

CPSS

The Child PTSD Symptom Scale (CPSS) – Part I

Clinic Number

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Study ID Number

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Visit Number

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Subject ID Number

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Rater Number

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Below is a list of problems that kids sometimes have after experiencing an upsetting event. Read each one carefully and fill in the number (0-3) that best describes how often that problem has bothered you IN THE LAST 2 WEEKS.

Please write down your most distressing event:

Length of time since the event:

	-	<input type="checkbox"/>	<input type="checkbox"/>	◀	
	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	
1.	-	<input type="checkbox"/>	<input type="checkbox"/>	◀	Having upsetting thoughts or images about the event that came into your head when you didn't want them to
2.	-	<input type="checkbox"/>	<input type="checkbox"/>	◀	Having bad dreams or nightmares
3.	-	<input type="checkbox"/>	<input type="checkbox"/>	◀	Acting or feeling as if the event was happening again (hearing something or seeing a picture about it and feeling as if you are there again)
4.	-	<input type="checkbox"/>	<input type="checkbox"/>	◀	Feeling upset when you think about or hear about the event (for example, feeling scared, angry, sad, guilty, etc)
5.	-	<input type="checkbox"/>	<input type="checkbox"/>	◀	Having feelings in your body when you think about or hear about the event (for example, breaking out into a

Initials: _____

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sweat, heart beating fast)

- | | - | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ◀ | |
|-----|------------|--------------------------|---|---------------------------------------|---|--|
| | 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 | |
| 6. | - | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ◀ | Trying not to think about, talk about, or have feelings about the event |
| 7. | - | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ◀ | Trying to avoid activities, people, or places that remind you of the traumatic event |
| 8. | - | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ◀ | Not being able to remember an important part of the upsetting event |
| 9. | - | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ◀ | Having much less interest in doing things you used to do |
| 10. | - | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ◀ | Not feeling close to people around you |
| 11. | - | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ◀ | Not being able to have strong feelings (for example, being unable to cry or unable to feel happy) |
| 12. | - | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ◀ | Feeling as if your future plans or hopes will not come true (for example, you will not have a job or get married or have kids) |
| 13. | - | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ◀ | Having trouble falling or staying asleep |
| 14. | - | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ◀ | Feeling irritable or having fits of anger |
| 15. | - | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ◀ | Having trouble concentrating (for example, losing track of a story on the television, forgetting what you read, not paying attention in class) |
| 16. | - | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ◀ | Being overly careful (for example, checking to see who is around you and what is around you) |
| 17. | - | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ◀ | Being jumpy or easily startled (for example, when someone walks up behind you) |

Initials: _____
Date: _____

The Child PTSD Symptom Scale (CPSS) – Part 2

Indicate below if the problems you rated in Part 1 have gotten in the way with any of the following areas of your life DURING THE PAST 2 WEEKS.

- | | Yes | No | |
|-----|--------------------------|----|----------------------------------|
| 18. | <input type="checkbox"/> | - | Doing your prayers |
| 19. | <input type="checkbox"/> | - | Chores and duties at home |
| 20. | <input type="checkbox"/> | - | Relationships with friends |
| 21. | <input type="checkbox"/> | - | Fun and hobby activities |
| 22. | <input type="checkbox"/> | - | Schoolwork |
| 23. | <input type="checkbox"/> | - | Relationships with your family |
| 24. | <input type="checkbox"/> | - | General happiness with your life |