



Bounce Back Clinical Assessments: Initial Screening and Baseline

Instructions: Complete the following 2 assessments for each child

Screening Tools:

1. Trauma Exposure Checklist (TEC)
2. Child PTSD Symptom Scale (CPSS) (screening/baseline)

Client Initials: _____

Client ID: _____

Client Date of Birth: ____/____/____

**Initial Screening Results
Summary**

Please attach the client's 2 initial screening/baseline assessments to this cover page.

A. Trauma Exposure Checklist (TEC):

Number of identified exposures to trauma (number of "Yes" responses on TEC) = _____

(Note: minimum of 0 and maximum of 17)

B. Child PTSD Symptom Scale (CPSS):

Total Score (addition of responses to all 17 questions on CPSS) = _____

(Note: minimum of 0 and maximum of 51)

Next Steps: If Part A has a value of 1 or greater AND Part B has a value of 14 or greater, the client should be scheduled for in person interview with the Bounce Back Clinician/Group Leader to: 1) confirm the results of the screening and 2) complete an intake form.

Notes:

Client Initials: _____

Date of Completion: ____/____/____

Client ID: _____

Assessment Not Completed Reason:

Client Date of Birth: ____/____/____

- ☐ Too young
☐ Developmental delay
☐ Other:

Trauma Exposure Checklist

People may have stressful events happen to them. Read the list of stressful things below and circle YES for each of them that have EVER happened TO YOU. Circle NO if it has never happened to you.

Do not include things you may have only heard about from other people or from the TV, radio, news, or the movies. Only answer what has happened to you in real life. Some questions ask about what you SAW happen to someone else. And other questions ask about what actually happened to YOU.

SAMPLE:

a. Have you EVER gone to a basketball game? (Circle YES or NO)	Yes	No
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Have any of the following events EVER happened to you? (Circle Yes or No)

1. Have you been in a serious accident, where you could have been badly hurt or could have been killed?	Yes	No
2. Have you seen a serious accident, where someone could have been (or was) badly hurt or died?	Yes	No
3. Have you thought that you or someone you know would get badly hurt during a natural disaster such as a hurricane, flood, or earthquake?	Yes	No
4. Has anyone close to you been very sick or injured?	Yes	No
5. Has anyone close to you died?	Yes	No
6. Have you had a serious illness or injury, or had to be rushed to the hospital?	Yes	No
7. Have you had to be separated from your parent or someone you depend on for more than a few days when you didn't want to be?	Yes	No
8. Have you been attacked by a dog or other animal?	Yes	No
9. Has anyone told you they were going to hurt you?	Yes	No
10. Have you seen someone else being told they were going to be hurt?	Yes	No
11. Have you yourself been slapped, punched, or hit by someone?	Yes	No
12. Have you seen someone else being slapped, punched, or hit by someone?	Yes	No
13. Have you been beaten up?	Yes	No
14. Have you seen someone else getting beaten up?	Yes	No
15. Have you seen someone else being attacked or stabbed with a knife?	Yes	No
16. Have you seen someone pointing a real gun at someone else ?	Yes	No
17. Have you seen someone else being shot at or shot with a real gun?	Yes	No

Client Initials: _____

Date of Completion: ____/____/____

Client ID: _____

Assessment Not Completed Reason:

Client Date of Birth: ____/____/____

- ☐ Too young
☐ Developmental delay
☐ Other:

The Child PTSD Symptom Scale (CPSS)

Below is a list of problems that kids sometimes have after experiencing an upsetting event. Read each statement below carefully and circle the number (0-3) that best describes how often that problem has bothered you IN THE LAST 2 WEEKS.

0	1	2	3
Not at all or only one time	Once a week or less/once in a while	2 to 4 times a week/ half of the time	5 or more times a week/ almost always

1. Having upsetting thoughts or images about the event that came into your head when you didn't want them to	0	1	2	3
2. Having bad dreams or nightmares	0	1	2	3
3. Acting or feeling as if the event was happening again (hearing something or seeing a picture about it and feeling as if you are there again)	0	1	2	3
4. Feeling upset when you think about it or hear about the event (for example, feeling scared, angry, sad, guilty, etc.)	0	1	2	3
5. Having feelings in your body when thinking about or hearing about the event (for example, breaking out into a sweat, heart beating fast)	0	1	2	3
6. Trying not to think about, talk about, or have feelings about the event	0	1	2	3
7. Trying to avoid activities, people, or places that remind you of the event	0	1	2	3
8. Not being able to remember an important part of the upsetting event	0	1	2	3
9. Having much less interest or doing things you used to do	0	1	2	3
10. Not feeling close to people around you	0	1	2	3
11. Not being able to have strong feelings (for example, being unable to cry or unable to feel happy)	0	1	2	3
12. Feeling as if your future plans or hopes will not come true (for example, not having a job or getting married or having kids)	0	1	2	3
13. Having trouble falling or staying asleep	0	1	2	3
14. Feeling irritable or having fits of anger	0	1	2	3
15. Having trouble concentrating (for example, losing track of a story on the television, forgetting what you read, not paying)	0	1	2	3
16. Being overly careful (for example, checking to see who and what is around you)	0	1	2	3
17. Being jumpy or easily startled (for example, when someone walks up behind you)	0	1	2	3

(Add ratings together) Total _____