MATCH-ADTC Follow Up Forms (Monthly, Periodic, & Discharge)

English

Required Forms

1. MATCH-ADTC Monthly Session Form ☐

2. Top Problems Assessment ☐

3. Child's Behavior & Functioning*
   Ohio- Caregiver Report (child 5+) ☐
   Ohio- Child Report (child 12+) ☐

4. Chosen Assessment(s) specific to MATCH-ADTC* ☐
   Note: The recommended ongoing assessment for MATCH-ADTC is an age appropriate measure given the child's Primary Problem Area. We suggest the PROMIS for anxiety, SMFQ for Depression; CPSS (7+) or YCPC (under 7) for Trauma; and Ohio for Conduct. Alternate or additional measures can be used based on clinical judgment of primary symptom area targeted by treatment

5. Satisfaction Questions (caregiver or child)* ☐

6. Client Discharge Face Sheet ☐

***Required at periodic and discharge**

MATCH-ADTC Monthly Session Form

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.

Data Entry Person: Greyed-out fields are pulled in from the completed Client Face Sheet-Intake, so you won't have to enter them again here

Direct Service Provider User Information

Clinician First Name:		**Clinician Last Name:**	
Project Name:			

Child Information

First Initial of First Name:		**First Initial of Last Name:**		**Date of Birth:**	

Child Identification Codes

Provider Client ID:		**PSDCRS ID:**	

Session Information

Was there a visit this month? (Circle one)	❒	**Yes**	❒	**No**

Please check all MATCH Modules used this month:

Anxiety							
❒	Getting Acquainted - Anxiety	❒	Fear Ladder	❒	Learning Anxiety - Child	❒	Learning Anxiety - Parent
❒	Practicing	❒	Maintenance	❒	Wrap Up	❒	Cognitive STOP
Depression							
❒	Getting Acquainted - Depression	❒	Learning Depression – Child	❒	Learning Depression - Parent	❒	Problem Solving
❒	Activity Selection	❒	Learning to Relax	❒	Quick Calming	❒	Positive Self
❒	Cognitive BLUE	❒	Cognitive TLC	❒	Plans for Coping	❒	Wrap Up
Trauma							
❒	Safety Planning			❒	Trauma Narrative		
Conduct							
❒	Engaging Parents	❒	Learning about Behavior	❒	One-on-One Time	❒	Praise
❒	Active Ignoring	❒	Effective Instructions	❒	Rewards	❒	Time Out
❒	Making a Plan	❒	Daily Report Card	❒	Looking Ahead	❒	Booster Session
Assessment Measures							
❒	Using measures (administer or share results)						

MATCH-ADTC Monthly Session Form

Collaboration						
During this month, did you communicate with the child's:	❒	DCF Worker	❒	Probation officer	❒	Physician
	❒	School	❒	Other		
Collaboration Notes:						

Functioning						
Compared to the child's condition at the start of MATCH, this child's condition is:	❒	Very much improved since the initiation of treatment	❒	Much Improved	❒	Minimally improved
	❒	No change from baseline (the initiation of treatment)	❒	Minimally worse	❒	Much Worse
	❒	Very much worse since the initiation of treatment				

Session Fidelity Checklist						
Session Structure						
Prior to how many sessions this month did you prepare materials or a session plan?	❒	None (0%)	❒	Some (34-66%)	❒	All (100%)
	❒	A few (1-33%)	❒	Most (67-99%)		
During how many sessions this month did you assign homework?	❒	None (0%)	❒	Some (34-66%)	❒	All (100%)
	❒	A few (1-33%)	❒	Most (67-99%)		
During how many sessions this month did you review homework?	❒	None (0%)	❒	Some (34-66%)	❒	All (100%)
	❒	A few (1-33%)	❒	Most (67-99%)		
During how many sessions this month was a role play used?	❒	None (0%)	❒	Some (34-66%)	❒	All (100%)
	❒	A few (1-33%)	❒	Most (67-99%)		
During how many sessions this month did the child and/or caregiver practice a skill in session?	❒	None (0%)	❒	Some (34-66%)	❒	All (100%)
	❒	A few (1-33%)	❒	Most (67-99%)		
During how many sessions this month did you discuss a COW (crisis of the week)?	❒	None (0%)	❒	Some (34-66%)	❒	All (100%)
	❒	A few (1-33%)	❒	Most (67-99%)		
Since at least one COW was present, during how many sessions this month did you use the COW to illustrate a MATCH skill?	❒	None (0%)	❒	Some (34-66%)	❒	All (100%)
	❒	A few (1-33%)	❒	Most (67-99%)		

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

Top Problems Assessment (TPA)

CAREGIVER ASSESSMENT (English)

Please enter each top problem in the text box below.

