Post-Treatment Clinical Assessment Tools

Included you will find:

1. **Trauma Screen (child/adolescent version)**
2. **CPSS (child/adolescent version)**
3. **Scoring Worksheet for CPSS (child/adolescent version)**
4. **Short Mood and Feelings Questionnaire (child/adolescent version)**
5. **Trauma Screen (parent version)**
6. **CPSS (parent version)**
7. **Scoring Worksheet for CPSS (parent version)**
5. **Short Mood and Feelings Questionnaire (parent version)**
6. **Child/Adolescent Satisfaction Questionnaire**
7. **Caregiver Satisfaction Questionnaire**
8. **TF-CBT Client Services (Self Report)**
9. **TF-CBT Client Services (Parent Report)**
10. **Client Treatment Exit Form**

Note: Only print out the versions and forms that you need for your case.

If you have any questions regarding data entry, please contact Carrie Jackson
Office: (843) 792-9524
E-mail: jaccar@musc.edu

Client ID#____________
Therapist ID#___________________

Date:_____________________

CHILD/ADOLESCENT SATISFACTION QUESTIONNAIRE

Please answer the questions below about your treatment.	Very much false	Mostly false	Both true & false	Mostly true	Very muc h true
1. The MAIN problems that I wanted help with have improved.	1	2	3	4	5
2. OTHER problems that I had before coming here for therapy have improved.	1	2	3	4	5
3. I am happy with what I have learned and my progress in therapy.	1	2	3	4	5
4. My treatment has improved other parts of my life (e.g. family relationships, my relationships with my friends, my own mood).	1	2	3	4	5
5. I know what to do if my problems get worse or bother me again.	1	2	3	4	5
6. My therapist has explained what we are doing in counseling.	1	2	3	4	5
7. I understand how Trauma-Focused Cognitive Behavioral Therapy works.	1	2	3	4	5
8. My parents have been included in counseling. They talk with the therapist and have sessions with me.	1	2	3	4	5
9. My therapist has listened to my thoughts, worries, and concerns.	1	2	3	4	5
10. My therapist knows how to help me.	1	2	3	4	5
11. If a friend needed the same kind of help, I would tell them to come here.	1	2	3	4	5
12. Overall, I am happy with the therapy I got here.	1	2	3	4	5

13. What were the MOST HELPFUL parts of your therapy?

____

____

____

14. What were the parts of counseling you liked the LEAST?

____

15. How could we make the counseling experience better? Please list your suggestions/thoughts:

____

____

____

PATS Client ID#____________ Date:____________________
Therapist ID#__________________

CAREGIVER SATISFACTION QUESTIONNAIRE

Please answer the questions below about your child's treatment.	Very much false	Mostly false	Both true & false	Mostly true	Very much true
1. The MAIN problems that I wanted my child treated for have improved.	1	2	3	4	5
2. OTHER problems that my child had have improved.	1	2	3	4	5
3. I am happy with my child's progress in treatment.	1	2	3	4	5
4. My child's treatment has improved other parts of my life (e.g. family relationships, my own mood).	1	2	3	4	5
5. I know what to do if my child's problems get worse or come back again.	1	2	3	4	5
6. My child's therapist has explained Trauma Focused Cognitive Behavioral Therapy to me.	1	2	3	4	5
7. I understand how Trauma Focused Cognitive Behavioral Therapy works.	1	2	3	4	5
8. I have felt included in my child's treatment.	1	2	3	4	5
9. My therapist has listened to my thoughts and concerns about my child.	1	2	3	4	5
10. My child's therapist knows how to help my child.	1	2	3	4	5
11. I would recommend this treatment to a friend who had a child in the same situation.	1	2	3	4	5
12. Overall, I am satisfied with my child's treatment.	1	2	3	4	5

13. What were the MOST HELPFUL parts of your child's treatment?

____

____

____

14. What were the LEAST HELPFUL parts of your child's treatment?

____

____

____

15. Do you have any suggestions about improving this treatment? If so, please describe:

____

____

____

Lang, J.M., & Franks, R. Connecticut Center for Effective Practice, CHDI (2007)

Client ID #:________Therapist ID #:__________Date: _______________

TF-CBT Client Services (Child Version)

We would like to learn about the counseling services you received. Please think about your time in counseling and answer the following questions to the best of your ability. Please place a check next to YES or NO for your response. When we ask you to answer questions about the traumatic event, we mean the____you experienced and came to counseling for.

