Child Health and Development Institute

CONNECTICUT Children & Families

EBP INTAKE ASSESSMENT PACKET

CBITS & BOUNCE BACK

English

Required Forms

1. Screening Data:
   Alchemer Survey Completion ☐

2. Child's Trauma History:
   Trauma Exposure Checklist- Child Report ☐

3. Child's Trauma Symptoms:
   YCPC- Caregiver Report ☐

4. Child's Behavior & Functioning:
   Ohio- Caregiver Report ☐

5. Demographic Information:
   Client Intake Facesheet ☐

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)

Screening Facesheet

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

Child Information

Client Assigned ID Number:					**Age:**			
Gender	❒·	Female	❒·	Transgender Female	❒·	Nonbinary	❒·	Preferred not to answer
	❒·	Male	❒·	Transgender Male	❒·	Another gender not listed		
Race/Ethnicity:	❒·	Black Non- Hispanic	❒·	White Non-Hispanic	❒·	Multiracial Non- Hispanic	❒·	Another Race Non- Hispanic
	❒·	Hispanic Black	❒·	Hispanic White	❒·	Hispanic Multiracial	❒·	Hispanic Another Race
							❒·	Preferred not to answer
Does this child qualify for the group based on screening criteria?						❒· Yes		❒· No

Client Assigned ID Number is the number assigned by agency/school/district for identification of the child.

Alchemer Survey: https://survey.alchemer.com/s3/7754888/UPDATED-CBITS-BB-Screening-Survey-March-2024-Version-2

Clinician Name: _____

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

Trauma Exposure Checklist

People may have stressful events happen to them. Read the list of stressful things below andcircle 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

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**

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 or less/ once in a while	2 to 4 times a week/ half the time	5 or more times a week/ almost always	Everyday

14. Does your child have intrusive memories of the trauma? Does s/he bring it up on his/her own?	0	1	2	3	4
15. 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
16. Is your child having more nightmares since the trauma(s) occurred?	0	1	2	3	4
17. 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
18. 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
19. 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
20. Does s/he get upset when exposed to reminders of the event(s)?	0	1	2	3	4

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.

21. 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?"	0	1	2	3	4

Think of the same type of examples as in #20.

22. Does your child show persistent negative emotions (fear, guilt, sadness, shame, confusion) that are <u>not</u> triggered by exposure to reminders of the event as in #20?	0	1	2	3	4

PLEASE CONTINUE ON NEXT PAGE…..

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

23. Does your child try to avoid people or 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
24. 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
25. 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
26. Since the trauma(s) has your child become more distant and withdrawn from family members, relatives, or friends?	0	1	2	3	4
27. 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
28. 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
29. 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
30. 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
31. Has your child had more trouble concentrating since the trauma(s)?	0	1	2	3	4
32. Has s/he had a hard time falling asleep or staying asleep since the trauma(s)?	0	1	2	3	4
33. Has your child become more physically aggressive since the trauma(s)? Like hitting, kicking, biting, or breaking things.	0	1	2	3	4
34. Has s/he become more clingy to you since the trauma(s)?	0	1	2	3	4

PLEASE CONTINUE ON NEXT PAGE…..

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

35. Since the trauma(s), has your child lost previously acquired skills? 0 1 2 3 4
    For example, lost toilet training?
    Or, lost language skills?
    Or, lost motor skills working snaps, buttons, or zippers?

36. Since the trauma(s), has your child developed any new fears about things that don't seem related to the trauma(s)? 0 1 2 3 4
    What about going to the bathroom alone?
    Or, being afraid of the dark?

FUNCTIONAL IMPAIRMENT

Do the symptoms that you endorsed above get in the way of your child's ability to function in the following areas?