How much has your child had each of the following problems during the past week? Use a 0 to 4 scale.

0=*not a problem* **4=*a very big problem***

Rank	Top Problem	Rating (0-4)
1		
2		
3		

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

PPSC (Caregiver: English)

18 months, 0 days to 65 months, 31 days

V1.06, 9-1-16

PRESCHOOL PEDIATRIC SYMPTOM CHECKLIST (PPSC)

These questions are about your child's behavior. Think about what you would expect of other children the same age, and tell us how much each statement applies to your child.

		Not at all	Somewhat	Very Much
Does your child...	Seem nervous or afraid?	0	1	2
	Seem sad or unhappy?	0	1	2
	Get upset if things are not done in a certain way?	0	1	2
	Have a hard time with change?	0	1	2
	Have trouble playing with other children?	0	1	2
	Break things on purpose?	0	1	2
	Fight with other children?	0	1	2
	Have trouble paying attention?	0	1	2
	Have a hard time calming down?	0	1	2
	Have trouble staying with one activity?	0	1	2
Is your child…	Aggressive?	0	1	2
	Fidgety or unable to sit still?	0	1	2
	Angry?	0	1	2
Is it hard to…	Take your child out in public?	0	1	2
	Comfort your child?	0	1	2
	Know what your child needs?	0	1	2
	Keep your child on a schedule or routine?	0	1	2
	Get your child to obey you?	0	1	2

Floating Hospital for Children at Tufts Medical Center

Response Scale for PPSC

0	1	2
Not at all	Somewhat	Very Much

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

(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: ___/____/____

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

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

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	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

Parent Proxy Anxiety – Short Form 8a

Please respond to each question or statement by marking one box per row.

In the past 7 days…	**Never**	**Almost Never**	**Sometimes**	**Often**	**Almost Always**
My child felt nervous.....	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
My child felt scared.....	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
My child felt worried.....	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
My child felt like something awful might happen.....	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
My child worried when he/she was at home	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
My child got scared really easy	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
My child worried about what could happen to him/her	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
My child worried when he/she went to bed at night	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Response Scale for PROMIS

1	2	3	4	5
Never	Almost	Sometimes	Often	Almost Always

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: ___/____/____

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: _____

Discharge Facesheet (MATCH-ADTC & TF-CBT)

! 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.

Data Entry Person: Greyed-out fields are pulled in from the completed Client Face Sheet-Intake, so you won't have to enter them again here

Direct Service Provider User Information

Clinician First Name:		**Clinician Last Name:**	
Project:		**Treatment Model Site:**	

Child Information

Grade (current): *	

Child Identification Codes

Provider's Unique Client ID:			**PSDCRS ID:**		
Which EBP?	❒	MATCH-ADTC	❒	TF-CBT	

Discharge Information

How many visits during this case:		**Discharge Date: *** _____/_____/_____
% of the total time spent with the child ONLY during this case:		**The total time spent for these three % questions should equal 100%**
% of the total time spent with the caregiver ONLY during this case:		**The total time spent for these three % questions should equal 100%**
% of the total time spent with the child and caregiver TOGETHER during this case:		**The total time spent for these three % questions should equal 100%**

CGI: Considering your experience, how severe are the child's emotional, behavioral, and/or cognitive concerns at discharge? (Circle one)*	Normal Slightly Severe Mildly Severe Moderately Severe Markedly Severe Very Severe Among the most severe symptoms that any child may experience		**CGI: Compared to the child's condition at intake, this child's condition is ____ (Circle one): ***	Very much improved Much improved Minimally improved No change Minimally worse Much worse Very much worse	

Discharge Reason: *	❒	Successfully completed selected EBP Model requirements-no more treatment needed	❒	Referred for other EBP (outpatient) within agency	❒	Family moved out of area
	❒	Successfully completed selected EBP Model requirements-continue with other treatment	❒	Referred for other non-EBP (outpatient) within agency	❒	Referred to other agency (outpatient)
	❒	Family discontinued treatment	❒	Referred to higher level of care	❒	Assessment Only-no treatment needed
	Other (specify):					

Discharge Facesheet (MATCH-ADTC & TF-CBT)

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: **DCF Regional Office:**	❒	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
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
Treatment Information: School						
Since 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						
Since 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						

Discharge Facesheet (MATCH-ADTC & TF-CBT)

Since 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

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