Child Health and Development Institute of Connecticut, Inc.

DCF CONNECTICUT

EBP INTAKE ASSESSMENT PACKET

CBITS & BOUNCE BACK

English

Required Forms

1. Screening Data:
   Alchemer Survey Completion ☐

2. Demographic Information:
   Client Intake Face Sheet ☐

3. Child's Trauma History:
   Trauma Exposure Checklist- Child Report ☐

4. Child's Trauma Symptoms:
   CPSSV-Child Report ☐

5. Child's Behavior & Functioning:
   Ohio- Child Report ☐

Supplemental Assessments

Child Symptoms:
SMFQ (Child Depression Symptoms) – Child & Caregiver Report
PROMIS (Child Anxiety Symptoms) – Child & Caregiver Report
YCPC (Child Trauma Symptoms-for those with children under 7) – Caregiver Report

Caregiver Symptoms:
PSS (Caregiver Stress Symptoms)
PCL-5 (Caregiver Trauma Symptoms)
CESD-R (Caregiver Depression Symptoms)

Screening Facesheet

Please collect this information during screening and enter into the monthly Alchemer Survey from CHDI.

Child Information

Clinician Assigned ID Number:					**Age:**			
Gender	❒·	Female	❒·	Transgender Female	❒·	Nonbinary	❒·	Preferred not to answer
	❒·	Male	❒·	Transgender Male	❒·	Another gender not listed		
Race/Ethnicity:	❒·	American Indian or Alaskan Native Non-Hispanic	❒·	Asian Non-Hispanic	❒·	Black/African American Non-Hispanic	❒·	Hispanic or Latino
	❒·	Native Hawaiian or Other Pacific Islander Non-Hispanic	❒·	White Non-Hispanic	❒·	Multiracial Non-Hispanic	❒·	Another Race Non-Hispanic
							❒·	Preferred not to answer
Does this child qualify for the group based on screening criteria?						❒· Yes		❒· No

Alchemer Survey: https://app.alchemer.com/builder/build/id/7754888

Clinician Name: _____

Date of Completion: _____/__/_____

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

Trauma Exposure Checklist

People may have stressful events happen to them. Read the list of stressful things below andcircle YES for each of them that have EVER happened TO YOU. Circle NO if it has never happened to you. Do not include things you may have only heard about from other people or from the TV, radio, news, or the movies. Only answer what has happened to you in real life. Some questions ask about what you SAW happen to someone else. And other questions ask about what actually happened to YOU.

SAMPLE	Have you EVER gone to a basketball game? *(Circle YES orNO)*	Yes	No

Have any of the following events EVER happened to you? (Circle Yes or No)

1. Have you **been in** a serious accident, where you could have been badly hurt or could have been killed?	**Yes**	**No**
2. Have you **seen** a serious accident, where someone could have been (or was) badly hurt or died?	**Yes**	**No**
3. Have you thought that **you or someone you know** would get badly hurt during a natural disaster such as a hurricane, flood, or earthquake?	**Yes**	**No**
4. Has **anyone close to you** been very sick or injured?	**Yes**	**No**
5. Has **anyone close to you** died?	**Yes**	**No**
6. Have **you** had a serious illness or injury, or had to be rushed to the hospital?	**Yes**	**No**
7. Have **you** had to be separated from your parent or someone you depend on for more than a few days when you didn't want to be?	**Yes**	**No**
8. Have **you** been attacked by a dog or other animal?	**Yes**	**No**
9. Has anyone told **you** they were going to hurt you?	**Yes**	**No**
10. Have you seen **someone else** being told they were going to behurt?	**Yes**	**No**
11. Have you **yourself** been slapped, punched, or hit bysomeone?	**Yes**	**No**
12. Have you seen **someone else** being slapped, punched, or hit by someone?	**Yes**	**No**
13. Have **you** been beaten up?	**Yes**	**No**
14. Have you seen **someone else** getting beaten up?	**Yes**	**No**
15. Have you seen **someone else** being attacked or stabbed with a knife?	**Yes**	**No**
16. Have you seen someone pointing a **real** gun at **someoneelse**?	**Yes**	**No**
17. Have you seen **someone else** being shot at or shot with a **real** gun?	**Yes**	**No**
18. Have **you** ever seen something else that was very scary or where you thought somebody might get hurt or die? What was it? _____	**Yes**	**No**

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

CPSS – V Child Report (English)

These questions ask about how you feel about the upsetting things you described. Choose the number (0-4) that best describes how often that problem has bothered you **IN THE LAST MONTH.**

0	1	2	3	4
Not at all	Once a week or less / a little	2 to 3 times a week / somewhat	4 to 5 times a week / a lot	6 or more times a week / almost always

1.	Having upsetting thoughts or pictures about it that came into your head when you didn't want them to	0	1	2	3	4
2.	Having bad dreams or nightmares	0	1	2	3	4
3.	Acting or feeling as if it was happening again (seeing or hearing something and feeling as if you are there again)	0	1	2	3	4
4.	Feeling upset when you remember what happened (for example, feeling scared, angry, sad, guilty, confused)	0	1	2	3	4
5.	Having feelings in your body when you remember what happened (for example, sweating, heart beating fast, stomach or head hurting)	0	1	2	3	4
6.	Trying not to think about it or have feelings about it	0	1	2	3	4
7.	Trying to stay away from anything that reminds you of what happened (for example, people, places, or conversations about it)	0	1	2	3	4
8.	Not being able to remember an important part of what happened	0	1	2	3	4
9.	Having bad thoughts about yourself, other people, or the world (for example, "I can't do anything right", "All people are bad", "The world is a scary place")	0	1	2	3	4
10.	Thinking that what happened is your fault (for example, "I should have known better", "I shouldn't have done that", "I deserved it")	0	1	2	3	4
11.	Having strong bad feelings (like fear, anger, guilt, or shame)	0	1	2	3	4
12.	Having much less interest in doing things you used to do	0	1	2	3	4
13.	Not feeling close to your friends or family or not wanting to be around them	0	1	2	3	4
14.	Trouble having good feelings (like happiness or love) or trouble having any feelings at all	0	1	2	3	4
15.	Getting angry easily (for example, yelling, hitting others, throwing things)	0	1	2	3	4
16.	Doing things that might hurt yourself (for example, taking drugs, drinking alcohol, running away, cutting yourself)	0	1	2	3	4
17.	Being very careful or on the lookout for danger (for example, checking to see who is around you and what is around you)	0	1	2	3	4
18.	Being jumpy or easily scared (for example, when someone walks up behind you, when you hear a loud noise)	0	1	2	3	4
19.	Having trouble paying attention (for example, losing track of a story on TV, forgetting what you read, unable to pay attention in class)	0	1	2	3	4
20.	Having trouble falling or staying asleep	0	1	2	3	4

Adapted from Foa, E.B.; Johnson, K.M., & Treadwell, K.R.H. The Child PTSD Symptom Scale for DSM 5 (2014)

Child PTSD Symptom Scale

0	1	2	3	4
Not at all	Once a week or less/ a little	2 to 3 times a week / somewhat	4 to 5 times a week / a lot	6 or more times a week/almost always

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

Y

Ohio Mental Health Consumer Outcomes System
Ohio Youth Problem and Functioning Scales (Child: English)

Youth Rating – Short Form (Ages 12-18)

Instructions: Please rate the degree to which you have experienced the following problems in the past 30 days.	Not at All	Once or Twice	Several Times	Often	Most of the Time	All of the Time
1. Arguing with others	0	1	2	3	4	5
2. Getting into fights	0	1	2	3	4	5
3. Yelling, swearing, or screaming at others	0	1	2	3	4	5
4. Fits of anger	0	1	2	3	4	5
5. Refusing to do things teachers or parents ask	0	1	2	3	4	5
6. Causing trouble for no reason	0	1	2	3	4	5
7. Using drugs or alcohol	0	1	2	3	4	5
8. Breaking rules or breaking the law (out past curfew, stealing)	0	1	2	3	4	5
9. Skipping school or classes	0	1	2	3	4	5
10. Lying	0	1	2	3	4	5
11. Can't seem to sit still, having too much energy	0	1	2	3	4	5
12. Hurting self (cutting or scratching self, taking pills)	0	1	2	3	4	5
13. Talking or thinking about death	0	1	2	3	4	5
14. Feeling worthless or useless	0	1	2	3	4	5
15. Feeling lonely and having no friends	0	1	2	3	4	5
16. Feeling anxious or fearful	0	1	2	3	4	5
17. Worrying that something bad is going to happen	0	1	2	3	4	5
18. Feeling sad or depressed	0	1	2	3	4	5
19. Nightmares	0	1	2	3	4	5
20. Eating problems	0	1	2	3	4	5

(Add ratings together) Total _____

Response Scale for OHIO Problem Scale

0	1	2	3	4	5
Not at all	Once or twice	Several times	Often	Most of the time	All of the time

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

Ohio Youth Problem and Functioning Scales (Child: English)

Youth Rating – Short Form (Ages 12-18) continued

Instructions: Below are some ways your problems might get in the way of your ability to do everyday activities. Read each item and circle the number that best describes your current situation.	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

(Add ratings together) Total _____

January 2000 (Youth-1)

Response Scale for OHIO Functioning Scale

0	1	2	3	4
Extreme troubles	Quite a few troubles	Some troubles	OK	Doing very well

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Intake Facesheet

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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

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Intake Facesheet

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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						

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Intake Facesheet

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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