0	1	2	3	4
Hardly ever/ none	Some of the time	About half the days	More than half the days	Everyday

37. 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

38. 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

39. Do these (symptoms) "get in the way" with the teacher or the class more than average? 0 1 2 3 4

40. 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

41. Do (symptoms) make it harder for you to take him/her out in public than it would be with an average child?" 0 1 2 3 4
    Is it harder to go out with your child to places like the grocery store?
    Or to a restaurant?

42. Do you think that these behaviors cause your child to feel upset? 0 1 2 3 4

version 12/9/13

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

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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

(Add ratings together) Total _____

January 2000 (Parent-1)

Response Scale for OHIO Problem Scale

0	1	2	3	4	5
Not at all	Once or twice	Several times	Often	Most of the time	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

 January 2000 (Parent-2)

(Add ratings together) Total _____

Response Scale for OHIO Functioning Scale

0	1	2	3	4
Extreme troubles	Quite a few troubles	Some troubles	OK	Doing very well

Child Health and Development Institute

Intake Facesheet

CONNECTICUT Children & Families

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: !	❒	Female	❒	Intersex	
	❒	Male	❒	Other (specify)→	
Grade (current): *					

Race: *
[select all that apply]

❒	**Declined/Not Disclosed**	❒	**Asian**				
❒	Decline to Identify	❒	Asian Indian	❒	Laotian		
❒	Unknown/Unsure	❒	Bangladeshi	❒	Malaysian		
❒	**American Indian or Alaska Native**	❒	Burmese	❒	Nepalese		
❒	Alaska Native	❒	Cambodian	❒	Pakistani		
❒	Cherokee	❒	Chinese	❒	Sri Lankan		
❒	Iroquois	❒	Filipino	❒	Taiwanese		
❒	Mashantucket Pequot	❒	Hmong	❒	Thai		
❒	Mohegan	❒	Indonesian	❒	Vietnamese		
❒	Other American Indian	❒	Japanese	❒	Other Asian		
		❒	Korean				
❒	**Black or African American**	❒	**Native Hawaiian or Other Pacific Islander**	❒	**White**		
❒	African			❒	Arab		
❒	African American	❒	Guamanian or Chamorro	❒	European		
❒	Dominican	❒	Native Hawaiian	❒	Middle Eastern or Northern African		
❒	Haitian	❒	Samoan				
❒	Jamaican	❒	Other Pacific Islander	❒	Portuguese		
❒	West Indian			❒	Other White		
❒	Other Black/African American						
❒	**Some other race, specify:**						

Hispanic Origin: * [select all that apply]	❒	Decline to Identify	❒	Unknown/Unsure/Not Disclosed	❒	No, Not Hispanic/ Latino/ Latina / Latine/ Spanish Origin
	❒	Yes, Argentinian	❒	Yes, Chilean	❒	Yes, Colombian
	❒	Yes, Cuban	❒	Yes, Dominican	❒	Yes, Ecuadorian
	❒	Yes, Guatemalan	❒	Yes, Honduran	❒	Yes, Mexican, Mexican American, Chicano/a
	❒	Yes, Nicaraguan	❒	Yes, Panamanian	❒	Yes, Peruvian
	❒	Yes, Puerto Rican	❒	Yes, Salvadoran	❒	Yes, Spaniard+
	❒	Yes, Spanish	❒	Yes, Uruguayan	❒	Yes, Venezuelan
	❒	Yes, Other Hispanic/Spanish				

City/town:		**ST:**		**Zip:** *	

Child Identification Codes

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

Family Information

Caregiver 1 Relationship: *		**Caregiver 2 Relationship:**			
Preferred Language of Adult Participating in Treatment: *					
Does the adult participating in treatment speak English?	❒	Yes, Very Well	❒	Yes, Well	❒	No, Not Well
	❒	No, Not at All	❒	Decline to Identify		
Primary Language of Child:						
Family Composition: * Select the choice that best describes the composition of the family.	❒	Two parent family	❒	Single parent - biological/adoptive parent	❒	Relative/guardian
	❒	Single Parent with unrelated partner	❒	Blended Family	❒	Other
Living Situation of Child: * What is the child's living situation?	❒	College Dormitory	❒	Job Corps	❒	Psychiatric Hospital
	❒	Crisis Residence	❒	Medical Hospital	❒	Residential Treatment Facility
	❒	DCF Foster Home	❒	Mentor	❒	TFC Foster Home (privately licensed)
	❒	Group Home	❒	Military Housing	❒	Transitional Housing
	❒	Homeless/Shelter	❒	Other (specify):		
	❒	Jail/Correctional Facility	❒	Private Residence		

