UCLA PTSD INDEX FOR DSM-IV (Parent Version, Revision 1) © Page 1 of 5

Child's Name ________________________________ Age _______ Sex (Circle): Girl Boy
Person Completing this Form _______________________ Relationship to Child ____________
Today's Date (**write month, day and year**) ____________________ Grade in School ____________
School ________________ Teacher ______________________ Town __________________

Below is a list of VERY SCARY, DANGEROUS, OR VIOLENT things that sometimes happen to children. These are times where someone was HURT VERY BADLY OR KILLED, or could have been. Some children have had these experiences, some children have not had these experiences.

FOR EACH QUESTION: Check "Yes" if this scary thing **HAPPENED TO YOUR CHILD**
Check "No" if it **DID *NOT* HAPPEN TO YOUR CHILD**____

1) Being in a big earthquake that badly damaged the building your child was in. Yes [ ] No [ ]

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2) Being in another kind of **disaster**, like a fire, tornado, flood or hurricane. Yes [ ] No [ ]

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3) Being in a bad **accident**, like a **very serious** car accident. Yes [ ] No [ ]

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4) Being in place where a **war** was going on around your child. Yes [ ] No [ ]

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5) Being **hit, punched, or kicked very hard** at home.
(**DO NOT INCLUDE** ordinary fights between brothers & sisters). Yes [ ] No [ ]

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6) Seeing a family member being **hit, punched or kicked very hard** at home.
(**DO NOT INCLUDE** ordinary fights between brothers & sisters). Yes [ ] No [ ]

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7) Being **beaten up, shot at or threatened to be hurt badly** in your town. Yes [ ] No [ ]

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8) Seeing someone in your town being **beaten up, shot at or killed.** Yes [ ] No [ ]

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9) Seeing a **dead body** in your town (do not include funerals). Yes [ ] No [ ]

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10) Having an adult or someone much older touch your child's
private sexual body parts when your child did not want them to. Yes [ ] No [ ]

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11) Hearing about the **violent death or serious injury** of a loved one. Yes [ ] No [ ]

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12) Having **painful and scary medical treatment in a hospital** when your child
was very sick or badly injured. Yes [ ] No [ ]

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13) **OTHER** than the situations described above, has **ANYTHING ELSE** ever happened
to your child that was **REALLY SCARY, DANGEROUS, OR VIOLENT?** Yes [ ] No [ ]
Please write what happened: ____

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14) a) If you answered "YES" to only **ONE** thing in the above list of questions #1 to #13, place the number of that thing (#1 to #13) in this blank. # ____________

b) If you answered "YES" to **MORE THAN ONE THING,** place the number of the thing that **BOTHERS YOUR CHILD THE MOST NOW** in this blank. #___________

c) About how long ago did this bad thing (your answer to Aa≅ or Ab≅) happen to your child? __________

d) Please write what happened: ____

____

____

FOR THE *NEXT* QUESTIONS, please **CHECK "Yes, No, or Don't know"** to answer **HOW YOUR CHILD FELT during or right after** the experience happened that you just wrote about in Question 14. Only check "Don't Know" if you absolutely cannot give an answer.

Question	Yes	No	Don't know
15) Was your child afraid that he/she would die?	Yes [ ]	No [ ]	Don't know [ ]
16) Was your child afraid that he/she would be seriously injured?	Yes [ ]	No [ ]	Don't know [ ]
17) Was your child seriously injured?	Yes [ ]	No [ ]	
18) Was your child afraid that someone else would die?	Yes [ ]	No [ ]	Don't know [ ]
19) Was your child afraid that someone else would be seriously injured?	Yes [ ]	No [ ]	Don't know [ ]
20) Was someone else seriously injured?	Yes [ ]	No [ ]	
21) Did someone die?	Yes [ ]	No [ ]	
22) Did your child feel terrified?	Yes [ ]	No [ ]	Don't know [ ]
23) Did your child feel intense helplessness?	Yes [ ]	No [ ]	Don't know [ ]
24) Did your child feel horrified; was what he/she saw disgusting or gross?	Yes [ ]	No [ ]	Don't know [ ]
25) Did your child get hysterical or run around?	Yes [ ]	No [ ]	Don't know [ ]
26) Did your child feel very confused?	Yes [ ]	No [ ]	Don't know [ ]
27) Did your child feel like what was happening did not seem real in some way, like it was going on in a movie instead of real life?	Yes [ ]	No [ ]	Don't know [ ]

