

EBP INTAKE ASSESSMENT PACKET

CBITS & BOUNCE BACK

English

Required Forms

1. Screening Data:
Alchemer Survey Completion
2. Demographic Information:
Client Intake Face Sheet
3. Child's Trauma History:
Trauma Exposure Checklist- Child Report
4. Child's Trauma Symptoms:
YCPC- Caregiver Report
5. Child's Behavior & Functioning:
Ohio- Child Report

Supplemental Assessments

Child Symptoms:

SMFQ (Child Depression Symptoms) – Child & Caregiver Report

PROMIS (Child Anxiety Symptoms) – Child & Caregiver Report

YCPC (Child Trauma Symptoms-for those with children under 7) – Caregiver Report

Caregiver Symptoms:

PSS (Caregiver Stress Symptoms)

PCL-5 (Caregiver Trauma Symptoms)

CESD-R (Caregiver Depression Symptoms)

Please collect this information during screening and enter into the monthly Alchemer Survey from CHDI.

Child Information

Clinician Assigned ID Number:					Age:			
Gender	<input type="checkbox"/>	Female	<input type="checkbox"/>	Transgender Female	<input type="checkbox"/>	Nonbinary	<input type="checkbox"/>	Preferred not to answer
	<input type="checkbox"/>	Male	<input type="checkbox"/>	Transgender Male	<input type="checkbox"/>	Another gender not listed		
Race/Ethnicity:	<input type="checkbox"/>	American Indian or Alaskan Native Non-Hispanic	<input type="checkbox"/>	Asian Non-Hispanic	<input type="checkbox"/>	Black/African American Non-Hispanic	<input type="checkbox"/>	Hispanic or Latino
	<input type="checkbox"/>	Native Hawaiian or Other Pacific Islander Non-Hispanic	<input type="checkbox"/>	White Non-Hispanic	<input type="checkbox"/>	Multiracial Non-Hispanic	<input type="checkbox"/>	Another Race Non-Hispanic
								<input type="checkbox"/>
Does this child qualify for the group based on screening criteria?					<input type="checkbox"/> Yes		<input type="checkbox"/> No	

Alchemer Survey: <https://app.alchemer.com/builder/build/id/7754888>

Clinician Name: _____

Date of Completion: ____/____/____

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	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
18. Have you ever seen something else that was very scary or where you thought somebody might get hurt or die? What was it? _____	Yes	No

YOUNG CHILD PTSD CHECKLIST (YCPC) (Caregiver: English)

For Child under 7 years old.

Below is a list of symptoms that children can have after life-threatening events.

When you think of ALL the life-threatening traumatic events from the first page, circle the number below (0-4) that best describes how often the symptom has bothered you in the LAST 2 WEEKS.

0	1	2	3	4
Not at all	Once a week/ Once in a while	2 to 4 times a week/ Half the time	5 or more times a week/ Almost always	Everyday

1.	Does your child have intrusive memories of the trauma? Does s/he bring it up on his/her own?	0	1	2	3	4
2.	Does your child re-enact the trauma in play with dolls or toys? This would be scenes that look just like the trauma. Or does s/he act it out by him/herself or with other kids?	0	1	2	3	4
3.	Is your child having more nightmares since the trauma(s) occurred?	0	1	2	3	4
4.	Does your child act like the traumatic event is happening to him/her again, even when it isn't? This is where a child is acting like they are back in the traumatic event and aren't in touch with reality. This is a pretty obvious thing when it happens.	0	1	2	3	4
5.	Since the trauma(s) has s/he had episodes when s/he seems to freeze? You may have tried to snap him/her out of it but s/he was unresponsive.	0	1	2	3	4
6.	Does s/he get upset when exposed to reminders of the event(s)? For example, a child who was in a car wreck might be nervous while riding in a car now. Or, a child who was in a hurricane might be nervous when it is raining. Or, a child who saw domestic violence might be nervous when other people argue. Or, a girl who was sexually abused might be nervous when someone touches her.	0	1	2	3	4
7.	Does your child get physically distressed when exposed to reminders? Like heart racing, shaking hands, sweaty, short of breath, or sick to his/her stomach? Think of the same type of examples as in #6.	0	1	2	3	4
8.	Does your child try to avoid conversations that might remind him/her of the trauma(s)? For example, if other people talk about what happened, does s/he walk away or change the topic?	0	1	2	3	4
9.	Does your child try to avoid things or places that remind him/her of the trauma(s)? For example, a child who was in a car wreck might try to avoid getting into a car. Or, a child who was in a flood might tell you not to drive over a bridge. Or, a child who saw domestic violence might be nervous to go in the house where it occurred. Or, a girl who was sexually abused might be nervous about going to bed because that's where she was abused before.	0	1	2	3	4
10.	Does your child have difficulty remembering the whole incident? Has s/he blocked out the entire event?					
11.	Has s/he lost interest in doing things that s/he used to like to do since the trauma(s)?	0	1	2	3	4
12.	Since the trauma(s), does your child show a restricted range of positive emotions on his/her face compared to before?	0	1	2	3	4