During your counseling sessions, did your therapist:		**Yes**	**No**
1.	Set an agenda for each therapy session (i.e., *she let me know what we were doing that day*).		
2.	Explain the reason for counseling and why it might be helpful.		
3.	Give me information about the type(s) of traumatic event (s) I have experienced and how many children feel and react to such events.		
4.	Let me choose whether or not I talked about the traumatic event(s).		
5.	Taught me how to identify and name different feelings I was experiencing.		
6.	Help me understand how thoughts, feelings, and behaviors are connected.		
7.	Help me to identify and change thoughts that were bothering me.		
8.	Help me learn safe ways to express my negative feelings (mad, frustrated, sad feelings).		
9.	Help me do an activity, such as write a book, draw a set of pictures, or write poems or songs that describe the traumatic event(s) and how I felt or thought about it.		
10.	Directly discuss the specific details of the traumatic event(s) with me.		
11.	Regularly assign homework or activities to complete at home before the next session.		
12.	Encourage me to describe thoughts, feelings, or sensations experienced during the traumatic event(s) or related experiences.		
13.	Taught my mom/dad or other person who takes care of me ways to get along with me, play, or help me to follow the rules.		
14.	Allow me to lead or direct most of the sessions (*I got to decide what we did each session*)		
15.	Have my parent and I talk about the traumatic event (s) together in a session.		
16.	Talk about new troubling events or crises that happened to me in the past week or two for most of the sessions.		
17.	Teach me how to relax (e.g., deep breathing, tightening & relaxing my muscles to feel less tense).		
18.	Teach me to think of (or imagine) something positive, like a pleasant place, person, or situation, when I am feeling scared or upset.		
19.	Have me and my parent practice using coping skills (deep breathing, imagining something pleasant or a stop sign, muscle relaxation, positive self-talk) to deal with things that reminded me of the trauma.		

Client ID #:________Therapist ID #:__________Date: _______________

During your counseling sessions, did your therapist:		**Yes**	**No**
20.	Spend most sessions playing fun activities (e.g., board game, videogame) without talking about the traumatic event(s).		
21.	Saw only me in most sessions (did not see my parent separately).		
22.	Talk about ways I can keep safe in the future (in my family, school, and/or community).		
23.	Often stop talking about the traumatic event(s) because I became upset.		
24.	Encourage me to vent or “get out” my negative feelings about the trauma or the offender (e.g., tearing up paper, destroying something).		
25.	Teach me about things I could say to myself to help me feel better if I ever feel unhappy, scared, sad, or mad.		
26.	Talked to me about any negative feelings I had about the abuse/trauma (feeling like it was my fault, feeling ashamed or embarrassed).		
27.	Talk about me telling other people, like parents, teachers or counselors, if anyone ever hurts me in any way or if I ever see someone hurting someone else.		

PATS Client ID#:______Therapist ID#:______Date: ______________________

TF-CBT Client Services (Parent Version)

We are eager to learn about the counseling services you received. Please think about your time in counseling and answer the following questions to the best of your ability. Please place a check next to YES or NO for your response.