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Here is a list of problems children sometimes have after very stressful experiences. Please think about your child's stressful experience that you wrote about in Question #14. Then, read each problem on the list carefully. CIRCLE one of the numbers (0, 1, 2, 3, 4 or 5) that tells how often the problem has happened to your child **in the past month**. Refer to the **Rating Sheet** (on page 5) to help you decide how often the problem has happened. Note: If you are unsure about how often your child has experienced a particular problem, then try to make your best estimation. **Only** circle "**Don't Know"** if you absolutely **cannot** give an answer. **PLEASE BE SURE TO ANSWER ALL QUESTIONS**

	None	Little	Some	Much	Most	Don't Know
1[D4] My child watches out for danger or things that he/she is afraid of.	0	1	2	3	4	5
2[B4] When something reminds my child of what happened he/she gets very upset, scared or sad.	0	1	2	3	4	5
3[B1] My child has upsetting thoughts, pictures or sounds of what happened come into his/her mind when he/she does not want them to.	0	1	2	3	4	5
4[D2] My child feels grouchy, angry or mad.	0	1	2	3	4	5
5[B2] My child has dreams about what happened or other bad dreams	0	1	2	3	4	5
6[B3] My child has flashbacks of what happened; he/she feels like he/she is back at the time when the bad thing happened living through it again.	0	1	2	3	4	5
7[C4] My child feels like staying by him/her self and not being with his/her friends.	0	1	2	3	4	5
8[C5] My child feels alone inside and not close to other people.	0	1	2	3	4	5
9[C1] My child tries not to talk about, think about, or have feelings about what happened.	0	1	2	3	4	5
10[C6] My child has trouble feeling happiness or love.	0	1	2	3	4	5
11 [C6] My child has trouble feeling sadness or anger.	0	1	2	3	4	5
12[D5] My child feels jumpy or startles easily, for example, when he/she hears a loud noise or when something surprises him/her.	0	1	2	3	4	5
13[D1] My child has trouble going to sleep or wakes up often during the night.	0	1	2	3	4	5
14[AF] My child feels that some part of what happened is his/her fault.	0	1	2	3	4	5

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	None	Little	Some	Much	Most	Don't Know
15[C3] My child has trouble remembering important parts of what happened.	0	1	2	3	4	5
16[D3] My child has trouble concentrating or paying attention.	0	1	2	3	4	5
17[C2] My child tries to stay away from people, places, or things that make him/her remember what happened.	0	1	2	3	4	5
18[B5] When something reminds my child of what happened, he/she has strong feelings in his/her body like heart beating fast, head aches, or stomach aches.	0	1	2	3	4	5
19[C7] My child thinks that he/she will not live a long life.	0	1	2	3	4	5
20[AF] My child is afraid that the bad thing will happen again.	0	1	2	3	4	5
21[B1] My child plays games or draws pictures that are like some part of what happened.	0	1	2	3	4	5

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FREQUENCY RATING SHEET

HOW OFTEN OR HOW MUCH OF THE TIME DURING THE PAST MONTH, THAT IS SINCE ____________________, DOES THE PROBLEM HAPPEN?

0

NONE

S	M	T	W	H	F	S

NEVER

1

LITTLE

S	M	T	W	H	F	S
	X					
					X	

TWO TIMES A MONTH

2

SOME

S	M	T	W	H	F	S
		X			X	
		X				
			X			
		X		X		

1-2 TIMES A WEEK

3

MUCH

S	M	T	W	H	F	S
	X		X		X	
X		X		X		
	X		X		X	
X	X	X				

2-3 TIMES EACH WEEK

4

MOST

S	M	T	W	H	F	S
X	X	X	X	X	X	X
	X	X	X	X		
	X	X		X	X	
X	X	X	X	X	X	X

ALMOST EVERY DAY