YCPC (Caregiver: English) continued

13.	Has your child lost hope for the future? For example, s/he believes will not have fun tomorrow, or will never be good at anything.					
14.	Since the trauma(s) has your child become more distant and withdrawn from family members, relatives, or friends?	0	1	2	3	4
15.	Has s/he had a hard time falling asleep or staying asleep since the trauma(s)?	0	1	2	3	4
16.	Has your child become more irritable, or had outbursts of anger, or developed extreme temper tantrums since the trauma(s)?	0	1	2	3	4
17.	Has your child had more trouble concentrating since the trauma(s)?	0	1	2	3	4
18.	Has s/he been more “on the alert” for bad things to happen? For example, does s/he look around for danger?	0	1	2	3	4
19.	Does your child startle more easily than before the trauma(s)? For example, if there’s a loud noise or someone sneaks up behind him/her, does s/he jump or seem startled?	0	1	2	3	4
20.	Has your child become more physically aggressive since the trauma(s)? Like hitting, kicking, biting, or breaking things.	0	1	2	3	4
21.	Has s/he become more clingy to you since the trauma(s)?	0	1	2	3	4
22.	Did night terrors start or get worse after the trauma(s)? Night terrors are different from nightmares: in night terrors a child usually screams in their sleep, they don’t wake up, and they don’t remember it the next day.	0	1	2	3	4
23.	Since the trauma(s), has your child lost previously acquired skills? For example, lost toilet training? Or, lost language skills? Or, lost motor skills working snaps, buttons, or zippers?	0	1	2	3	4
24.	Since the trauma(s), has your child developed any new fears about things that <u>don’t seem related</u> to the trauma(s)? What about going to the bathroom alone? Or, being afraid of the dark?	0	1	2	3	4
	FUNCTIONAL IMPAIRMENT Do the symptoms that you endorsed above get in the way of your child’s ability to function in the following areas?					
25.	Do (symptoms) substantially “get in the way” of how s/he gets along with you, interfere in your relationship, or make you feel upset or annoyed?	0	1	2	3	4
26.	Do these (symptoms) “get in the way” of how s/he gets along with brothers or sisters, and make them feel upset or annoyed?	0	1	2	3	4
27.	Do (symptoms) “get in the way” of how s/he gets along with friends at all – at daycare, school, or in your neighborhood?	0	1	2	3	4
28.	Do these (symptoms) “get in the way” with the teacher or the class more than average?	0	1	2	3	4
29.	Do (symptoms) make it harder for you to take him/her out in public than it would be with an average child? Is it harder to go out with your child to places like the grocery store? Or to a restaurant?	0	1	2	3	4
30.	Do you think that these behaviors cause your child to feel upset?	0	1	2	3	4

Young Child PTSD Checklist Caregiver Response Scale

0

Not at all

1

Once a
week/
Once in a
while

2

2 to 4 times
a week/
Half the
time

3

5 or more
times a week/
Almost
always

4

Everyday

Client Initials: _____

Client ID: _____

Date of Completion: ___/___/___

P



Ohio Mental Health Consumer Outcomes System
Ohio Youth Problem and Functioning Scales (Caregiver: English)
 Parent Rating – Short Form

