

# Supplemental Assessments

## English

### CHILD SYMPTOMS

1. SMFQ (Depression)
  - Caregiver Report
  - Child Report
2. PROMIS (Anxiety)
  - Caregiver Report
  - Child Report

### CAREGIVER SYMPTOMS

1. CESD-R (Caregiver Depression)
2. PCL5-Intake and PCL5-Periodic/Discharge (Caregiver Trauma)
3. Parental Stress Scale (Caregiver Stress)

*These are alternate or additional measures that can be used based on clinical judgment of primary symptom area targeted by treatment*

Client Initials: \_\_\_\_\_ Client ID: \_\_\_\_\_ Date of Completion: \_\_\_/\_\_\_/\_\_\_

### SHORT MOOD AND FEELINGS QUESTIONNAIRE (Caregiver: English)

I'm going to ask you some questions about how your child might have been feeling or acting recently.

For each question, please answer how much your child has felt or acted this way ***in the past two weeks***.

If a sentence was true about your child most of the time, check TRUE.

If it was only sometimes true, check SOMETIMES.

If a sentence was not true about your child, check NOT TRUE

	True	Sometimes	Not True
	2	1	0
1. S/he felt miserable or unhappy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. S/he didn't enjoy anything at all.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. S/he felt so tired s/he just sat around and did nothing.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. S/he was very restless.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. S/he felt s/he was no good any more.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. S/he cried a lot.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. S/he found it hard to think properly or concentrate.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. S/he hated him/herself.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. S/he felt s/he was a bad person.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. S/he felt lonely.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. S/he thought nobody really loved him/her.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. S/he thought s/he could never be as good as other kids.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. S/he felt s/he did everything wrong.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

# Response Scale for SMFQ

<b>0</b>	<b>1</b>	<b>2</b>
Not True	Sometimes	True

Client Initials: \_\_\_\_\_ Client ID: \_\_\_\_\_ Date of Completion: \_\_/\_\_/\_\_\_\_

### SHORT MOOD AND FEELINGS QUESTIONNAIRE (Child: English)

This form is about how you might have been feeling or acting recently.

For each question, please check how much you have felt or acted this way ***in the past two weeks.***

If a sentence was true about you most of the time, check TRUE.

If it was only sometimes true, check SOMETIMES.

If a sentence was not true about you, check NOT TRUE.

	True	Sometimes	Not True
	2	1	0
1. I felt miserable or unhappy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. I didn't enjoy anything at all.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. I felt so tired I just sat around and did nothing.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I was very restless.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. I felt I was no good any more.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. I cried a lot.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. I found it hard to think properly or concentrate.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. I hated myself.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. I was a bad person.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. I felt lonely.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. I thought nobody really loved me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. I thought I could never be as good as other kids.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. I did everything wrong.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

# Response Scale for SMFQ

**0**      **1**      **2**

Not True

Sometimes

True

## Pediatric Anxiety – Short Form 8a

Please respond to each question or statement by marking one box per row.

In the past 7 days...	Never	Almost Never	Sometimes	Often	Almost Always
I felt like something awful might happen..	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
I felt nervous.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
I felt scared .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
I felt worried.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
I worried when I was at home .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
I got scared really easy .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
I worried about what could happen to me ..	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
I worried when I went to bed at night .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

Response Scale for PROMIS

1

Never

2

Almost

3

Sometimes

4

Often

5

Almost  
Always

## Parent Proxy Anxiety – Short Form 8a

Please respond to each question or statement by marking one box per row.

In the past 7 days...	Never	Almost Never	Sometimes	Often	Almost Always
My child felt nervous.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
My child felt scared .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
My child felt worried.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
My child felt like something awful might happen.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
My child worried when he/she was at home .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
My child got scared really easy .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
My child worried about what could happen to him/her .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
My child worried when he/she went to bed at night .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5



Response Scale for PROMIS

1

Never

2

Almost

3

Sometimes

4

Often

5

Almost  
Always

**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**      **1**      **2**      **3**      **4**

Last week	Last week	Last week	Last week	Nearly
Not at all <i>or</i>	1-2 days	3-4 days	5-7 days	every day
less than 1 day				for 2 weeks

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

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

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

## 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

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

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

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

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

Client Initials: \_\_\_\_\_ Client ID: \_\_\_\_\_ Date of Completion: \_\_\_\_/\_\_\_\_/\_\_\_\_

# PCL-5 Caregiver Intake Scale

**0**

**1**

**2**

**3**

**4**

Not at

A little

Moderately

Quite a

Extremely

all

bit

bit

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

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

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

## 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

<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
Not at all	A little bit	Moderately	Quite a bit	Extremely



## 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.

# Response Scale for Parent Stress

1

Strongly  
disagree

2

Disagree

3

Undecided

4

Agree

5

Strongly  
agree