CHILD STRESS DISORDERS CHECKLIST- SCREENING FORM (CSDC-SF)

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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) ____
2) Other Accident ____ Age(s) ____
3) Fire ____ Age(s) ____
4) Storm ____ Age(s) ____
5) Physical Illness ____ Age(s) ____
6) Physical Assault ____ Age(s) ____
7) Sexual Assault ____ 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 **SOMEWHAT** 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.