During your counseling sessions, please indicate whether your therapist:		Yes	No
1.	Established an agenda and structure for each therapy session.		
2.	Explained the rationale and benefits of the intervention and described the treatment approach.		
3.	Provided specific information about the types of traumatic event(s) my child has experienced and common reactions to these events.		
4.	Let my child choose whether or not they talked about the traumatic event(s).		
5.	Taught my child how to identify and correctly label emotions.		
6.	Helped my child understand the connection between thoughts, feelings, and behaviors.		
7.	Helped my child identify and correct unhelpful or troubling thoughts.		
8.	Helped my child to use effective ways to express negative feelings (mad, frustrated, sad feelings).		
9.	Helped my child do an activity, such as writing a book, drawing a set of pictures, or writing poems or songs that describe the traumatic event(s) and my child's reactions.		
10.	Directly discussed or drew about the specific details of the traumatic event(s) with my child.		
11.	Regularly assigned homework or activities to complete for the next session.		
12.	Encouraged my child to describe thoughts, feelings, or sensations experienced during the traumatic event(s) or related experiences.		
13.	Taught me strategies to enhance my relationship with my child, such as active listening, play skills, and ways to praise my child, and help my child follow the rules.		
14.	Allowed my child or me to lead or direct most of the sessions.		
15.	Had my child and I talk about the traumatic event(s) in a joint session.		
16.	Helped me to prepare for the joint session (e.g., talked about structure of session, ways to respond, how to express my thoughts and feelings, how to show support to my child).		
17.	Dealt with crises or events that happened to my child or me in the past week(s) for most of the sessions.		
18.	Taught my child how to relax (e.g., deep breathing, tightening & relaxing his/her muscles to feel less tense).		
19.	Taught my child to think of (or imagine) something positive, like a pleasant place, person, or situation, when s/he was feeling scared or upset.		
20.	Taught me how to use effective discipline strategies, such as proper use of time out, work chores, privilege losses, and active ignoring.		

PATS Client ID#:______Therapist ID#:______Date: ________________________

During your counseling sessions, please indicate whether your therapist:		Yes	No
21.	Had me and my child practice using coping skills to deal with trauma reminders or trauma related distress.		
22.	Spend most sessions playing fun activities (e.g., board game, videogame) without any discussion of the traumatic event(s).		
23.	Saw only my child in most sessions.		
24.	Talked about ways my child can keep safe in the future (in my family, school, and/or community).		
25.	Often stopped talking about the traumatic event(s) because my child became distressed or upset.		
26.	Encouraged my child to engage in a cathartic exercise to vent his/her negative feelings about the trauma or the offender (e.g., tearing up paper, destroying an object).		
27.	Taught your child about things s/he could say to her/himself to help feel better if s/he ever feel unhappy, scared, sad, or mad.		
28.	Talked to your child about any negative feelings he/she had about the abuse/trauma (e.g., guilt, shame).		
29.	Talked about your child telling other people, like parents, teachers or counselors, if anyone ever hurts him/her in any way or if s/he ever sees someone hurting someone else.		

PATS Client ID#___________
Therapist ID#____________
Date: _______________

PATS

Client Treatment Exit Form*

Please submit completed form within 2 weeks of final treatment session to:

Carrie Jackson
National Crime Victims Research & Treatment Center
MSC 861, Ste 207, 2nd floor Institute of Psychiatry 67
President Street
Charleston, SC 29425
Fax: 843-792-7146

Today's Date: ____________________________

Last Clinical Contact: ___________________________

Reason for Exit from PATS Evaluation/Protocol:

- ☐ 1. Client does not meet eligibility symptoms that would result in benefit from TF-CBT treatment protocol
- ☐ 2. Client is clinically unstable (suicidal, homicidal, active drug use, psychotic, and/or requires alternative treatment that precludes TF-CBT at this time)
- ☐ 3. Client's home environment is clinically unstable (client continues to be exposed to trauma, client's caregivers are actively unsupportive)
- ☐ 4. Client moved
- ☐ 5. Client's case was transferred to another PATS clinician
- ☐ 6. Client's case was transferred to a non-PATS clinician
- ☐ 7. Client and/or family refused TF-CBT treatment
- ☐ 8. Client and family stopped TF-CBT treatment for the following other reason (specify):

  ____

- ☐ 9. Client dropped out of TF-CBT treatment prior to completion for unknown reasons
- ☐ **10. Client successfully completed TF-CBT protocol**

* Note: This form should be submitted for all identified PATS clients/patients upon final clinical encounter, regardless of when or why the patient/client exited treatment.

