CHILD STRESS DISORDERS CHECKLIST- SCREENING FORM (CSDC-SF) (v. 1.0- 3/04) Glenn N. Saxe, M.D. & Michelle Bosquet, Ph.D. National Child Traumatic Stress Network & Boston University School of Medicine

Child’s Name (or ID #): _________________ Age: _______ Sex: M  F
Person Completing Questionnaire: ______________________ Date ____________
Relationship to Child: ________________________________

Has your child experienced or witnessed an event that caused, or threatened to cause, serious harm to him or herself or to someone else? Please check any and all events (and age(s) of your child at the time of the event or events) below-

1) Car Accident    ____  Age(s) ____  5) Physical Illness   ____   Age(s) ____
2) Other Accident ____  Age(s) ____  6) Physical Assault  ____  Age(s) ____
3) Fire        ____  Age(s) ____  7) Sexual Assault     ____  Age(s) ____
4) Storm       ____  Age(s) ____  8) Any Other Event  ____  Age(s) ____

Directions: Below is a list of behaviors that describe children. For each item that describes your child NOW or WITHIN THE PAST MONTH, please circle 2 if the item is VERY TRUE or OFTEN TRUE of your child. Circle 1 if the item is SOMETHING or SOMETIMES TRUE of your child. If the item is NOT TRUE of your child, circle 0. Please answer all items as well as you can even if some do not seem to apply to your child. The term “event” refers to the most stressful experience that you have described above.

0 = Not True (as far as you know)  1 = Somewhat or Sometimes True  2 = Very True or Often True

0 1 2  1) Child gets very upset if reminded of the event.

0 1 2  2) Child reports more physical complaints when reminded of the event. For example, headaches, stomach-aches, nausea, difficulty breathing.

0 1 2  3) Child reports that he or she does not want to talk about the event.

0 1 2  4) Child startles easily. For example, he or she jumps when hears sudden or loud noises.