

SCREENING FOR TRAUMATIC STRESS IN CHILDREN AND ADOLESCENTS (CATS)

SCORE

Name of child/adolescent _____

Date of evaluation _____

Name of caregiver _____

Name of evaluator _____

CAREGIVER Report

Exposure to trauma: _____

_____ Total severity score

PTSD: _____

Criteria	# of Symptoms <small>(Count only elements classified as 2 or 3)</small>	# Symptoms Required	DSM 5 Criteria	
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Re-living/experiencing Items 1-5		1+	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Avoidance Items 6-7		1+	<input type="checkbox"/> Yes	No
Mood/ Negative thoughts Items 8-15		2+	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arousal Items 16-20		2+	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Functional Impairment Group of yes/no questions 1-5		1+	<input type="checkbox"/> Yes	<input type="checkbox"/> No

CHILD/ ADOLESCENT Report

Exposure to trauma: _____

Total severity score PTSD: _____

Criteria	# of Symptoms <small>(Count only elements classified as 2 or 3)</small>	# Symptoms Required	DSM 5 Criteria	
			<input type="checkbox"/> es	<input type="checkbox"/> No
Re-living/experiencing Items 1-5		1+	<input type="checkbox"/> es	<input type="checkbox"/> No
Avoidance Items 6-7		1+	<input type="checkbox"/> es	<input type="checkbox"/> No
Mood/ Negative thoughts Items 8-15		2+	<input type="checkbox"/> es	<input type="checkbox"/> No
Arousal Items 16-20		2+	<input type="checkbox"/> es	<input type="checkbox"/> No
Functional Impairment Group of yes/no questions 1-5		1+	<input type="checkbox"/> es	<input type="checkbox"/> No

**Screening for traumatic stress in children and adolescents. Version for caregivers
(CATS-C) ages 3-6**

Name _____

Date _____

Many children suffer stressful or frightening events. Below, you will find a list of stressful or frightening events that sometimes happen. Mark YES if you know it has happened to the child. Mark NO if it has not happened to the child.

1. Natural disasters such as floods, tornadoes, hurricanes, earthquakes or fires. Desastres naturales como inundaciones, tornados, huracanes, terremotos o incendios.		Ye s		NO
2. Severe traffic/bicycle accidents or injuries, dog bites, or sport-related injuries.		Ye s		NO
3. Robbery using intimidation, force or a weapon.		Ye s		NO
4. Slaps, hits or punches from the family.		Ye s		NO
5. Slaps, hits or punches from someone outside the family.		Ye s		NO
6. Has seen someone in your family being punched, hit, or beaten.		Ye s		NO
7. Has seen someone in your community getting hit or beaten.		Ye s		NO
8. Someone older than the child has touched his/her private parts when they shouldn't have.		Ye s		NO
9. Someone has forced or pressured the child into having sex.		Ye s		NO
10. Someone close to the child died suddenly or in a violent way.		Ye s		NO
11. The child has been attacked, stabbed, shot or severely hurt.		Ye s		NO
12. The child has seen someone being attacked, stabbed, shot, severity hurt or killed.		Ye s		NO

13. Has suffered a medical treatment that caused stress or fear.		Ye s		NO
14. Has been in a wartime area.		Ye s		NO
15. Has he/she suffered any other stressful or traumatic event?		Ye s		NO
Describe the event:				

Which of these events upsets him/her the most?

If you marked any of the traumatic or stressful events, turn the page and respond to the following questions.

Mark 0, 1, 2, or 3 indicating the frequency in which the following situations have upset the child in the past two weeks. Respond to the best of your ability:

0 Never/ 1 Sometimes / 2 Half the time / 3 Almost always

1. Have disturbing thoughts or images about the stressful event or reenact the stressful event during play/while playing.	0	1	2	3
2. Have nightmares related to the stressful event.	0	1	2	3
3. Act, play or feel as if the stressful event were happening in this (very) moment.	0	1	2	3
4. Feel very sad when remembering the stressful event.	0	1	2	3
5. Physical reactions when remembering the stressful event (sweat, palpitations).	0	1	2	3
6. Try to not remember, think, or have feelings about the traumatic event.	0	1	2	3
7. Avoid anything that reminds him/her of the traumatic experience (activities, people, places, objects, conversations).	0	1	2	3
8. Increase in negative emotion (fear, anger, guilt, shame, confusion).	0	1	2	3
9. Lost interest in activities that she/he used to like/enjoy before the stressful event. Including not playing as much as before.	0	1	2	3
10. Act shy/withdrawn in society/public.	0	1	2	3

11. Decrease of expressing positive feelings (being happy, feeling love).	0	1	2	3
12. Be irritable or having attacks of anger/tantrums without any good reason and towards other people or objects.	0	1	2	3
13. Is excessively alert or on edge.	0	1	2	3
14. Is nervous or easily startled.	0	1	2	3
15. Difficulty concentrating.	0	1	2	3
16. Difficulty falling or staying asleep.	0	1	2	3

Please, mark YES or NO if the problems interfere with:

1. Maintaining relationships with others.

YES		NO	
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4. Family Relationships.

