday

18. Has s/he been more “on the alert” for bad things to happen? For example, does s/he look around for danger?
    - ☐ Not at all
    - ☐ Once a week or less/once in a while
    - ☐ 2 to 4 times a week/half the time
    - ☐ 5 or more times a week/almost always
    - ☐ Everyday

Screener ID:

Child Name:

19. Does your child startle more easily than before the trauma(s)? For example, if there's a loud noise or someone sneaks up behind him/her, does s/he jump or seem startled?
    - ☐ Not at all
    - ☐ Once a week or less/once in a while
    - ☐ 2 to 4 times a week/half the time
    - ☐ 5 or more times a week/almost always
    - ☐ Everyday

20. Has your child become more physically aggressive since the trauma(s)? Like hitting, kicking, biting, or breaking things?
    - ☐ Not at all
    - ☐ Once a week or less/once in a while
    - ☐ 2 to 4 times a week/half the time
    - ☐ 5 or more times a week/almost always
    - ☐ Everyday

21. Has s/he become more clingy to you since the trauma(s)?
    - ☐ Not at all
    - ☐ Once a week or less/once in a while
    - ☐ 2 to 4 times a week/half the time
    - ☐ 5 or more times a week/almost always
    - ☐ Everyday

22. Did night terrors start or get worse after the trauma(s)? Night terrors are different from nightmares: in night terrors a child usually screams in their sleep, they don't wake up, and they don't remember it the next day.
    - ☐ Not at all
    - ☐ Once a week or less/once in a while
    - ☐ 2 to 4 times a week/half the time
    - ☐ 5 or more times a week/almost always
    - ☐ Everyday

23. Since the trauma(s), has your child lost previously acquired skills? For example, lost toilet training? Or, lost language skills? Or, lost motor skills working snaps, buttons, or zippers?
    - ☐ Not at all
    - ☐ Once a week or less/once in a while
    - ☐ 2 to 4 times a week/half the time
    - ☐ 5 or more times a week/almost always
    - ☐ Everyday

Screener ID:

Child Name:

24. Since the trauma(s), has your child developed any new fears about things that don't seem related to the trauma(s)? What about going to the bathroom alone? Or, being afraid of the dark?
    - ☐ Not at all
    - ☐ Once a week or less/once in a while
    - ☐ 2 to 4 times a week/half the time
    - ☐ 5 or more times a week/almost always
    - ☐ Everyday

Do the symptoms that you endorsed above get in the way of your child's ability to function in the following areas?

25. Do (symptoms) substantially "get in the way" of how s/he gets along with you, interfere in your relationship, or make you feel upset or annoyed?
    - ☐ Hardly ever/none
    - ☐ Some of the time
    - ☐ About half the days
    - ☐ More than half the days
    - ☐ Everyday

26. Do these (symptoms) "get in the way" of how s/he gets along with brothers or sisters, and make them feel upset or annoyed?
    - ☐ Hardly ever/none
    - ☐ Some of the time
    - ☐ About half the days
    - ☐ More than half the days
    - ☐ Everyday

27. Do these (symptoms) "get in the way" with the teacher or the class more than average?
    - ☐ Hardly ever/none
    - ☐ Some of the time
    - ☐ About half the days
    - ☐ More than half the days
    - ☐ Everyday

28. Do (symptoms) "get in the way" of how s/he gets along with friends at all – at daycare, school, or in your neighborhood?
    - ☐ Hardly ever/none
    - ☐ Some of the time
    - ☐ About half the days
    - ☐ More than half the days
    - ☐ Everyday

Screener ID:

Child Name:

29. Do (symptoms) make it harder for you to take him/her out in public than it would be with an average child? Is it harder to go out with your child to places like the grocery store? Or to a restaurant?
    - ☐ Hardly ever/none
    - ☐ Some of the time
    - ☐ About half the days
    - ☐ More than half the days
    - ☐ Everyday

30. Do you think that these behaviors cause your child to feel upset?
    - ☐ Hardly ever/none
    - ☐ Some of the time
    - ☐ About half the days
    - ☐ More than half the days
    - ☐ Everyday

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YOUNG CHILD SCREENER – ADDENDUM (0-6 YRS)

Select whether your child has experienced each below **during the past 12 months and/or prenatal exposure.**

1. Multiple separations from parent or caregiver
   - ☐ YES
   - ☐ NO

2. Multiple moves or homelessness
   - ☐ YES
   - ☐ NO

3. Exposure to drugs and/or drug activity (including NAS diagnosis, fetal alcohol, etc.)
   - ☐ YES
   - ☐ NO

4. Failure to reciprocate (e.g. lack of eye contact; not responding to vocalizations, play, or smiling)
   - ☐ YES
   - ☐ NO