Instructions: Please rate the degree to which your child has experienced the following problems in the past 30 days.	Not at All	Once or Twice	Several Times	Often	Most of the Time	All of the Time
1. Arguing with others	0	1	2	3	4	5
2. Getting into fights	0	1	2	3	4	5
3. Yelling, swearing, or screaming at others	0	1	2	3	4	5
4. Fits of anger	0	1	2	3	4	5
5. Refusing to do things teachers or parents ask	0	1	2	3	4	5
6. Causing trouble for no reason	0	1	2	3	4	5
7. Using drugs or alcohol	0	1	2	3	4	5
8. Breaking rules or breaking the law (out past curfew, stealing)	0	1	2	3	4	5
9. Skipping school or classes	0	1	2	3	4	5
10. Lying	0	1	2	3	4	5
11. Can't seem to sit still, having too much energy	0	1	2	3	4	5
12. Hurting self (cutting or scratching self, taking pills)	0	1	2	3	4	5
13. Talking or thinking about death	0	1	2	3	4	5
14. Feeling worthless or useless	0	1	2	3	4	5
15. Feeling lonely and having no friends	0	1	2	3	4	5
16. Feeling anxious or fearful	0	1	2	3	4	5
17. Worrying that something bad is going to happen	0	1	2	3	4	5
18. Feeling sad or depressed	0	1	2	3	4	5
19. Nightmares	0	1	2	3	4	5
20. Eating problems	0	1	2	3	4	5

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(Add ratings together) Total _____

January 2000 (Parent-1)

Response Scale for OHIO Problem Scale

0

Not at
all

1

Once or
twice

2

Several
times

3

Often

4

Most of
the time

5

All of
the time

Client Initials: _____

Client ID: _____

Date of Completion: ___/___/___

Ohio Youth Problem and Functioning Scales (Caregiver: English)

Parent Rating – Short Form continued

Instructions: Please rate the degree to which your child's problems affect his or her current ability in everyday activities. Consider your child's current level of functioning.	Extreme Troubles	Quite a Few Troubles	Some Troubles	OK	Doing Very Well
1. Getting along with friends	0	1	2	3	4
2. Getting along with family	0	1	2	3	4
3. Dating or developing relationships with boyfriends or girlfriends	0	1	2	3	4
4. Getting along with adults outside the family (teachers, principal)	0	1	2	3	4
5. Keeping neat and clean, looking good	0	1	2	3	4
6. Caring for health needs and keeping good health habits (taking medicines or brushing teeth)	0	1	2	3	4
7. Controlling emotions and staying out of trouble	0	1	2	3	4
8. Being motivated and finishing projects	0	1	2	3	4
9. Participating in hobbies (baseball cards, coins, stamps, art)	0	1	2	3	4
10. Participating in recreational activities (sports, swimming, bike riding)	0	1	2	3	4
11. Completing household chores (cleaning room, other chores)	0	1	2	3	4
12. Attending school and getting passing grades in school	0	1	2	3	4
13. Learning skills that will be useful for future jobs	0	1	2	3	4
14. Feeling good about self	0	1	2	3	4
15. Thinking clearly and making good decisions	0	1	2	3	4
16. Concentrating, paying attention, and completing tasks	0	1	2	3	4
17. Earning money and learning how to use money wisely	0	1	2	3	4
18. Doing things without supervision or restrictions	0	1	2	3	4
19. Accepting responsibility for actions	0	1	2	3	4
20. Ability to express feelings	0	1	2	3	4

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January 2000 (Parent-2)

(Add ratings together) Total _____

Response Scale for OHIO Functioning Scale

0

Extreme
troubles

1

Quite a few
troubles

2

Some
troubles

3

OK

4

Doing
very well

Intake Facesheet

VALIDATION REQUIREMENTS AND SYMBOLS EXPLAINED

- !** This symbol means the field is one of the minimum fields that must be filled out to save the record. No data will be saved unless these fields are completed.
- *** This symbol means the field is a required field in order to save the record as completed. Although you can save the record, the system does not consider the record to be completed unless ALL of these fields are completed.

