Child/Adolescent Name: _____ ID #_____ Age: _____ Sex: ☐ Girl ☐ Boy
Grade in School _____ School: _____ Teacher: _____ City/State _____
Interviewer Name/I.D. _____ Date (*month, day, year*) ____/____/____ (Session #_____)
Parent/Caregiver Name: _____ ☐ Mother ☐ Father ☐ Other Relative ☐ Foster Parent ☐ Other _____

CLINICIAN ADMINISTERED TRAUMA HISTORY PROFILE In completing the Trauma History Profile, use information from parents, caregivers, and other appropriate informants. For each traumatic experience, indicate the specified trauma details, whether the child/adolescent was a *victim*, *witness* or *learned about** the trauma, and the age(s) over which the trauma occurred. (This form may be updated over the course of treatment as additional information about trauma history is revealed or as additional traumas occur.)
Learned about* **only refers to indirect exposure in learning aversive details of violent personal assault, homicide, suicide, serious accident, or serious injury to a close relative or friend. It does **not** include learning about death due to natural causes.

TRAUMA HISTORY PROFILE

Trauma Type	Trauma Details	Role in Event	Age(s) Experienced 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18
Neglect/Maltreatment	☐ Physical ☐ Psychological	☐ Victim ☐ Witness	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Sexual Abuse	☐ Penetration ☐ Non-Family ☐ Intra-familial ☐ CPS Report	☐ Victim ☐ Witness ☐ Learned about	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Physical Abuse	☐ Serious Injury ☐ Weapon Used ☐ CPS Report	☐ Victim ☐ Witness ☐ Learned about	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Emotional Abuse	☐ Caregiver Substance Abuse ☐ Other _____	☐ Victim ☐ Witness	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Domestic Violence	☐ Weapon Used ☐ Serious Injury ☐ Report Filed	☐ Victim ☐ Witness ☐ Learned about	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Community Violence	☐ Gang-Related ☐ High Crime Community ☐ Drug Traffic ☐ Other ____	☐ Victim ☐ Witness ☐ Learned about	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
War/Political Violence	☐ Specify: _____ _____ _____	☐ Victim ☐ Witness ☐ Learned about	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Trauma Type	Trauma Details	Role in Event	Age(s) Experienced 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18
Life-Threatening Medical Illness	☐ Type _____ _____ _____	☐ Self ☐ Family ☐ Friend	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Serious Accident	☐ Motor Vehicle ☐ Dog Bite ☐ Hospitalized ☐ Other _____	☐ Victim ☐ Witness ☐ Learned about	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
School Violence	☐ Shooting ☐ Bullying ☐ Suicide ☐ Assault ☐ Other _____ _____	☐ Victim ☐ Witness ☐ Learned about	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Disaster	☐ Earthquake ☐ Fire ☐ Flood ☐ Hurricane ☐ Tornado ☐ Toxic Substance ☐ Other __ _____ ☐ Lost Home ☐ Injured	☐ Victim ☐ Witness ☐ Learned about	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Terrorism	☐ Conventional Weapon ☐ Biological ☐ Chemical ☐ Radiological ☐ Other _____	☐ Victim ☐ Witness ☐ Learned about	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Kidnapping	☐ Stranger ☐ Relative ☐ Acquaintance ☐ Other ____	☐ Victim ☐ Witness ☐ Learned about	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Sexual Assault/Rape	☐ Weapon Used ☐ Stranger ☐ Date Rape ☐ Prosecution	☐ Victim ☐ Witness ☐ Learned about	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Interpersonal Violence	☐ Robbery ☐ Assault ☐ Homicide ☐ Suicide ☐ Suicide Attempt ☐ Other _ _____	☐ Victim ☐ Witness ☐ Learned about	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Bereavement	☐ Parent ☐ Sibling ☐ Friend ☐ Other Relative ☐ Other _____ ☐ Sudden Death Cause of Death: ☐ Illness ☐ Accident ☐ Homicide ☐ Suicide ☐ Disaster ☐ Terrorism ☐ Other_____ _____	☐ Witness ☐ Learned about (exclude death due to natural causes)	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Trauma Type	Trauma Details	Role in Event	Age(s) Experienced 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18
Separation	☐ Divorce ☐ Foster Care ☐ Parent Deported ☐ Parent/Sibling Incarcerated ☐ Parent Hospitalized ☐ Refugee ☐ Separation from relatives/ friends in country of origin ☐ Other _____ _____		☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Impaired Caregiver	☐ Biological Mother ☐ Biological Father ☐ Other Relative ☐ Other Adult Impairment Due to: ☐ Drug use/abuse/addiction ☐ Mental Health Problem ☐ Medical Illness ☐ Other _____ _____		☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

In interviewing the parent/caregiver, ask: ***Sometimes people have scary or violent things happen to them where someone could have or was badly hurt or killed. Has anything like this ever happened to your child?***

1. Provide a brief description of what happened:

_____
_____
_____
_____
_____

Below is a list of other scary or violent things. These can be times when someone was or could have been hurt badly or killed. For each question, check **"Yes"** if this has **happened to your child**; check **"No"** if this **did NOT happen to your child**.

