Metropolitan Pediatrics, L.L.C.

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

Patient Name: _____ DOB: _____ MR#: _____ Date of Service: _____

## 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 you. Mark NO if it didn't happen to you.

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

Which one is bothering you the most now? _____

**If you marked any stressful or scary events, 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 you in the **last 2 weeks**.

## Rating Scale

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

| How often have the following things bothered you in the LAST 2 WEEKS? | Rating |
|---|---|
| 1. Upsetting thoughts or pictures about what happened that pop into your head. | |
| 2. Bad dreams reminding you of what happened. | |
| 3. Feeling as if what happened is happening all over again. | |
| 4. Feeling very upset when you are reminded of what happened. | |
| 5. Strong feelings in your body when you are reminded of what happened (sweating, heart beating fast, upset stomach). | |
| 6. Trying not to think about what happened. Or to not have feelings about it. | |
| 7. Staying away from anything that reminds you of what happened (people, places, things, situations, talks). | |
| 8. Not being able to remember part of what happened. | |
| 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. | |
| 10. Blaming yourself for what happened. Or blaming someone else when it isn't their fault. | |
| 11. Bad feelings (afraid, angry, guilty, ashamed) a lot of the time. | |
| 12. Not wanting to do things you used to do. | |
| 13. Not feeling close to people. | |
| 14. Not being able to have good or happy feelings. | |
| 15. Feeling mad. Having fits of anger and taking it out on others. | |
| 16. Doing unsafe things. | |
| 17. Being overly careful (checking to see who is around you). | |
| 18. Being jumpy. | |
| 19. Problems paying attention. | |
| 20. Trouble falling or staying asleep. | |

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

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

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| | |
|---|---|
| Total Score | 0 |
| # of questions 1-5 rated 2 or 3 | 0 |
| # of questions 6-7 rated 2 or 3 | 0 |
| # of questions 8-14 rated 2 or 3 | 0 |
| # of questions 15-20 rated 2 or 3 | 0 |

Adapted from Berliner & Goldbeck, 2014