

## Child and Adolescent Trauma Screen (CATS)

### SCORING

Child's Name: \_\_\_\_\_ Assessment Date: \_\_\_\_\_

Caregiver's Name: \_\_\_\_\_

Provider's Name: \_\_\_\_\_

#### CAREGIVER Report

Trauma Exposure: \_\_\_\_\_

Total PTSD Severity Score: \_\_\_\_\_

Criteria	# of Symptoms (Only count items rated 2 or 3)	# Symptoms Required	DSM-5 Criteria Met?	
			Yes	No
<b>Re-experiencing</b> Items 1-5		1+	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Avoidance</b> Items 6-7		1+	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Negative Mood/ Cognitions</b> Items 8-14		2+	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Arousal</b> Items 15-20		2+	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Functional Impairment</b> Set of 1-5 Yes/No Questions		1+	<input type="checkbox"/> Yes	<input type="checkbox"/> No

#### CHILD Report

Trauma Exposure: \_\_\_\_\_

Total PTSD Severity Score: \_\_\_\_\_

Criteria	# of Symptoms (Only count items rated 2 or 3)	# Symptoms Required	DSM-5 Criteria Met?	
			Yes	No
<b>Re-experiencing</b> Items 1-5		1+	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Avoidance</b> Items 6-7		1+	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Negative Mood/ Cognitions</b> Items 8-14		2+	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Arousal</b> Items 15-20		2+	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Functional Impairment</b> Set of 1-5 Yes/No Questions		1+	Yes	No