YES		NO	
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2. Hobbies/pastime.

YES		NO	
-----	--	----	--

5. General happiness.

YES		NO	
-----	--	----	--

3. School or daycare.

YES		NO	
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**Screening for traumatic stress in children and adolescents. Version for caregivers
(CATS-C) ages 7- 17**

Name _____

Date _____

Many children/adolsecents suffer stressful or frightening events. Below, you will find a list of stressful events that sometimes happen. Mark YES if you know it has happened to the child/adolescent. Mark NO if it has not happened to the child/adolescent.

1. Natural disasters such as floods, tornadoes, hurricanes, earthquakes or fires.		YES		NO
2. Severe traffic/bicycle accidents or injuries, dog bites, or sport-related injuries.		YES		NO
3. Robbery using intimidation, force or a weapon.		YES		NO
4. Slaps, hits or punches in his/her family.		YES		NO
5. Slaps, hits or punches from someone outside his/her family.		YES		NO
6. Has seen someone in his/her family being punched, hit, or beaten.		YES		NO
7. Has seen someone in his/her/the community getting hit or beaten.		YES		NO
8. Someone older than the child/adolescent has touched his/her private parts when they shouldn't have.		YES		NO
9. Someone has forced or pressured the child/adolescent into having sex when he/she couldn't say no/refuse.		YES		NO
10. Someone close to the child or adolescent died suddenly or in a violent way.		YES		NO
11. The child or adolescent has been attacked, stabbed, shot or severely hurt.		YES		NO
12. The child or adolescent has seen someone being attacked, stabbed, shot, severity hurt or killed.		YES		NO
13. Has have suffered a medical treatment that caused him/her stress or fear.		YES		NO

14. Has been in a wartime area.		YES		NO
15. Has he/she suffered any other stressful or traumatic event?		YES		NO
Describe the event/describe it:				

Which of these events upsets the child/adolescent the most?

If you marked any of the traumatic or stressful events, turn the page and respond to the following questions.

Mark 0, 1, 2, or 3 indicating the frequency in which the following situations have upset the child/adolescent in the past two weeks. Respond to the best of your ability:

0 Never/ 1 Sometimes / 2 Half the time / 3 Almost always

1. Have disturbing thoughts or images about the stressful event or reenact the stressful event during play/while playing.	0	1	2	3
2. Have nightmares related to the stressful event.	0	1	2	3
3. Act, play or feel as if the stressful event were happening in this (very) moment.	0	1	2	3
4. Feel very sad when remembering the stressful event.	0	1	2	3
5. Physical reactions when remembering the stressful event (sweat, palpitations).	0	1	2	3
6. Try to not remember, think, or have feelings about the traumatic event.	0	1	2	3
7. Avoid anything that reminds him/her of the traumatic experience (activities, people, places, objects, conversations).	0	1	2	3
8. Not be able to remember an important part of the traumatic event.	0	1	2	3

9. Negative thoughts about him/herself, about others, or the world after the stressful event.	0	1	2	3
10. Think that the stressful event happened because he/she or someone else did something bad or did not do enough to stop it.	0	1	2	3
11. Have very negative moods (fear, anger, guilt, shame).	0	1	2	3
12. Loss of interest in activities that he/she used to love/enjoy before the stressful event.	0	1	2	3
13. Feel distant or isolated from the people around him/her.	0	1	2	3
14. Does not show positive emotion (feeling happy or love).	0	1	2	3
15. Feel irritable, have bursts of anger for no good reason and towards other people or objects.	0	1	2	3
16. Risky behavior or conduct that could harm him/her.	0	1	2	3
17. Are excessively alter or on edge.	0	1	2	3
18. Feel nervous or startled easily.	0	1	2	3
19. Trouble concentrating.	0	1	2	3
20. Difficulty falling or staying asleep.	0	1	2	3

Please, mark YES or NO if the problems you indicated interfere with:

1. Maintaining relationships with others.

YES		NO	
-----	--	----	--

4. Family Relationships.

YES		NO	
-----	--	----	--

2. Hobbies/pastime.

YES		NO	
-----	--	----	--

5. General happiness.

YES		NO	
-----	--	----	--

3. School or daycare.

YES		NO	
-----	--	----	--

Screening for traumatic stress in children and adolescents (CATS-C) ages 7- 17

Name _____

Date _____

Many children suffer stressful or frightening events. Below, you will find a list of stressful or frightening events that sometimes happen. Mark YES if they have happened to you. Mark NO if they have not happened to you.