Direct Service Provider User Information

Clinician First and Last Name: !		Sub-Team (CBITS/BB Only):	
Provider Name: !		Site Name: !	

Child Information

First Initial Child's First Name: !		First Initial Child's Last Name: !	
Date of Birth: !		Age:	
Sex: !	<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/> Intersex <input type="checkbox"/> Other (specify) →	
Grade (current): *			
Race: *	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Black or African American	<input type="checkbox"/> White
	<input type="checkbox"/> Asian	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	<input type="checkbox"/> Other (specify)
Hispanic Origin: *	<input type="checkbox"/> Yes, Cuban	<input type="checkbox"/> Yes, of Hispanic/Latino Origin	<input type="checkbox"/> Yes, South or Central American
	<input type="checkbox"/> Yes, Mexican, Mexican American, Chicano	<input type="checkbox"/> Yes, Puerto Rican	<input type="checkbox"/> No, Not of Hispanic, Latino, or Spanish Origin
City/town:		ST:	Zip: *

Child Identification Codes

Agency-assigned Client ID Number (not PHI): !		PSDCRS Client ID Number: !	
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Family Information

Caregiver 1 Relationship: *		Caregiver 2 Relationship:	
Preferred Language of Adult Participating in Treatment: *			
Does the adult participating in treatment speak English?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Primary Language of Child:			
Family Composition: * Select the choice that best describes the composition of the family.	<input type="checkbox"/> Two parent family	<input type="checkbox"/> Single parent - biological/adoptive parent	<input type="checkbox"/> Relative/guardian
	<input type="checkbox"/> Single Parent with unrelated partner	<input type="checkbox"/> Blended Family	<input type="checkbox"/> Other

Intake Facesheet

Living Situation of Child: * What is the child's living situation?	<input type="checkbox"/>	College Dormitory	<input type="checkbox"/>	Job Corps	<input type="checkbox"/>	Psychiatric Hospital
	<input type="checkbox"/>	Crisis Residence	<input type="checkbox"/>	Medical Hospital	<input type="checkbox"/>	Residential Treatment Facility
	<input type="checkbox"/>	DCF Foster Home	<input type="checkbox"/>	Mentor	<input type="checkbox"/>	TFC Foster Home (privately licensed)
	<input type="checkbox"/>	Group Home	<input type="checkbox"/>	Military Housing	<input type="checkbox"/>	Transitional Housing
	<input type="checkbox"/>	Homeless/Shelter	<input type="checkbox"/>	Other (specify):		
	<input type="checkbox"/>	Jail/Correctional Facility	<input type="checkbox"/>	Private Residence		
System Involvement						
Child/Family involved with DCF? *			<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
If child / family is involved with DCF, please complete ALL of the following questions:						
DCF Case ID: (if available)			DCF Person Link ID: (if available)			
DCF Status:	<input type="checkbox"/>	Child Protective Services – In-Home	<input type="checkbox"/>	Family with Service Needs – (FWSN) In-Home	<input type="checkbox"/>	Not DCF – On Probation
	<input type="checkbox"/>	Child Protective Services – Out of Home	<input type="checkbox"/>	Family with Service Needs (FWSN) Out of Home	<input type="checkbox"/>	Not DCF – Other Court Involved
	<input type="checkbox"/>	Dual Commitment (JJ and Child Protective Services)	<input type="checkbox"/>	Juvenile Justice (delinquency) commitment	<input type="checkbox"/>	Termination of Parental Rights
	<input type="checkbox"/>	Family Assessment Response	<input type="checkbox"/>	Not DCF	<input type="checkbox"/>	Voluntary Services Program
DCF Regional Office:						
Youth involved with Juvenile Justice (JJ) System? *			<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
If youth is involved with JJ, please complete ALL of the following questions:						
CSSD Client ID: (if available)			CSSD Case ID: (if available)			
CSSD Case Type:			<input type="checkbox"/>	Delinquency	<input type="checkbox"/>	Family with Service Needs (Status Offense)
CSSD Case Status:	<input type="checkbox"/>	Administrative Supervision	<input type="checkbox"/>	Juvenile probation	<input type="checkbox"/>	Restore Probation
	<input type="checkbox"/>	Extended Probation	<input type="checkbox"/>	Non-Judicial FWSN Family Service Agreement	<input type="checkbox"/>	Suspended Order
	<input type="checkbox"/>	Interim Orders	<input type="checkbox"/>	Non-Judicial Supervision (NJS)	<input type="checkbox"/>	Waived PDS - Probation
	<input type="checkbox"/>	Judicial FWSN Supervision	<input type="checkbox"/>	Non-Judicial Supervision Agreement	<input type="checkbox"/>	
Court District:						
Court Handling Decision:			<input type="checkbox"/>	Judicial	<input type="checkbox"/>	Non-Judicial
Specific Treatment Information						
What treatment model are you using with this child? *			<input type="checkbox"/>	CBITS	<input type="checkbox"/>	Bounce Back
			<input type="checkbox"/>	ARC	<input type="checkbox"/>	CPP
First Clinical Session Date: * Date of first EBP clinical session						

