



# Child & Adolescent Trauma Screen (CATS-Caregiver): Ages 7-17

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ MR#: \_\_\_\_\_ Date of Service: \_\_\_\_\_

Name of Person Completing Form: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

## Section 1 Instructions

Stressful or scary events happen to many children. Below is a list of stressful and scary events that sometimes happen. Mark YES if it happened to the child to the best of your knowledge. Mark NO if it didn't happen to the child.

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

Which one is bothering the child the most now? \_\_\_\_\_

**If you marked any stressful or scary events for the child, turn the page and answer the next questions.**

## Section 2 Instructions

For each statement, write the number that corresponds to how often it has bothered the child in the **last 2 weeks**. Answer the best you can.

## Rating Scale

0 = Never  
1 = Once in a while  
2 = Half the time  
3 = Almost always

### How often have the following things bothered the child in the LAST 2 WEEKS?

Rating

1. Upsetting thoughts or images about a stressful event. Or re-enacting a stressful event in play.	<input type="text"/>
2. Having bad dreams related to a stressful event.	<input type="text"/>
3. Acting, playing, or feeling as if a stressful event is happening right now.	<input type="text"/>
4. Feeling very emotionally upset when reminded of a stressful event.	<input type="text"/>
5. Strong physical reactions when reminded of a stressful event (sweating, heart beating fast).	<input type="text"/>
6. Trying not to remember, think about, or have feelings about a stressful event.	<input type="text"/>
7. Avoiding anything that is a reminder of a stressful event (activities, people, places, things, talks).	<input type="text"/>
8. Not being able to remember an important part of a stressful event.	<input type="text"/>
9. Negative changes in how s/he thinks about self, others, or the world after a stressful event.	<input type="text"/>
10. Thinking a stressful event happened because s/he or someone else did something wrong or did not do enough to stop it.	<input type="text"/>
11. Having very negative emotional states (afraid, angry, guilty, ashamed).	<input type="text"/>
12. Losing interest in activities s/he enjoyed before a stressful event.	<input type="text"/>
13. Feeling distant or cut off from people around her/him.	<input type="text"/>
14. Not showing positive feelings (being happy, having loving feelings).	<input type="text"/>
15. Being irritable. Or having angry outbursts without a good reason and taking it out on other people or things.	<input type="text"/>
16. Risky behavior or behavior that could be harmful.	<input type="text"/>
17. Being overly alert or on guard.	<input type="text"/>
18. Being jumpy or easily startled.	<input type="text"/>
19. Problems with concentration.	<input type="text"/>
20. Trouble falling or staying asleep.	<input type="text"/>

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

- Getting along with others:  Yes  No
- Hobbies/Fun:  Yes  No
- School:  Yes  No
- Family relationships:  Yes  No
- General happiness:  Yes  No

### OFFICE USE ONLY

Total Score	
# of questions 1-5 rated 2 or 3	
# of questions 6-7 rated 2 or 3	
# of questions 8-14 rated 2 or 3	
# of questions 15-20 rated 2 or 3	

Adapted from Berliner & Goldbeck, 2014

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