## 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 glenn.saxe@bmc.org

Child's Name (or ID #):	Age:	Sex:	M	$\mathbf{F}$
Person Completing Questionnaire:		Date		
Relationship to Child:				
Has your child experienced or witnessed serious harm to him or herself or to some age(s) of your child at the time of the eve	one else? Please check			
1) Car Accident Age(s)	5) Physical Illness	Age	e(s)	
2) Other Accident Age(s)	6) Physical Assault	t Age	(s)	
3) Fire Age(s)	7) Sexual Assault	Age	(s)	
4) Storm Age(s)	8) Any Other Even	t Age	e(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.