Client ID#____________ Therapist ID#_____________ Date:_____________

SHORT MOOD AND FEELINGS QUESTIONNAIRE

Self-Report Version

This form is about how you might have been feeling or acting recently.

For each question, please check how much you have felt or acted this way *in the past two weeks*.

If a sentence was true about you most of the time, check TRUE.
If it was only sometimes true, check SOMETIMES.
If a sentence was not true about you, check NOT TRUE.

	True 2	**Sometimes 1**	**Not True 0**
1. I felt miserable or unhappy.	☐	☐	☐
2. I didn't enjoy anything at all.	☐	☐	☐
3. I felt so tired I just sat around and did nothing.	☐	☐	☐
4. I was very restless.	☐	☐	☐
5. I felt I was no good any more.	☐	☐	☐
6. I cried a lot.	☐	☐	☐
7. I found it hard to think properly or concentrate.	☐	☐	☐
8. I hated myself.	☐	☐	☐
9. I was a bad person.	☐	☐	☐
10. I felt lonely.	☐	☐	☐
11. I thought nobody really loved me.	☐	☐	☐
12. I thought I could never be as good as other kids.	☐	☐	☐
13. I did everything wrong.	☐	☐	☐

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Client ID#____________ Therapist ID#_____________ Date:_____________

SHORT MOOD AND FEELINGS QUESTIONNAIRE

Parent Report Version

This form is about how your child might have been feeling or acting recently.

For each question, please check how much she or he has felt or acted this way *in the past two weeks*.

If a sentence was true about your child most of the time, check TRUE.
If it was only sometimes true, check SOMETIMES.
If a sentence was not true about your child, check NOT TRUE.

	True 2	**Sometimes 1**	**Not True 0**
1. S/he felt miserable or unhappy.	☐	☐	☐
2. S/he didn't enjoy anything at all.	☐	☐	☐
3. S/he felt so tired s/he just sat around and did nothing.	☐	☐	☐
4. S/he was very restless.	☐	☐	☐
5. S/he felt s/he was no good any more.	☐	☐	☐
6. S/he cried a lot.	☐	☐	☐
7. S/he found it hard to think properly or concentrate.	☐	☐	☐
8. S/he hated him/herself.	☐	☐	☐
9. S/he felt s/he was a bad person.	☐	☐	☐
10. S/he felt lonely.	☐	☐	☐
11. S/he thought nobody really loved him/her.	☐	☐	☐
12. S/he thought s/he could never be as good as other kids.	☐	☐	☐
13. S/he felt s/he did everything wrong.	☐	☐	☐

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= # Trauma Screen

Name____________________________ Date______________

Stressful or scary events happen to many kids. 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.

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

Which one is bothering you the most now? ___________________

If you answered **NO** to all of the above questions, ***STOP***
If you answered **YES** to any of the above questions, please complete the rest of this form

When the event happened, did you feel?

Afraid I would die or be hurt badly. ☐ Yes ☐ No

Afraid someone else would die or be hurt badly. ☐ Yes ☐ No

Helpless to do anything. ☐ Yes ☐ No

Ashamed or disgusted. ☐ Yes ☐ No

Client ID:___________ Therapist ID:____________ Date: _____________

CHILD PTSD Symptom Scale (CPSS) - 7-17 years

Mark 0, 1, 2 or 3 for how often the following things have bothered you in the last two weeks:

