Supplemental Assessments

English

CHILD SYMPTOMS

1. SMFQ (Caregiver Depression)
   SMFQ-Caregiver Report
   SMFQ-Child Report

CAREGIVER SYMPTOMS

1. CESD-R (Caregiver Depression)

2. PCL5-Intake and PCL5-Periodic/Discharge (Caregiver Trauma)

3. Parental Stress Scale (Caregiver Stress)

4. Youth/Caregiver Satisfaction
   OHIO Satisfaction-Caregiver Report
   OHIO Satisfaction-Child Report

These are alternate or additional measures that can be used based on clinical judgment of primary symptom area targeted by treatment

Client Initials: _____ Client ID: _____ Date of Completion: ___/____/____

SHORT MOOD AND FEELINGS QUESTIONNAIRE (Caregiver: English)

I'm going to ask you some questions about how your child might have been feeling or acting recently.

For each question, please answer how much your child has felt or acted this way ***in the past two weeks***.

If a sentence was true about your child most of the time, check TRUE.
If it was only sometimes true, check SOMETIMES.
If a sentence was not true about your child, check NOT TRUE

	True	Sometimes	Not True
	2	**1**	**0**
1. S/he felt miserable or unhappy.	☐	☐	☐
2. S/he didn't enjoy anything at all.	☐	☐	☐
3. S/he felt so tired s/he just sat around and did nothing.	☐	☐	☐
4. S/he was very restless.	☐	☐	☐
5. S/he felt s/he was no good any more.	☐	☐	☐
6. S/he cried a lot.	☐	☐	☐
7. S/he found it hard to think properly or concentrate.	☐	☐	☐
8. S/he hated him/herself.	☐	☐	☐
9. S/he felt s/he was a bad person.	☐	☐	☐
10. S/he felt lonely.	☐	☐	☐
11. S/he thought nobody really loved him/her.	☐	☐	☐
12. S/he thought s/he could never be as good as other kids.	☐	☐	☐
13. S/he felt s/he did everything wrong.	☐	☐	☐

Response Scale for SMFQ

0	1	2
Not True	Sometimes	True

Client Initials: _____ Client ID: _____ Date of Completion: ___/____/____

SHORT MOOD AND FEELINGS QUESTIONNAIRE (Child: English)

This form is about how you might have been feeling or acting recently.

For each question, please check how much you have felt or acted this way ***in the past two weeks***.

If a sentence was true about you most of the time, check TRUE.
If it was only sometimes true, check SOMETIMES.
If a sentence was not true about you, check NOT TRUE.

	True	**Sometimes**	**Not True**
	2	**1**	**0**
1. I felt miserable or unhappy.	☐	☐	☐
2. I didn't enjoy anything at all.	☐	☐	☐
3. I felt so tired I just sat around and did nothing.	☐	☐	☐
4. I was very restless.	☐	☐	☐
5. I felt I was no good any more.	☐	☐	☐
6. I cried a lot.	☐	☐	☐
7. I found it hard to think properly or concentrate.	☐	☐	☐
8. I hated myself.	☐	☐	☐
9. I was a bad person.	☐	☐	☐
10. I felt lonely.	☐	☐	☐
11. I thought nobody really loved me.	☐	☐	☐
12. I thought I could never be as good as other kids.	☐	☐	☐
13. I did everything wrong.	☐	☐	☐

Response Scale for SMFQ

0	1	2
Not True	Sometimes	True

Client Initials: _____ Client ID: _____ Date of Completion: ___/____/____

Center for Epidemiologic Studies Depression Scale – Revised (CESD-R) (Caregiver: English)

Below is a list of the ways you might have felt or behaved. Please check the boxes to tell me how often you have felt this way in the past week or so.	Last Week				Nearly every day for 2 weeks
	Not at all *or* Less than 1 day	1 – 2 days	3 – 4 days	5 – 7 days	
My appetite was poor.	0	1	2	3	4
I could not shake off the blues.	0	1	2	3	4
I had trouble keeping my mind on what I was doing.	0	1	2	3	4
I felt depressed.	0	1	2	3	4
My sleep was restless.	0	1	2	3	4
I felt sad.	0	1	2	3	4
I could not get going.	0	1	2	3	4
Nothing made me happy.	0	1	2	3	4
I felt like a bad person.	0	1	2	3	4
I lost interest in my usual activities.	0	1	2	3	4
I slept much more than usual.	0	1	2	3	4
I felt like I was moving too slowly.	0	1	2	3	4
I felt fidgety.	0	1	2	3	4
I wished I were dead.	0	1	2	3	4
I wanted to hurt myself.	0	1	2	3	4
I was tired all the time.	0	1	2	3	4
I did not like myself.	0	1	2	3	4
I lost a lot of weight without trying to.	0	1	2	3	4
I had a lot of trouble getting to sleep.	0	1	2	3	4
I could not focus on the important things.	0	1	2	3	4

REFERENCE: Eaton, W. W., Smith, C., Ybarra, M., Muntaner, C., Tien, A. (2004). Center for Epidemiologic Studies Depression Scale: review and revision (CESD and CESD-R). In ME Maruish (Ed.). *The Use of Psychological Testing for Treatment Planning and Outcomes Assessment* (3rd Ed.), Volume 3: Instruments for Adults, pp. 363-377. Mahwah, NJ: Lawrence Erlbaum.