1. Natural disasters such as floods, tornadoes, hurricanes, earthquakes or fires.		YES		NO
2. Severe traffic/bicycle accidents or injuries, dog bites, or sport-related injuries.		YES		NO
3. Robbery using intimidation, force or a weapon.		YES		NO
4. Slaps, hits or punches in your family.		YES		NO
5. Slaps, hits or punches from someone outside your family		YES		NO
6. You have seen someone in your family being punched, hit, or beaten.		YES		NO
7. You have seen someone in your community getting hit or beaten.		YES		NO
8. Someone older than you has touched your private parts when they shouldn't have.		YES		NO
9. Someone has forced or pressured you into having sex.		YES		NO
10. Someone close to you died suddenly or in a violent way.		YES		NO
11. You have been attacked, stabbed, shot or severely hurt.		YES		NO
12. You have seen someone being attacked, stabbed, shot, severity hurt or killed.		YES		NO
13. You have suffered a medical treatment that caused stress or fear.		YES		NO
14. You have been in a wartime area.		YES		NO
15. Have you suffered any other stressful or traumatic event?		YES		NO

Describe the event/describe it:

Which of these events upsets you the most?

If you marked any of the traumatic or stressful events, turn the page and respond to the following questions.

Mark 0, 1, 2, or 3 indicating the frequency in which the following situations have upset you in the past two weeks. Respond to the best of your ability:

0 Never/ 1 Sometimes / 2 Half the time / 3 Almost always

1. Have disturbing thoughts or images about what happened that burst into your mind.	0	1	2	3
2. Have nightmares related to what happened.	0	1	2	3
3. Feel as if what happened were happening around you again.	0	1	2	3
4. Feel very sad when remembering what happened.	0	1	2	3
5. Intense/strong physical reactions when remembering what happened (sweat, fast heart beat, stomach pain).	0	1	2	3
6. Try to not think about what happened or not have feelings about it.	0	1	2	3
7. Stay away from anything that reminds you of what happened (people, places, objects, situations, conversations).	0	1	2	3
8. Not be able to remember parts of what happened.	0	1	2	3
9. Negative thoughts about yourself and/or others. Thoughts such as I won't have a good life, I can't trust anyone, the whole world is dangerous.	0	1	2	3
10. Blame yourself for what happened or blame someone else when it is not their fault.	0	1	2	3
11. Negative feelings (fear, anger, guilt, shame) the majority of the time.	0	1	2	3
12. Not feel like doing things you used to do.	0	1	2	3
13. Not feel close to others.	0	1	2	3

14. Feel incapable of having positive feelings or being happy.	0	1	2	3
15. Feel angry. Have attacks/bursts of anger towards others.	0	1	2	3
16. Do dangerous things.	0	1	2	3
17. Are excessively cautious (checking who is around you).	0	1	2	3
18. Feel nervous.	0	1	2	3
19. Problems paying attention.	0	1	2	3
20. Difficulty falling or staying asleep.	0	1	2	3

Please, mark YES or NO if the problems you indicated interfere with:

1. Maintaining relationships with others.

YES		NO	

4. Family Relationships.

YES		NO	

2. Hobbies/pastime.

YES		NO	

5. General happiness.

YES		NO	

3. School or daycare.

YES		NO	

Screening for traumatic stress in children and adolescents (CATS) SCORING

Name of child/adolescent: _____ Date of evaluation: _____

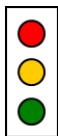
Name of caretaker: _____ Name of evaluator: _____

Test completed by: Child /adolescent Caretaker Severity score for PTSD: _____

Most disturbing trauma: _____

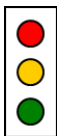
Reliving

B1



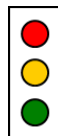
Disturbing memories of the trauma

B2



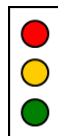
Nightmares

B3



Act/ feel as if the event were happening

B4



Emotional reactions to traumatic memories

B5



Physical reactions to traumatic memories

Severity of symptoms

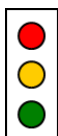
2 – 3 = Red light

1 = Yellow light

0 = Green light

Avoidance/ Isolation

C1



Avoid thoughts/feelings related to the trauma

C2



Avoid traumatic memories

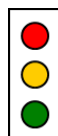
Mood/Negative beliefs

D1



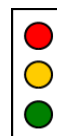
Difficulty remembering details of the trauma

D2



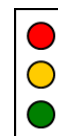
Negative beliefs and expectations

D3



Blame oneself or others who are not responsible

D4



Negative emotions (fear, anger, guilt)

D5



Loss of interest in activities

D6



Feel distant from others

D7



Incapable of experiencing positive emotions

Hyperarousal

E1

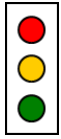
E2

E3

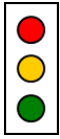
E4

E5

E6



Outbursts of
irritability/anger



Reckless/harmful
conduct



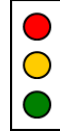
On guard/
alert



Nervous/on edge



Difficulty
concentrating



Sleep
disturbances