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

1.	Having upsetting thoughts or images about the event that came into your head when you didn't want them to.	0	1	2	3
2.	Having bad dreams or nightmares.	0	1	2	3
3.	Acting or feeling as if the event was happening again.	0	1	2	3
4.	Feeling upset when you think about or hear about the event.	0	1	2	3
5.	Having feelings in your body when you think about or hear about the event. (Heart beating fast, upset stomach, breaking out in a sweat)	0	1	2	3
6.	Trying not to think about, talk about or have feelings about the event.	0	1	2	3
7.	Trying to avoid activities or people, or places that remind you of the event.	0	1	2	3
8.	Not being able to remember an important part of the upsetting event.	0	1	2	3
9.	Having much less interest or not doing the things you used to do.	0	1	2	3
10.	Not feeling too close to the people around you.	0	1	2	3
11.	Not being able to have strong feelings (being able to cry or feel really happy).	0	1	2	3
12.	Feeling as if your future hopes or plans will not come true.	0	1	2	3
13.	Having trouble falling or staying asleep.	0	1	2	3
14.	Feeling irritable or having fits of anger.	0	1	2	3
15.	Having trouble concentrating.	0	1	2	3
16.	Being overly careful (checking to see who is around you).	0	1	2	3
17.	Being jumpy or easily startled.	0	1	2	3

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

1. Saying prayers D Yes D No
2. Doing chores D Yes D No
3. Friendships D Yes D No
4. Hobbies/Fun D Yes D No
5. Schoolwork D Yes D No
6. Family relationships D Yes D No
7. General happiness D Yes D No

Client ID: ___________ Therapist ID:________ Date: ____________

CPSS Scoring Form- CHILD

CRITERION A – TRAUMATIC EVENT

FROM THE TRAUMA SCREEN

Exposure to Traumatic Event? **YES** **NO**

Type of event most distressing:

____

Criterion A1 met
Questions 1-15 at least 1 "Yes" answer **YES** **NO**

Criterion A2 met
At least one "Yes" answer below **YES** **NO**

Criterion A met **YES** **NO**

PTSD SEVERITY – OVERALL SCORE

FROM THE CPSS SYMPTOM SCALE

PTSD SEVERITY SCORE
Sum of questions 1-17: ________

INTERFERENCE SCORE
Sum of questions 1-7: ________

CRITERION B – REEXPERIENCING

FROM THE CPSS SYMPTOM SCALE

REEXPERIENCING SEVERITY SCORE

Sum of questions 1-5: ________

DSM-IV CRITERION B MET

# of questions 1-5 scores 2 or 3: _________

At least 1 question 1-5 score 2 or 3? **YES** **NO**

CRITERION C - AVOIDANCE

FROM THE CPSS SYMPTOM SCALE

AVOIDANCE SEVERITY SCORE

Sum of questions 6-12: ________

DSM-IV CRITERION C MET

# of questions 6-12 scores 2 or 3: _________

At least 3 question 6-12 scores 2 or 3? **YES** **NO**

CRITERION D – INCREASED AROUSAL

FROM THE CPSS SYMPTOM SCALE

INCREASED AROUSAL SEVERITY SCORE

Sum of questions 13-17: ________

DSM-IV CRITERION D MET

# of questions 13-17 scores 2 or 3: _________

At least 2 question 13-17 score 2 or 3? **YES** **NO**

DSM-IV PTSD DIAGNOSTIC INFO

DSM-IV FULL PTSD DIAGNOSIS LIKELY

Criteria A, B, C, D all met **YES** **NO**

PARTIAL PTSD LIKELY

Criteria A, and 2 other criteria met **YES** **NO**

= **Trauma Screen – Caregiver Completed**

Name____________________________ Date______________

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

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

Which one is bothering him/her the most now? ______________

If you answered **NO** to all of the above questions, ***STOP***
If you answered **YES** to any of the above questions, please complete the rest of this form.

When the event happened, did your child feel?

