EBP ASSESSMENT PACKET

CPP
Ages 1-17 Months
English

Required Forms		
Measure	Intake	Periodic/Discharge
1. Demographic Information: Client Intake Face Sheet ☐	X	n/a
2. Child's Trauma History: *Trauma History Screen*- Caregiver Report ☐	X	n/a
3. Child's Trauma Symptoms: *YCPC*- Caregiver Report ☐	X	X
4. Child's Behavior & Functioning: *BPSC*- Caregiver Report	X	X
5. Caregiver Symptoms: *CESD-R Caregiver Depression* ☐	X	MUST select at least 1
6. Parental Capacity: *Parental Stress Scale* ☐	X	
7. Caregiver Trauma Symptoms: PCL-5 ☐	optional	
8. CPP Monthly Session form ☐	MONTHLY	
9. Discharge Face Sheet ☐	n/a	Discharge Only

Note: *The recommended ongoing assessment for CPP is an age appropriate measure of child symptoms and a measure of caregiver symptoms. We suggest the CESDR or Parental Stress Scale. Alternate or additional measures can be used based on clinical judgment of primary symptom area targeted by treatment.*

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: !	❒	Female	❒	Intersex	
	❒	Male	❒	Other (specify)→	
Grade (current): *					
Race: *	❒	American Indian or Alaska Native	❒	Black or African American	❒ White
	❒	Asian	❒	Native Hawaiian or Other Pacific Islander	❒ Other (specify)
Hispanic Origin: *	❒	Yes, Cuban	❒	Yes, of Hispanic/Latino Origin	❒ Yes, South or Central American
	❒	Yes, Mexican, Mexican American, Chicano	❒	Yes, Puerto Rican	❒ 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: !**	

Family Information

Caregiver 1 Relationship: *			**Caregiver 2 Relationship:**		
Preferred Language of Adult Participating in Treatment: *					
Does the adult participating in treatment speak English?			❒	Yes	❒ No
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

Intake Facesheet

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		

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				

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	❒	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

Client Initials: _____
ID: _____
Date: _____

Trauma History Screen (THS) (Caregiver: English)

	Directions: Ask how many times each event happened, and how much it affected the child when it happened and now (the worst time).	How many times has this happened?					The worst time this happened, how much **did it affect him/her?**					How much **does this still affect your child?**				
	"Has your child ever….."	Never	Once	2-3 times	4-10 times	10+ times	Not at all	A little bit	Moderately	Quite a bit	Extremely	Not at all	A little bit	Moderately	Quite a bit	Extremely
1	Been in or seen a very bad accident?						1	2	3	4	5	1	2	3	4	5
2	Had someone s/he know been so badly injured or sick that s/he almost died?						1	2	3	4	5	1	2	3	4	5
3	Known somebody who died?						1	2	3	4	5	1	2	3	4	5
4	Been so sick or hurt that you or the doctor thought s/he might die?						1	2	3	4	5	1	2	3	4	5
5	Been unexpectedly separated from someone who s/he depends on for love or security for more than a few days?						1	2	3	4	5	1	2	3	4	5
6	Had somebody close to him/her try to kill or hurt themself?						1	2	3	4	5	1	2	3	4	5
7	Been physically hurt or threatened by someone?						1	2	3	4	5	1	2	3	4	5
8	Been robbed or seen someone get robbed?						1	2	3	4	5	1	2	3	4	5
9	Been kidnapped by somebody?						1	2	3	4	5	1	2	3	4	5
10	Been in or seen a hurricane, earthquake, tornado, or bad fire?						1	2	3	4	5	1	2	3	4	5
11	Been attacked by a dog or other animal?						1	2	3	4	5	1	2	3	4	5
12	Seen or heard people physically fighting or threatening to hurt each other?						1	2	3	4	5	1	2	3	4	5
13	Seen or heard somebody shooting a gun, using a knife, or using another weapon?						1	2	3	4	5	1	2	3	4	5
14	Seen a family member arrested or in jail?						1	2	3	4	5	1	2	3	4	5
15	Had a time in your life when s/he did not have the right care (e.g. food, clothing, a place to live)?						1	2	3	4	5	1	2	3	4	5
16	Been forced to see or do something sexual?						1	2	3	4	5	1	2	3	4	5
17	Seen or heard someone else being forced to do something sexual?						1	2	3	4	5	1	2	3	4	5
18	Watched people using drugs (like smoking, sniffing, or using needles)?						1	2	3	4	5	1	2	3	4	5
19	Seen something else that was very scary or where s/he thought somebody might get hurt or die? **Specify:**_____						1	2	3	4	5	1	2	3	4	5