2. My child was in a **disaster**, like an earthquake, wildfire, hurricane, tornado or flood.	□Yes	□ No
3. My child was in a bad **accident**, like a **serious** car accident or fall.	□Yes	□ No
4. My child was in a place where a **war** was going on around him/her.	□Yes	□ No
5. My child was **hit, punched, or kicked very hard** at home (**DO** NOT **INCLUDE** ordinary fights between brothers and sisters). .	□Yes	□ No
6. My child saw a family member being hit, punched or kicked very hard at home. (**DO NOT INCLUDE** ordinary fights between brothers and sisters).	□Yes	□ No
7. My child was **beaten up, shot at or threatened to be hurt badly** in his/her school, neighborhood or town.	□Yes	□ No
8. My child saw someone in our neighborhood or town **beaten up, shot at or killed.**	□Yes	□ No
9. My child saw a **dead body** in our neighborhood or town (do not include funerals).	□Yes	□ No
10. My child had an adult or someone much older touch his/her **private parts when he/she** did not want them to (**DO NOT INCLUDE** a visit to the doctor)	□Yes	□ No
11. My child heard about the **violent death or serious injury** of a loved one.	□Yes	□ No
12. My child had a **painful and scary medical treatment in a hospital** when he/she was very sick or badly injured.	□Yes	□ No
13. My child was **forced to have sex** with someone against his/her will.	□Yes	□ No
14. Has anyone **close to your child died**?	□Yes	□ No
15. OTHER than the things described above, has **ANYTHING ELSE** ever happened to your child that was **REALLY SCARY, DANGEROUS, OR VIOLENT?**	□Yes	□ No

If you answered "YES" to only ONE thing in the above list of questions (# 1 to #15), place the number of that thing (#1 to #15) in this blank: #___ _____ If you answered "YES" to MORE THAN ONE THING, place the number of the thing that BOTHERS YOUR CHILD THE MOST NOW in this blank: #_____

About how long ago did this bad thing happen to your child? _____

Has it been <u>at least one month since</u> this bad thing happened? □ Yes □ No

Clinician: Provide a brief description of what happened (***if different from #1 above***):

_____
_____
_____
_____

Here is a list of problems that children may have after bad things happen. Please think about the bad thing that happened to your child that seems to bother your child the most now. For each problem, **CIRCLE ONE** of the numbers (0, 1, 2, 3, 4 or 5) that tells how often the problem happened to your child **in the past month**, even if the bad thing happened a long time ago. Use the **Frequency Rating Sheet** to help you decide how often the problem happened **in the past month**. Note: If you are unsure about how often your child has experienced a problem, make your best estimation. **Only** circle **"Don't Know"** if you absolutely **cannot** give an answer. **PLEASE BE SURE TO ANSWER ALL QUESTIONS.**

HOW MUCH OF THE TIME DURING THE PAST MONTH…		**None**	**Little**	**Some**	**Much**	**Most**	**Don't Know**
1_{E3}	My child is on the lookout for danger or things that he/she is afraid of (like looking over his/her shoulder even when nothing is there).	0	1	2	3	4	5
2_{D2}	My child has thoughts like "I am bad."	0	1	2	3	4	5
3_{C2}	My child tries to stay away from people, places, or things that remind him/her about what happened.	0	1	2	3	4	5
4_{E1}	My child gets upset easily or gets into arguments or physical fights.	0	1	2	3	4	5
5_{B3}	My child feels like he/she is back at the time when the bad thing happened, like it's happening all over again.	0	1	2	3	4	5
6_{D4}	My child feels like what happened was sickening or gross.	0	1	2	3	4	5
7_{D5}	My child doesn't feel like doing things with family or friends or other things that he/she liked to do.	0	1	2	3	4	5
8_{E5}	My child has trouble concentrating or paying attention.	0	1	2	3	4	5
9_{D2}	My child has thoughts like, "The world is really dangerous."	0	1	2	3	4	5
10_{B2}	My child has bad dreams about what happened, or other bad dreams.	0	1	2	3	4	5
11_{B4}	When something reminds my child of what happened, he/she gets very upset, afraid, or sad.	0	1	2	3	4	5
12_{D7}	My child has trouble feeling happiness or love.	0	1	2	3	4	5
13_{C1}	My child tries not to think about or have feelings about what happened.	0	1	2	3	4	5