Response Scale for Caregiver Depression

0	1	2	3	4
Last week Not at all *or* less than 1 day	Last week 1-2 days	Last week 3-4 days	Last week 5-7 days	Nearly every day for 2 weeks

Client Initials: _____ Client ID: _____ Date of Completion: ___/____/____

PCL-5 (Caregiver Intake: English)

Instructions: These questions ask about very stressful experiences and how they might be affecting you.

1	Have you seen someone get seriously hurt, killed, or die suddenly?	Y	N
2	Have you been seriously hurt or injured by somebody else?	Y	N
3	Have you been forced or made to have unwanted sexual contact?	Y	N
4	Have you experienced any other very stressful or life threatening event?	Y	N

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	*Not at all*	*A little bit*	*Moderately*	*Quite a bit*	*Extremely*
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again *(as if you were actually back there reliving it)*?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience *(for example, heart pounding, trouble breathing, sweating)*?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience *(for example, people, places, conversations, activities, objects, or situations)*?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world *(for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completelydangerous)*?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4

Client Initials: _____ Client ID: _____ Date of Completion: ___/____/____

14. Trouble experiencing positive feelings *(for example, being unable to feel happiness or have loving feelings for people close to you)*?	**0**	**1**	**2**	**3**	**4**
15. Irritable behavior, angry outbursts, or acting aggressively?	**0**	**1**	**2**	**3**	**4**
16. Taking too many risks or doing things that could cause you harm?	**0**	**1**	**2**	**3**	**4**
17. Being "super alert" or watchful or on guard?	**0**	**1**	**2**	**3**	**4**
18. Feeling jumpy or easily startled?	**0**	**1**	**2**	**3**	**4**
19. Having difficulty concentrating?	**0**	**1**	**2**	**3**	**4**
20. Trouble falling or staying asleep?	**0**	**1**	**2**	**3**	**4**

Client Initials: _____ Client ID: _____ Date of Completion: ___/____/____

PCL-5 Caregiver Intake Scale

0	1	2	3	4
Not at all	A little bit	Moderately	Quite a bit	Extremely

Client Initials: _____ Client ID: _____ Date of Completion: ___/____/____

PCL-5 Periodic/Discharge (Caregiver: English)

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	*Not at all*	*A little bit*	*Moderately*	*Quite a bit*	*Extremely*
1. Repeated, disturbing, and unwanted memories of the stressful experience?	**0**	**1**	**2**	**3**	**4**
2. Repeated, disturbing dreams of the stressful experience?	**0**	**1**	**2**	**3**	**4**
3. Suddenly feeling or acting as if the stressful experience were actually happening again *(as if you were actually back there reliving it)*?	**0**	**1**	**2**	**3**	**4**
4. Feeling very upset when something reminded you of the stressful experience?	**0**	**1**	**2**	**3**	**4**
5. Having strong physical reactions when something reminded you of the stressful experience *(for example, heart pounding, trouble breathing, sweating)*?	**0**	**1**	**2**	**3**	**4**
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	**0**	**1**	**2**	**3**	**4**
7. Avoiding external reminders of the stressful experience *(for example, people, places, conversations, activities, objects, or situations)*?	**0**	**1**	**2**	**3**	**4**
8. Trouble remembering important parts of the stressful experience?	**0**	**1**	**2**	**3**	**4**
9. Having strong negative beliefs about yourself, other people, or the world *(for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completelydangerous)*?	**0**	**1**	**2**	**3**	**4**
10. Blaming yourself or someone else for the stressful experience or what happened after it?	**0**	**1**	**2**	**3**	**4**
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	**0**	**1**	**2**	**3**	**4**
12. Loss of interest in activities that you used to enjoy?	**0**	**1**	**2**	**3**	**4**
13. Feeling distant or cut off from other people?	**0**	**1**	**2**	**3**	**4**
14. Trouble experiencing positive feelings *(for example, being unable to feel happiness or have loving feelings for people close to you)*?	**0**	**1**	**2**	**3**	**4**
15. Irritable behavior, angry outbursts, or acting aggressively?	**0**	**1**	**2**	**3**	**4**
16. Taking too many risks or doing things that could cause you harm?	**0**	**1**	**2**	**3**	**4**
17. Being "super alert" or watchful or on guard?	**0**	**1**	**2**	**3**	**4**
18. Feeling jumpy or easily startled?	**0**	**1**	**2**	**3**	**4**
19. Having difficulty concentrating?	**0**	**1**	**2**	**3**	**4**
20. Trouble falling or staying asleep?	**0**	**1**	**2**	**3**	**4**