20. Which one **bothers your child the MOST** right now: # _____ How long ago did it happen: _____

Lang, J.M., & Franks, R. (2007). Adapted *from the TESI (Ford & Rogers, 1997) and the THQ (Stover et al., 2007)*

Response Scale for THS

1	2	3	4	5
Not at All	Little Bit	Moderately	Quite A bit	Extremely

Lang, J.M., & Franks, R. Connecticut Center for Effective Practice, CHDI (2007)

Client Initials: _____
ID: _____
Date: _____

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

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 don't seem related 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

BPSC (Caregiver: English)

1 month, 0 days to 17 months, 31 days

V1.06, 9-1-16

Client Initials: _____

ID: _____

Date: _____

BABY PEDIATRIC SYMPTOM CHECKLIST (BPSC)

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 have a hard time being with new people?	0	1	2
Does your child have a hard time in new places?	0	1	2
Does your child have a hard time with change?	0	1	2
Does your child mind being held by other people?	0	1	2
Does your child cry a lot?	0	1	2
Does your child have a hard time calming down?	0	1	2
Is your child fussy or irritable?	0	1	2
Is it hard to comfort your child?	0	1	2
Is it hard to keep your child on a schedule or routine?	0	1	2
Is it hard to put your child to sleep?	0	1	2
Is it hard to get enough sleep because of your child?	0	1	2
Does your child have trouble staying asleep?	0	1	2

Floating Hospital for Children at Tufts Medical Center

Response Scale for BPSC

0	1	2
Not at all	Somewhat	Very Much

Client Initials: _____
ID: _____
Date: _____

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: ___/____/____

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: _____
ID: _____
Date: _____

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

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 Intake Scale

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

Client Initials: _____
ID: _____
Date: _____

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 completely dangerous)*?	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

CPP 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 User ID:			
Clinician First Name:		**Clinician Last Name:**	
Organization Name:		**Site Name:**	

Child Information

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

Child Identification Codes

Agency-assigned Client ID Number (not PHI):		**PSDCRS Client ID Number:**	
CSSD Client ID Number:		**CSSD Case Number:**	
DCF Case ID:		**DCF Person Link ID:**	

Session Information

Total Number of Visits this month:		**Total Number of No-Show Appointments this month:**		**Total Number of Visits this month conducted via telehealth:**	
% of the total time spent with the child ONLY during this month:		**The total time spent for these three % questions should equal 100%**			
% of the total time spent with the caregiver ONLY during this month:		**The total time spent for these three % questions should equal 100%**			
% of the total time spent with the child and caregiver TOGETHER during this month:		**The total time spent for these three % questions should equal 100%**			

Phase of Treatment

❒	Foundational	❒	Core Intervention	❒	Termination	❒	Completed Termination

Activities						
Please check activities/CPP objectives focused on this month:	❒	Convey Hope	❒	Develop Empathic Relationship with Family Members	❒	Enhance Safety
	❒	Strengthen Family Relationships: Promote Emotional Reciprocity	❒	Coordinate Care	❒	Strengthen Dyadic Affect Regulation Capacities
	❒	Strengthen Dyadic Body-Based Regulation	❒	Support Child's Relationship with Other Important Caregivers	❒	Enhance Understanding of the Meaning of Behavior
	❒	Support Child in Returning to a Normal Developmental Trajectory	❒	Normalize the Traumatic Response	❒	Support Dyad in Acknowledging the Impact of Trauma
	❒	Help Dyad Differentiate Between Then and Now	❒	Help Dyad Put the Traumatic Experience in Perspective		
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 CPP, this child's condition is: (CGI-I)	❒	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	❒	Some	❒	ALL
	❒	A few	❒	Most		
During how many sessions this month was homework assigned or reviewed?	❒	None	❒	Some	❒	ALL
	❒	A few	❒	Most		
During how many sessions this month were COWS saved for the end of the session?	❒	None	❒	Some	❒	ALL
	❒	A few	❒	Most		
During how many sessions this month did the child and/or caregiver practice/demonstrate skill(s) in session (behavior rehearsal)?	❒	None	❒	Some	❒	ALL
	❒	A few	❒	Most		

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Discharge Facesheet

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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: !**	

Child Information

Child First Initial: !		**Child Last Initial :!**	

Child Identification Codes

Which EBP?	❒	**ARC**	❒	**CBITS**	❒	**Bounce Back**	❒	**CPP**

Discharge Information

Discharge Date: * _____/_____/_____

CGI: **Considering your experience, how severe are the child's emotional, behavioral, and/or cognitive concerns at the time of 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):					

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

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Discharge Facesheet

	❒	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						
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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