

# EBP INTAKE ASSESSMENT PACKET

## TF-CBT & MATCH-ADTC

**Ages 5-6 Years**  
**English**

### Required Forms

1. Demographic Information:  
Client Intake Face Sheet ☐
2. Child's Trauma History:  
*Trauma History Screen*- Caregiver Report ☐
3. Child's Trauma Symptoms:  
*YCPC*- Caregiver Report ☐
4. Child's Behavior & Functioning:  
*Ohio*- Caregiver Report ☐
5. CESD-R (Caregiver Depression) ☐

### Supplemental Assessments

(Included in Supplemental Assessment Packet)

Child Depression:

*SMFQ*- Child Report

*SMFQ*- Caregiver Report

Child Anxiety:

*PROMIS* - Child Report

*PROMIS* - Caregiver Report

Caregiver Symptoms:

*PSS* (Parenting Stress)

*PCL-5* (Caregiver Trauma Symptoms)

# 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: !**

**Treatment Setting:**

**Circle only ONE**

Administrative  
Agency-Based School  
Community Support  
CSSD

CYFSC  
DCF  
Detention/Corrections  
Extended Day Treatment

Group Home  
Hospital  
In-Home  
Outpatient Clinic

Psych Residential Treatment Facility  
Residential Treatment Center  
School-Based  
S-FIT

Shelter  
Training Only  
Other

## 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

<b>Living Situation of Child: *</b> What is the child's living situation?	<input type="checkbox"/>	College Dormitory	<input type="checkbox"/>	Job Corps	<input type="checkbox"/>	Psychiatric Hospital
	<input type="checkbox"/>	Crisis Residence	<input type="checkbox"/>	Medical Hospital	<input type="checkbox"/>	Residential Treatment Facility
	<input type="checkbox"/>	DCF Foster Home	<input type="checkbox"/>	Mentor	<input type="checkbox"/>	TFC Foster Home (privately licensed)
	<input type="checkbox"/>	Group Home	<input type="checkbox"/>	Military Housing	<input type="checkbox"/>	Transitional Housing
	<input type="checkbox"/>	Homeless/Shelter	<input type="checkbox"/>	Other (specify):		
	<input type="checkbox"/>	Jail/Correctional Facility	<input type="checkbox"/>	Private Residence		
<b>System Involvement</b>						
<b>Child/Family involved with DCF? *</b>		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	
<b>If child / family is involved with DCF, please complete ALL of the following questions:</b>						
<b>DCF Case ID: (if available)</b>				<b>DCF Person Link ID: (if available)</b>		
<b>DCF Status:</b>	<input type="checkbox"/>	Child Protective Services – In-Home	<input type="checkbox"/>	Family with Service Needs – (FWSN) In-Home	<input type="checkbox"/>	Not DCF – On Probation
	<input type="checkbox"/>	Child Protective Services – Out of Home	<input type="checkbox"/>	Family with Service Needs (FWSN) Out of Home	<input type="checkbox"/>	Not DCF – Other Court Involved
	<input type="checkbox"/>	Dual Commitment (JJ and Child Protective Services)	<input type="checkbox"/>	Juvenile Justice (delinquency) commitment	<input type="checkbox"/>	Termination of Parental Rights
	<input type="checkbox"/>	Family Assessment Response	<input type="checkbox"/>	Not DCF	<input type="checkbox"/>	Voluntary Services Program
<b>DCF Regional Office:</b>						
<b>Youth involved with Juvenile Justice (JJ) System? *</b>		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	
<b>If youth is involved with JJ, please complete ALL of the following questions:</b>						
<b>CSSD Client ID: (if available)</b>				<b>CSSD Case ID: (if available)</b>		
<b>CSSD Case Type:</b>			<input type="checkbox"/>	Delinquency	<input type="checkbox"/>	Family with Service Needs (Status Offense)
<b>CSSD Case Status:</b>	<input type="checkbox"/>	Administrative Supervision	<input type="checkbox"/>	Juvenile probation	<input type="checkbox"/>	Restore Probation
	<input type="checkbox"/>	Extended Probation	<input type="checkbox"/>	Non-Judicial FWSN Family Service Agreement	<input type="checkbox"/>	Suspended Order
	<input type="checkbox"/>	Interim Orders	<input type="checkbox"/>	Non-Judicial Supervision (NJS)	<input type="checkbox"/>	Waived PDS - Probation
	<input type="checkbox"/>	Judicial FWSN Supervision	<input type="checkbox"/>	Non-Judicial Supervision Agreement	<input type="checkbox"/>	
<b>Court District:</b>						
<b>Court Handling Decision:</b>			<input type="checkbox"/>	Judicial	<input type="checkbox"/>	Non-Judicial
<b>Specific Treatment Information</b>						
<b>What treatment model are you using with this child? *</b>		<input type="checkbox"/>	TF-CBT	<input type="checkbox"/>	MATCH-ADTC	
<b>First Clinical Session Date: *</b> Date of first EBP clinical session						