Child Health and Development Institute

Intake Facesheet

CONNECTICUT Children & Families

System Involvement						
Child/Family involved with DCF? *			❒	Yes	❒	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:	❒	Child Protective Services – In-Home	❒	Family with Service Needs – (FWSN) In-Home	❒	Not DCF – On Probation
	❒	Child Protective Services – Out of Home	❒	Family with Service Needs (FWSN) Out of Home	❒	Not DCF – Other Court Involved
	❒	Dual Commitment (JJ and Child Protective Services)	❒	Juvenile Justice (delinquency) commitment	❒	Termination of Parental Rights
	❒	Family Assessment Response	❒	Not DCF	❒	Voluntary Services Program
DCF Regional Office:						
Youth involved with Juvenile Justice (JJ) System? *			❒	Yes	❒	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:			❒	Delinquency	❒	Family with Service Needs (Status Offense)
CSSD Case Status:	❒	Administrative Supervision	❒	Juvenile probation	❒	Restore Probation
	❒	Extended Probation	❒	Non-Judicial FWSN Family Service Agreement	❒	Suspended Order
	❒	Interim Orders	❒	Non-Judicial Supervision (NJS)	❒	Waived PDS - Probation
	❒	Judicial FWSN Supervision	❒	Non-Judicial Supervision Agreement	❒	
Court District:						
Court Handling Decision:			❒	Judicial	❒	Non-Judicial
Specific Treatment Information						
What treatment model are you using with this child? *			❒	CBITS	❒	Bounce Back
			❒	ARC	❒	CPP
First Clinical Session Date: * Date of first EBP clinical session						

Child Health and Development Institute

Intake Facesheet

CONNECTICUT Children & Families

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	❒	Child Youth-Family Support Center (CYFSC)	❒	Family Advocate	❒	Physician
	❒	Community Natural Support	❒	Foster Parent	❒	Police
	❒	Congregate Care Facility	❒	Info-Line (211)	❒	Probation/Court
	❒	CTBHP/Insurer	❒	Juvenile Probation / Court	❒	Psychiatric Hospital
	❒	DCF	❒	Other Community Provider Agency	❒	School
	❒	Detention Involved	❒	Other Program within Agency	❒	Self/Family
	❒	Emergency Department	❒	Other State Agency		
Assessment Outcome: What was the outcome of the referral to the agency's EBP team? *	❒	Assessment not completed	❒	Not appropriate for selected EBP	❒	No treatment needed
	❒	Appropriate for selected EBP	❒	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: *	❒	Good (few or no days missed)	❒	No School Attendance: Child Too Young for School	❒	No School Attendance: Other
	❒	Fair (several days missed)	❒	No School Attendance: Child Suspended/Expelled from School		
	❒	Poor (many days missed)	❒	No School Attendance: Child Dropped Out of School		
Suspended or expelled: *			❒	Yes	❒	No
IEP: *Does the child have an Individual Education Plan (special education)?			❒	Yes	❒	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?	❒	Yes	❒	No
Detained or incarcerated: * Has the child been detained or incarcerated since start of treatment?	❒	Yes	❒	No

Treatment Information: Medical

During the 3 months prior to the start of EBP treatment…

Alcohol and/or drugs problems: *	❒	Yes	❒	No
Evaluated in ER/ED for psychiatric issues: *	❒	Yes	❒	No
Certified medically complex: *	❒	Yes	❒	No