Intake Facesheet

Treatment Information						
Agency Referral Date/Request for Service: * Date child was referred to agency		Agency Intake Date: * What is the intake date for the client at the agency?				
Referral Date: * Date referred for EBP services						
CGI *- Considering your experience, how severe are the child's emotional, behavioral and/or cognitive concerns at the time of intake? Circle only one.*						
Normal Slightly severe Mildly severe Moderately severe Markedly severe Very Severe		Among the most severe symptoms that any child may experience				
Referral Source: * Select the source of the EBP referral	<input type="checkbox"/>	Child Youth-Family Support Center (CYFSC)	<input type="checkbox"/>	Family Advocate	<input type="checkbox"/>	Physician
	<input type="checkbox"/>	Community Natural Support	<input type="checkbox"/>	Foster Parent	<input type="checkbox"/>	Police
	<input type="checkbox"/>	Congregate Care Facility	<input type="checkbox"/>	Info-Line (211)	<input type="checkbox"/>	Probation/Court
	<input type="checkbox"/>	CTBHP/Insurer	<input type="checkbox"/>	Juvenile Probation / Court	<input type="checkbox"/>	Psychiatric Hospital
	<input type="checkbox"/>	DCF	<input type="checkbox"/>	Other Community Provider Agency	<input type="checkbox"/>	School
	<input type="checkbox"/>	Detention Involved	<input type="checkbox"/>	Other Program within Agency	<input type="checkbox"/>	Self/Family
	<input type="checkbox"/>	Emergency Department	<input type="checkbox"/>	Other State Agency		
Assessment Outcome: What was the outcome of the referral to the agency's EBP team? *	<input type="checkbox"/>	Assessment not completed	<input type="checkbox"/>	Not appropriate for selected EBP	<input type="checkbox"/>	No treatment needed
	<input type="checkbox"/>	Appropriate for selected EBP	<input type="checkbox"/>	Not appropriate for selected EBP but needs other treatment		
EBP Intake Date: !						
Treatment Information: School						
During the 3 months prior to the start of EBP treatment...						
Child's school attendance: *	<input type="checkbox"/>	Good (few or no days missed)	<input type="checkbox"/>	No School Attendance: Child Too Young for School	<input type="checkbox"/>	No School Attendance: Other
	<input type="checkbox"/>	Fair (several days missed)	<input type="checkbox"/>	No School Attendance: Child Suspended/Expelled from School		
	<input type="checkbox"/>	Poor (many days missed)	<input type="checkbox"/>	No School Attendance: Child Dropped Out of School		
Suspended or expelled: *	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No		
IEP: * Does the child have an Individual Education Plan (special education)?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No		
Treatment Information: Legal						
During the 3 months prior to the start of EBP treatment...						
Arrested: * Has the child been arrested since start of treatment?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No		
Detained or incarcerated: * Has the child been detained or incarcerated since start of treatment?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No		
Treatment Information: Medical						
During the 3 months prior to the start of EBP treatment...						
Alcohol and/or drugs problems: *	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No		
Evaluated in ER/ED for psychiatric issues: *	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No		
Certified medically complex: *	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No		