

## Child and Adolescent Trauma Screen (CATS)

### SCORING

Child's Name: \_\_\_\_\_ Assessment Date: \_\_\_\_\_

Caregiver's Name: \_\_\_\_\_

Provider's Name: \_\_\_\_\_

#### CAREGIVER Report

Trauma Exposure: \_\_\_\_\_

Total PTSD Severity Score: \_\_\_\_\_ *Add ALL items, 1-20; Score of 12+ indicates need for treatment*

| Criteria  | # of Symptoms<br>(Only count items rated 2 or 3) | # Symptoms<br>Required | DSM-5 Criteria Met?          |                             |
|---|--|------------------------|------------------------------|-----------------------------|
| <b>Re-experiencing</b><br>Items 1-5                         |  | 1+                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>Avoidance</b><br>Items 6-7                               |  | 1+                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>Negative Mood/ Cognitions</b><br>Items 8-14              |  | 2+                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>Arousal</b><br>Items 15-20                               |  | 2+                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>Functional Impairment</b><br>Set of 1-5 Yes/No Questions |  | 1+                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

\*Age 6 & Under - Only need 1 symptom of avoidance OR negative mood/cognitions

#### CHILD Report

Trauma Exposure: \_\_\_\_\_

Total PTSD Severity Score: \_\_\_\_\_ *Add ALL items, 1-20; Score of 12+ indicates need for treatment*

| Criteria  | # of Symptoms<br>(Only count items rated 2 or 3) | # Symptoms<br>Required | DSM-5 Criteria Met?          |                             |
|---|--|------------------------|------------------------------|-----------------------------|
| <b>Re-experiencing</b><br>Items 1-5                         |  | 1+                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>Avoidance</b><br>Items 6-7                               |  | 1+                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>Negative Mood/ Cognitions</b><br>Items 8-14              |  | 2+                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>Arousal</b><br>Items 15-20                               |  | 2+                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>Functional Impairment</b><br>Set of 1-5 Yes/No Questions |  | 1+                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |