

EBP ASSESSMENT PACKET

CPP

Ages 18 Months to 5 Years English

Required Forms		
Measure	Intake	Periodic/Discharge
1. Demographic Information: Client Intake Face Sheet <input type="checkbox"/>	X	n/a
2. Child's Trauma History: <i>Trauma History Screen</i> - Caregiver Report <input type="checkbox"/>	X	n/a
3. Child's Trauma Symptoms: <i>YCPC</i> - Caregiver Report <input type="checkbox"/>	X	X
4. Child's Behavior & Functioning: <i>PPSC</i> - Caregiver Report	X	X
5. Caregiver Symptoms: <i>CESD-R Caregiver Depression</i> <input type="checkbox"/>	X	MUST select at least 1
6. Parental Capacity: <i>Parental Stress Scale</i> <input type="checkbox"/>	X	
7. Caregiver Trauma Symptoms: PCL-5 <input type="checkbox"/>	optional	
8. CPP Monthly Session form <input type="checkbox"/>	MONTHLY	
9. Discharge Face Sheet <input type="checkbox"/>	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: !	<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/> Intersex <input type="checkbox"/> Other (specify) →	
Grade (current): *			
Race: *	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian	<input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander	<input type="checkbox"/> White <input type="checkbox"/> Other (specify)
Hispanic Origin: *	<input type="checkbox"/> Yes, Cuban <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano	<input type="checkbox"/> Yes, of Hispanic/Latino Origin <input type="checkbox"/> Yes, Puerto Rican	<input type="checkbox"/> Yes, South or Central American <input type="checkbox"/> 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: !	
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Family Information

Caregiver 1 Relationship: *		Caregiver 2 Relationship:	
Preferred Language of Adult Participating in Treatment: *			
Does the adult participating in treatment speak English?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Primary Language of Child:			
Family Composition: * Select the choice that best describes the composition of the family.	<input type="checkbox"/> Two parent family <input type="checkbox"/> Single Parent with unrelated partner	<input type="checkbox"/> Single parent - biological/adoptive parent <input type="checkbox"/> Blended Family	<input type="checkbox"/> Relative/guardian <input type="checkbox"/> Other

Intake Facesheet

Living Situation of Child: * 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		
System Involvement						
Child/Family involved with DCF? *		<input type="checkbox"/>	Yes	<input type="checkbox"/>	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:	<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
DCF Regional Office:						
Youth involved with Juvenile Justice (JJ) System? *		<input type="checkbox"/>	Yes	<input type="checkbox"/>	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:		<input type="checkbox"/>	Delinquency	<input type="checkbox"/>	Family with Service Needs (Status Offense)	
CSSD Case Status:	<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"/>	
Court District:						
Court Handling Decision:		<input type="checkbox"/>	Judicial	<input type="checkbox"/>	Non-Judicial	
Specific Treatment Information						
What treatment model are you using with this child? *		<input type="checkbox"/>	CBITS	<input type="checkbox"/>	Bounce Back	
		<input type="checkbox"/>	ARC	<input type="checkbox"/>	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	<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		
Assessment Outcome: 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		
EBP Intake Date: !						
Treatment Information: School						
During the 3 months prior to the start of EBP treatment...						
Child's school attendance: *	<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		
Suspended or expelled: *			<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
IEP: * 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...						
Arrested: * Has the child been arrested since start of treatment?			<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Detained or incarcerated: * 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...						
Alcohol and/or drugs problems: *			<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Evaluated in ER/ED for psychiatric issues: *			<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Certified medically complex: *			<input type="checkbox"/>	Yes	<input type="checkbox"/>	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?				
		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? 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: _____

Response Scale for THS

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

Client Initials: _____	1
ID: _____	1
Date: _____	1

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 <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

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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



PPSC (Caregiver: English)

18 months, 0 days to 65 months, 31 days

V1.06, 9-1-16

Client Initials:	
ID:	
Date:	

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

Response Scale for PPSC

0

Not at all

1

Somewhat

2

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

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

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
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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

Strongly
disagree

2

Disagree

3

Undecided

4

Agree

5

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.

<u>1</u>	Have you seen someone get seriously hurt, killed, or die suddenly?	Y	N
<u>2</u>	Have you been seriously hurt or injured by somebody else?	Y	N
<u>3</u>	Have you been forced or made to have unwanted sexual contact?	Y	N
<u>4</u>	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.

<i>In the past month, how much were you bothered by:</i>	<i>Not at all</i>	<i>A little bit</i>	<i>Moderately</i>	<i>Quite a bit</i>	<i>Extremely</i>
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 (<i>as if you were actually back there reliving it</i>)?	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 (<i>for example, heart pounding, trouble breathing, sweating</i>)?	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 (<i>for example, people, places, conversations, activities, objects, or situations</i>)?	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 (<i>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</i>)?	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.

<i>In the past month, how much were you bothered by:</i>	<i>Not at all</i>	<i>A little bit</i>	<i>Moderately</i>	<i>Quite a bit</i>	<i>Extremely</i>
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 (<i>as if you were actually back there reliving it</i>)?	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 (<i>for example, heart pounding, trouble breathing, sweating</i>)?	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 (<i>for example, people, places, conversations, activities, objects, or situations</i>)?	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 (<i>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</i>)?	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 (<i>for example, being unable to feel happiness or have loving feelings for people close to you</i>)?	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:	
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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

<input type="checkbox"/> Foundational	<input type="checkbox"/> Core Intervention	<input type="checkbox"/> Termination	<input type="checkbox"/> Completed Termination
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Activities						
Please check activities/CPP objectives focused on this month:	<input type="checkbox"/>	Convey Hope	<input type="checkbox"/>	Develop Empathic Relationship with Family Members	<input type="checkbox"/>	Enhance Safety
	<input type="checkbox"/>	Strengthen Family Relationships: Promote Emotional Reciprocity	<input type="checkbox"/>	Coordinate Care	<input type="checkbox"/>	Strengthen Dyadic Affect Regulation Capacities
	<input type="checkbox"/>	Strengthen Dyadic Body-Based Regulation	<input type="checkbox"/>	Support Child's Relationship with Other Important Caregivers	<input type="checkbox"/>	Enhance Understanding of the Meaning of Behavior
	<input type="checkbox"/>	Support Child in Returning to a Normal Developmental Trajectory	<input type="checkbox"/>	Normalize the Traumatic Response	<input type="checkbox"/>	Support Dyad in Acknowledging the Impact of Trauma
	<input type="checkbox"/>	Help Dyad Differentiate Between Then and Now	<input type="checkbox"/>	Help Dyad Put the Traumatic Experience in Perspective		
Collaboration						
During this month, did you communicate with the child's:	<input type="checkbox"/>	DCF Worker	<input type="checkbox"/>	Probation officer	<input type="checkbox"/>	Physician
	<input type="checkbox"/>	School	<input type="checkbox"/>	Other		
Collaboration Notes:						
Functioning						
Compared to the child's condition at the start of CPP, this child's condition is: (CGI-I)	<input type="checkbox"/>	Very much improved since the initiation of treatment	<input type="checkbox"/>	Much Improved	<input type="checkbox"/>	Minimally improved
	<input type="checkbox"/>	No change from baseline (the initiation of treatment)	<input type="checkbox"/>	Minimally worse	<input type="checkbox"/>	Much worse
	<input type="checkbox"/>	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?	<input type="checkbox"/>	None	<input type="checkbox"/>	Some	<input type="checkbox"/>	ALL
	<input type="checkbox"/>	A few	<input type="checkbox"/>	Most		
During how many sessions this month was homework assigned or reviewed?	<input type="checkbox"/>	None	<input type="checkbox"/>	Some	<input type="checkbox"/>	ALL
	<input type="checkbox"/>	A few	<input type="checkbox"/>	Most		
During how many sessions this month were COWS saved for the end of the session?	<input type="checkbox"/>	None	<input type="checkbox"/>	Some	<input type="checkbox"/>	ALL
	<input type="checkbox"/>	A few	<input type="checkbox"/>	Most		
During how many sessions this month did the child and/or caregiver practice/demonstrate skill(s) in session (behavior rehearsal)?	<input type="checkbox"/>	None	<input type="checkbox"/>	Some	<input type="checkbox"/>	ALL
	<input type="checkbox"/>	A few	<input type="checkbox"/>	Most		

Discharge Facesheet

! 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: !

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

Discharge Facesheet

	<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
Youth involved with Juvenile Justice (JJ) System? *			<input type="checkbox"/>	Yes	<input type="checkbox"/>	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:			<input type="checkbox"/>	Delinquency	<input type="checkbox"/>	Family with Service Needs (Status Offense)
CSSD Case Status:	<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"/>	
Court District:						
Court Handling Decision:			<input type="checkbox"/>	Judicial	<input type="checkbox"/>	Non-Judicial
Treatment Information: School						
Since the start of EBP treatment...						
Child's school attendance: *	<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		
Suspended or expelled: *			<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
IEP: * Does the child have an Individual Education Plan (special education)?			<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Treatment Information: Legal						
Since the start of EBP treatment...						
Arrested: * Has the child been arrested since start of treatment?			<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Detained or incarcerated: * Has the child been detained or incarcerated since start of treatment?			<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Treatment Information: Medical						
Since the start of EBP treatment...						
Alcohol and/or drugs problems: *			<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Evaluated in ER/ED for psychiatric issues: *			<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Certified medically complex: *			<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

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