# Intake Facesheet

Treatment Information						
<b>Agency Referral Date/Request for Service: *</b> Date child was referred to agency			<b>Agency Intake Date: *</b> What is the intake date for the client at the agency?			
<b>Referral Date: *</b> Date referred for EBP services	<b>Intake Date: !</b> EBP Intake Date					
<b>Referral Source: *</b> Select the source of the EBP referral	<input type="checkbox"/>	Child Youth-Family Support Center (CYFSC)	<input type="checkbox"/>	Family Advocate	<input type="checkbox"/>	Physician
	<input type="checkbox"/>	Community Natural Support	<input type="checkbox"/>	Foster Parent	<input type="checkbox"/>	Police
	<input type="checkbox"/>	Congregate Care Facility	<input type="checkbox"/>	Info-Line (211)	<input type="checkbox"/>	Probation/Court
	<input type="checkbox"/>	CTBHP/Insurer	<input type="checkbox"/>	Juvenile Probation / Court	<input type="checkbox"/>	Psychiatric Hospital
	<input type="checkbox"/>	DCF	<input type="checkbox"/>	Other Community Provider Agency	<input type="checkbox"/>	School
	<input type="checkbox"/>	Detention Involved	<input type="checkbox"/>	Other Program within Agency	<input type="checkbox"/>	Self/Family
	<input type="checkbox"/>	Emergency Department	<input type="checkbox"/>	Other State Agency		
<b>Assessment Outcome:</b> What was the outcome of the referral to the agency's EBP team? *	<input type="checkbox"/>	Assessment not completed	<input type="checkbox"/>	Not appropriate for selected EBP	<input type="checkbox"/>	No treatment needed
	<input type="checkbox"/>	Appropriate for selected EBP	<input type="checkbox"/>	Not appropriate for selected EBP but needs other treatment		
<b>CGI: Considering your experience, how severe are the child's emotional, behavioral, and/or cognitive concerns at the time of Intake? Circle only ONE:*</b> Normal    Slightly Severe    Mildly Severe    Moderately Severe    Markedly Severe    Very Severe    Among the most severe symptoms that any child may experience						
Treatment Information: School						
During the 3 months prior to the start of EBP treatment...						
<b>Child's school attendance: *</b>	<input type="checkbox"/>	Good (few or no days missed)	<input type="checkbox"/>	No School Attendance: Child Too Young for School	<input type="checkbox"/>	No School Attendance: Other
	<input type="checkbox"/>	Fair (several days missed)	<input type="checkbox"/>	No School Attendance: Child Suspended/Expelled from School		
	<input type="checkbox"/>	Poor (many days missed)	<input type="checkbox"/>	No School Attendance: Child Dropped Out of School		
<b>Suspended or expelled: *</b>			<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<b>IEP: *</b> Does the child have an Individual Education Plan (special education)?			<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Treatment Information: Legal						
During the 3 months prior to the start of EBP treatment...						
<b>Arrested: *</b> Has the child been arrested since start of treatment?			<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<b>Detained or incarcerated: *</b> Has the child been detained or incarcerated since start of treatment?			<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Treatment Information: Medical						
During the 3 months prior to the start of EBP treatment...						
<b>Alcohol and/or drugs problems: *</b>			<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<b>Evaluated in ER/ED for psychiatric issues: *</b>			<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<b>Certified medically complex: *</b>			<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

Client Initials: \_\_\_\_\_

Client ID: \_\_\_\_\_

Date of Completion: \_\_\_\_/\_\_\_\_/\_\_\_\_

**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.		How many times has this happened?					The worst time this happened, how much <b>did it</b> affect him/her?					How much <b>does this still affect</b> your child?				
		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
	“Has your child ever....”															
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 himself?						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? <b>Specify:</b> _____						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: \_\_\_\_\_

# Response Scale for THS

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

**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

**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
	<b>FUNCTIONAL IMPAIRMENT</b> 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

Not at all

1

Once a  
week/  
Once in a  
while

2

2 to 4 times  
a week/  
Half the  
time

3

5 or more  
times a week/  
Almost  
always

4

Everyday

Client Initials: \_\_\_\_\_

Client ID: \_\_\_\_\_

Date of Completion: \_\_\_\_/\_\_\_\_/\_\_\_\_



## Ohio Mental Health Consumer Outcomes System

### Ohio Youth Problem and Functioning Scales (Caregiver: English)

#### Parent Rating – Short Form

**P**

<b>Instructions:</b> 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

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(Add ratings together) Total \_\_\_\_\_

January 2000 (Parent-1)

# **Response Scale for OHIO Problem Scale**

0

Not at all

1

Once or  
twice

2

Several  
times

3

Often

4

Most of  
the time

5

All of  
the time

## Ohio Youth Problem and Functioning Scales (Caregiver: English)

Parent Rating – Short Form continued

<b>Instructions:</b> 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 orgirlfriends	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

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January 2000 (Parent-2)

(Add ratings together) Total \_\_\_\_\_

# Response Scale for OHIO Functioning Scale

0

Extreme  
troubles

1

Quite a few  
troubles

2

Some  
troubles

3

OK

4

Doing  
very well

**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* (3<sup>rd</sup> Ed.), Volume 3: Instruments for Adults, pp. 363-377. Mahwah, NJ: Lawrence Erlbaum.

# Response Scale for Caregiver Depression

0

Last week  
Not at all *or*  
less than 1 day

1

Last week  
1-2 days

2

Last week  
3-4 days

3

Last week  
5-7 days

4

Nearly  
every day  
for 2 weeks