Afraid s/he would die or be hurt badly. ☐ Yes ☐ No

Afraid someone else would die or be hurt badly. ☐ Yes ☐ No

Helpless to do anything. ☐ Yes ☐ No

Ashamed or disgusted. ☐ Yes ☐ No

Client ID:___________ Therapist ID:____________ Date: _____________

Child PTSD Symptom Scale CPSS (4-17 years) Caregiver Completed

Mark 0, 1, 2 or 3 for how often the following things have bothered your child in the last two weeks:

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

1.	Your child having unwanted, upsetting thoughts or images about the traumatic event .	0	1	2	3
2.	Your child having bad dreams or nightmares.	0	1	2	3
3.	Your child acting or feeling as if the event were happening again.	0	1	2	3
4.	Your child feeling upset when s/he thinks about or hears about the event.	0	1	2	3
5.	Your child having feelings in the body when thinking or hearing about the event.(Heart beating fast, upset stomach, breaking out in a sweat).	0	1	2	3
6.	Your child trying not to think about, talk about or have feelings about the event.	0	1	2	3
7.	Your child trying to avoid activities or people, or places that remind you of the event.	0	1	2	3
8.	Your child not being able to remember an important part of the upsetting event.	0	1	2	3
9.	Your child having much less interest or not doing the things s/he used to do.	0	1	2	3
10.	Your child not feeling too close to the people around him/her.	0	1	2	3
11.	Your child not being able to have strong feelings (being able to cry or feel really happy).	0	1	2	3
12.	Your child feeling as if his/her future hopes or plans will not come true.	0	1	2	3
13.	Your child having trouble falling or staying asleep.	0	1	2	3
14.	Your child feeling irritable or having fits of anger.	0	1	2	3
15.	Your child having trouble concentrating.	0	1	2	3
16.	Your child being overly careful (checking to see who is around).	0	1	2	3
17.	Your child being jumpy or easily startled.	0	1	2	3

Please mark YES or NO if the problems above interfered with the following:

1. Saying prayers	D Yes	D No	5. Schoolwork	D Yes	D No
2. Doing chores	D Yes	D No	6. Family relationships	D Yes	D No
3. Friendships	D Yes	D No	7. General happiness	D Yes	D No
4. Hobbies/Fun	D Yes	D No			

Client ID: __________ Therapist ID:________ Date: ___________

CPSS Scoring Form- CAREGIVER

CRITERION A – TRAUMATIC EVENT	PTSD SEVERITY – OVERALL SCORE
FROM THE TRAUMA SCREEN Exposure to Traumatic Event? **YES NO** Type of event most distressing: _______________________________________ **Criterion A1 met** Questions 1-15 at least 1 "Yes" answer **YES NO** **Criterion A2 met** At least one "Yes" answer below **YES NO** **Criterion A met** **YES NO**	**FROM THE CPSS SYMPTOM SCALE** **PTSD SEVERITY SCORE** Sum of questions 1-17: ________ **INTERFERENCE SCORE** Sum of questions 1-7: ________

CRITERION B – REEXPERIENCING	CRITERION C - AVOIDANCE
FROM THE CPSS SYMPTOM SCALE **REEXPERIENCING SEVERITY SCORE** Sum of questions 1-5: ________ **DSM-IV CRITERION B MET** # of questions 1-5 scores 2 or 3: _________ At least 1 question 1-5 score 2 or 3? **YES NO**	**FROM THE CPSS SYMPTOM SCALE** **AVOIDANCE SEVERITY SCORE** Sum of questions 6-12: ________ **DSM-IV CRITERION C MET** # of questions 6-12 scores 2 or 3: _________ At least 3 question 6-12 scores 2 or 3? **YES NO**

CRITERION D – INCREASED AROUSAL	DSM-IV PTSD DIAGNOSTIC INFO
FROM THE CPSS SYMPTOM SCALE **INCREASED AROUSAL SEVERITY SCORE** Sum of questions 13-17: ________ **DSM-IV CRITERION D MET** # of questions 13-17 scores 2 or 3: _________ At least 2 question 13-17 score 2 or 3? **YES NO**	**DSM-IV FULL PTSD DIAGNOSIS LIKELY** Criteria A, B, C, D all met **YES NO** **PARTIAL PTSD LIKELY** Criteria A, and 2 other criteria met **YES NO**