PCL-5 Caregiver Periodic/Discharge Scale

0	1	2	3	4
Not at all	A little bit	Moderately	Quite a bit	Extremely

Client Initials: _____ Client ID: _____ Date of Completion: ___/____/____

Parental Stress Scale (Caregiver: English)

The following statements describe feelings and perceptions about the experience of being a parent. Think of each of the items in terms of how your relationship with your child or children typically is. Please indicate the degree to which you agree or disagree with the following items by placing the appropriate number in the space provided.

1 = Strongly disagree	2 = Disagree	3 = Undecided	4 = Agree	5 = Strongly agree

Rating		
	1.	I am happy in my role as a parent.
	2.	There is little or nothing I wouldn't do for my child(ren) if it was necessary.
	3.	Caring for my child(ren) sometimes takes more time and energy than I have to give.
	4.	I sometimes worry whether I am doing enough for my child(ren).
	5.	I feel close to my child(ren).
	6.	I enjoy spending time with my child(ren).
	7.	My child(ren) is an important source of affection for me.
	8.	Having child(ren) gives me a more certain and optimistic view for the future.
	9.	The major source of stress in my life is my child(ren).
	10.	Having child(ren) leaves little time and flexibility in my life.
	11.	Having child(ren) has been a financial burden.
	12.	It is difficult to balance different responsibilities because of my child(ren).
	13.	The behavior of my child(ren) is often embarrassing or stressful to me.
	14.	If I had it to do over again, I might decide not to have child(ren).
	15.	I feel overwhelmed by the responsibility of being a parent.
	16.	Having child(ren) has meant having too few choices and too little control over my life.
	17.	I am satisfied as a parent.
	18.	I find my child(ren) enjoyable.

Scoring

To compute the parental stress score, items 1, 2, 5, 6, 7, 8, 17, and 18 should be reverse scored as follows: (1=5) (2=4) (3=3) (4=2) (5=1). The item scores are then summed.

Reference: Berry, J. O., & Jones, W. H. (1995). The Parental Stress Scale: Initial psychometric evidence. Journal of Social and Personal Relationships, 12, 463-472

Response Scale for Parent Stress

1	2	3	4	5
Strongly disagree	Disagree	Undecided	Agree	Strongly agree

Client Initials: _____ Client ID: _____ Date of Completion: ___/____/____

Satisfaction Questionnaire

P

Parent Rating –OHIO SATISFACTION SCALE (English)

Instructions: Please circle your response to each question.

1. How satisfied are you with the mental health services your child has received so far?

1. Extremely satisfied
2. Moderately satisfied
3. Somewhat satisfied
4. Somewhat dissatisfied
5. Moderately dissatisfied
6. Extremely dissatisfied

2. To what degree have you been included in the treatment planning process for your child?

1. A great deal
2. Quite a bit
3. Moderately
4. Somewhat
5. A little
6. Not at all

3. Mental health workers involved in my case listen to and value my ideas about treatment planning for my child.

1. A great deal
2. Quite a bit
3. Moderately
4. Somewhat
5. A little
6. Not at all

4. To what extent does your child's treatment plan include your ideas about your child's treatment needs?

1. A great deal
2. Quite a bit
3. Moderately
4. Somewhat
5. A little
6. Not at all

Total: _____

Client Initials: _____ Client ID: _____ Date of Completion: ___/____/____

Satisfaction Questionnaire

Y

Youth Rating – OHIO SATISFACTION SCALE

Form Completed By: ☐ Caregiver ☐ Child ☐ Other: _____

Instructions: Please circle your response to each question.

1. How satisfied are you with the mental health services you have received so far?

1. Extremely satisfied
2. Moderately satisfied
3. Somewhat satisfied
4. Somewhat dissatisfied
5. Moderately dissatisfied
6. Extremely dissatisfied

2. How much are you included in deciding your treatment?

1. A great deal
2. Quite a bit
3. Moderately
4. Somewhat
5. A little
6. Not at all

3. Mental health workers involved in my case listen to me and know what I want.

1. A great deal
2. Quite a bit
3. Moderately
4. Somewhat
5. A little
6. Not at all

4. I have a lot of say about what happens in my treatment.

1. A great deal
2. Quite a bit
3. Moderately
4. Somewhat
5. A little
6. Not at all

Total: _____