14_{B5}	When something reminds my child of what happened, he/she has strong feelings in his/her body, like heart beating fast, headaches, or stomach aches.	0	1	2	3	4	5
15_{D3}	My child is mad with someone for making the bad thing happen, not doing more to stop it, or to help after.	0	1	2	3	4	5
16_{D2}	My child has thoughts like "I will never be able to trust other people."	0	1	2	3	4	5
17_{D6}	My child feels alone even when he/she is around other people.	0	1	2	3	4	5
18_{B1}	My child has upsetting thoughts, pictures, or sounds of what happened come to mind when he/she doesn't want them to.	0	1	2	3	4	5
19_{D3}	My child feels that part of what happened was his/her fault.	0	1	2	3	4	5
20_{E2}	My child feels he/she hurt himself/herself on purpose.	0	1	2	3	4	5
21_{E6}	My child has trouble going to sleep, wakes up often, or has trouble getting back to sleep.	0	1	2	3	4	5
22_{D4}	My child feels ashamed or embarrassed over what happened.	0	1	2	3	4	5
23_{D1}	My child has trouble remembering important parts of what happened.	0	1	2	3	4	5
24_{E4}	My child feels jumpy or startles easily, like when he/she hears a loud noise or when something surprises him/her.	0	1	2	3	4	5
25_{D4}	My child feels afraid or scared.	0	1	2	3	4	5
26_{E2}	My child does risky or unsafe things that could really hurt him/her or someone else.	0	1	2	3	4	5
27_{D4}	My child wants to get back at someone for what happened.	0	1	2	3	4	5
With Dissociative Symptoms (Dissociative Subtype)							
28_{A1}	My child feels like he/she is seeing himself/herself or what he/she is doing from outside his/her body (like watching himself/herself in a movie).	0	1	2	3	4	5
29_{A1}	My child feels not connected to his/her body, like he/she is not really there inside.	0	1	2	3	4	5
30_{A2}	My child feels like things around him/her look strange, different, or like he/she is in a fog.	0	1	2	3	4	5
31_{A2}	My child feels like things around him/her are not real, like he/she is in a dream.	0	1	2	3	4	5

Have some of these reactions lasted *at least one month*? □ Yes □ No

Clinician: Ask the parent/caregiver whether the reactions (thoughts and feelings) above cause significant ***distress*** *or* ***functional impairment*** to the child.

□ **Significant Distress: (**check if parent/caregiver endorses #1 below)

□ Yes □ No □ Don't Know 1. Do these reactions (thoughts and feelings) bother or upset your child a lot?

Describe: _____

□ **Significant Functional Impairment**: (check if functional impairment at home, at school, in peer relationships, in developmental progression)

□ **Home**: (check if parent/caregiver endorses #1, #2 or #3 below)

□ Yes □ No □ Don't Know 1. Do these reactions (thoughts and feelings) make it harder for your child to get along with people at home?

□ Yes □ No □ Don't Know 2. Do these reactions (thoughts and feelings) get your child into trouble at home?

□ Yes □ No □ Don't Know 3. Do these reactions (thoughts and feelings) cause your child to have some other problem at home?

Describe: _____

□ **School**: (check if parent/caregiver endorses #1 *or* #2 below)

□ Yes □ No □ Don't Know 1. Do these reactions (thoughts and feelings) make it harder for your child to do well in school?

□ Yes □ No □ Don't Know 2. Do these reactions (thoughts and feelings) cause your child other problems at school?

Describe: _____

□ **Peer Relationships**: (check if parent/caregiver endorses #1 below)

□ Yes □ No □ Don't Know 1. Do these reactions (thoughts and feelings) make it hard for your child to get along with or make friends?

Describe: _____

□ **Developmental Progression**: (check if parent/caregiver endorses #1 below)

□ Yes □ No □ Don't Know 1. Do these reactions (thoughts and feelings) make it harder for your child to do important things that other kids his/her age are doing?

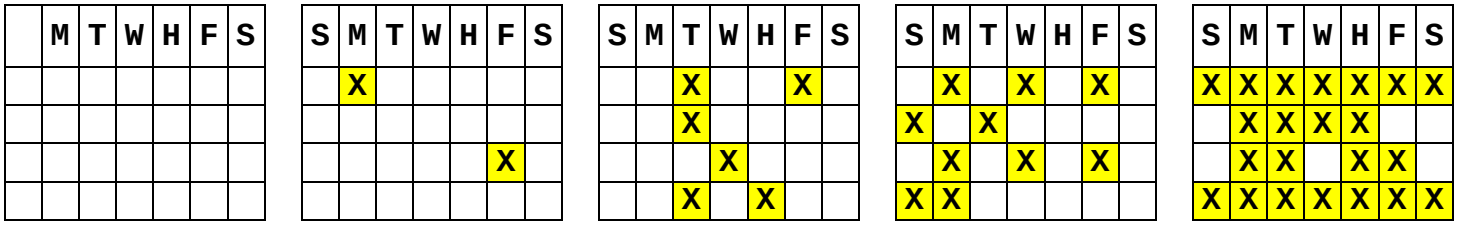
□ Yes □ No □ Don't Know 2. Do these reactions interfere with other areas of your child's development?

Describe: _____

FREQUENCY RATING SHEET

HOW MUCH OF THE TIME
DURING THE PAST MONTH DID THE PROBLEM HAPPEN?

0	1	2	3	4
NONE	**LITTLE**	**SOME**	**MUCH**	**MOST**



NEVER	TWO TIMES A MONTH	1-2 TIMES A WEEK	2-3 TIMES A WEEK	ALMOST EVERY DAY

CLINICIAN SCORE SHEET

Subject ID#_____ Age____ Sex (circle): M F Date: _____ Subject Name: _____

For Items 2, 9, and 16: indicate highest score only for DSM-5 Symptom D2; for Items 15 and19: indicate highest score only for DSM-5 Symptom D3; for Items 6, 22, 25, and 27: indicate highest score only for DSM-5 Symptom D4; for Items 20 and 26: indicate highest score only for DSM-5 Symptom E2. Category B Total: Sum scores for symptoms B1-B5; Category C Total: Sum scores for symptoms C1* and C*2; Category D Total: Sum scores for symptoms D1-D7; Category E Total: Sum scores for symptoms E1-E6; PTSD-RI Total Scale Score: Sum Category B, C, D, and E.

Item #	DSM-5 Symptom	Score *(0-4)*
18	B1	
10	B2	
5	B3	
11	B4	
14	B5	
SYMPTOM CATEGORY B SUMMATIVE SCORE:		____
13	C1	
3	C2	
SYMPTOM CATEGORY C SUMMATIVE SCORE:		____

Item #	DSM-5 Symptom	Score *(0-4)*
23	D1	
2*	D2	____
9*	D2	
16*	D2	
15*	D3	____
19*	D3	
6*	D4	____
22*	D4	
25*	D4	
27*	D4	
7	D5	
17	D6	
12	D7	
SYMPTOM CATEGORY D SUMMATIVE SCORE:		____

Item #	DSM-5 Symptom	Score *(0-4)*
4	E1	
20*	E2	____
26*	E2	
1	E3	
24	E4	
8	E5	
21	E6	
SYMPTOM CATEGORY E SUMMATIVE SCORE		____

Dissociative Symptoms

28. A1 ____
29. A1 ____
(***Indicate highest score for A1***) ____

30. A2 ____
31. A2 ____
(***Indicate highest score for A2***) ____

PTSD-RI TOTAL SCALE SCORE

_____

DSM-5 PTSD DIAGNOSIS

B: One or more Category B symptoms present: ☐
C: One or more Category C symptoms present: ☐
D: Two or more Category D symptoms present: ☐
E: Two or more Category E symptoms present: ☐
F: Symptom duration greater than one month: ☐
G: Symptoms cause clinically significant ***distress*** or ***impairment***: ☐
Specify Dissociative Subtype:
One or more dissociative symptoms present: ☐

Estimating Whether DSM-5 PTSD Category B, C, D, and E Symptom Criteria are Met

If symptom score is 3 or 4, then score symptom as "present." For question #4, #10, and #26; use a rating of 2 or more for symptom presence. Then determine whether one or more B symptoms are present; whether one or more C symptoms are present; whether two or more D symptoms are present; and whether two or more E symptoms are present. If one or more Dissociative Symptoms are present, then assign Dissociative Subtype.