Name _____ Age _____ Sex (Circle): Girl Boy

Today's Date (**write month, day and year**) _____ Grade in School _____

School _____ Teacher _____ Town _____

Below is a list of VERY SCARY, DANGEROUS, OR VIOLENT things that sometimes happen to people. These are times where someone was HURT VERY BADLY OR KILLED, or could have been. Some people have had these experiences, some people have not had these experiences. Please be honest in answering if the violent thing happened to you, or if it did not happen to you.

FOR EACH QUESTION: **Check "Yes"** if this scary thing **HAPPENED TO YOU**
Check "No" if it **DID *NOT* HAPPEN TO YOU**

1)	Being in a big earthquake that badly damaged the building you were in.	Yes [ ]	No [ ]
2)	Being in another kind of **disaster**, like a fire, tornado, flood or hurricane.	Yes [ ]	No [ ]
3)	Being in a bad **accident**, like a **very serious** car accident.	Yes [ ]	No [ ]
4)	Being in place where a **war** was going on around you.	Yes [ ]	No [ ]
5)	Being **hit, punched, or kicked very hard** at home. (**DO NOT INCLUDE** ordinary fights between brothers & sisters).	Yes [ ]	No [ ]
6)	Seeing a family member being **hit, punched or kicked very hard** at home. (**DO NOT INCLUDE** ordinary fights between brothers & sisters).	Yes [ ]	No [ ]
7)	Being **beaten up, shot at or threatened to be hurt badly** in your town.	Yes [ ]	No [ ]
8)	Seeing someone in your town being **beaten up, shot at or killed.**	Yes [ ]	No [ ]
9)	Seeing a **dead body** in your town (do not include funerals).	Yes [ ]	No [ ]
10)	Having an adult or someone much older touch your **private sexual body parts** when you did not want them to.	Yes [ ]	No [ ]
11)	Hearing about the **violent death or serious injury** of a loved one.	Yes [ ]	No [ ]
12)	Having **painful and scary medical treatment in a hospital** when you were very sick or badly injured.	Yes [ ]	No [ ]

Contact: UCLA Trauma Psychiatry Service
300 UCLA Medical Plaza, Ste 2232
Los Angeles, CA 90095-6968 (310) 206-8973
EMAIL: rpynoos@mednet.ucla.edu

13) **OTHER** than the situations described above, has **ANYTHING ELSE** ever happened to you that was **REALLY SCARY, DANGEROUS, OR VIOLENT?** Yes [ ] No [ ]

14) a) If you answered "YES" to only **ONE** thing in the above list of questions #1 to #13, place the number of that thing (#1 to #13) in this blank: # _____

b) If you answered "YES" to **MORE THAN ONE THING,** place the number of the thing that **BOTHERS YOU THE MOST NOW** in this blank: #_____

c) About how long ago did this bad thing (your answer to [a] or [b]) happen to you? _____

d) Please write what happened: _____

_____

_____

_____

_____

FOR THE *NEXT* QUESTIONS, please **CHECK [YES] or [NO]** to answer **HOW YOU FELT during or right after** the bad thing happened that you just wrote about in Question 14.

15) Were you scared that you would die?	Yes [ ]	No [ ]
16) Were you scared that you would be hurt badly?	Yes [ ]	No [ ]
17) Were you hurt badly?	Yes [ ]	No [ ]
18) Were you scared that someone else would die?	Yes [ ]	No [ ]
19) Were you scared that someone else would be hurt badly?	Yes [ ]	No [ ]
20) Was someone else hurt badly?	Yes [ ]	No [ ]
21) Did someone die?	Yes [ ]	No [ ]

22) Did you feel very scared, like this was one of your most scary experiences ever?	Yes [ ]	No [ ]
23) Did you feel that you could not stop what was happening or that you needed someone to help?	Yes [ ]	No [ ]
24) Did you feel that what you saw was disgusting or gross?	Yes [ ]	No [ ]
25) Did you run around or act like you were very upset?	Yes [ ]	No [ ]
26) Did you feel very confused?	Yes [ ]	No [ ]
27) Did you feel like what was happening did not seem real in some way, like it was going on in a movie instead of real life?	Yes [ ]	No [ ]

Here is a list of problems people sometimes have after very bad things happen. Please **THINK** about the bad thing that happened to you that you wrote about in Question #14 on the page 2. Then, **READ** each problem on the list carefully. **CIRCLE ONE** of the numbers (0, 1, 2, 3 or 4) that tells how often the problem has happened to you **in the past month**. Use the **Rating Sheet** on Page 5 to help you decide how often the problem has happened in the past month.

PLEASE BE SURE TO ANSWER ALL QUESTIONS

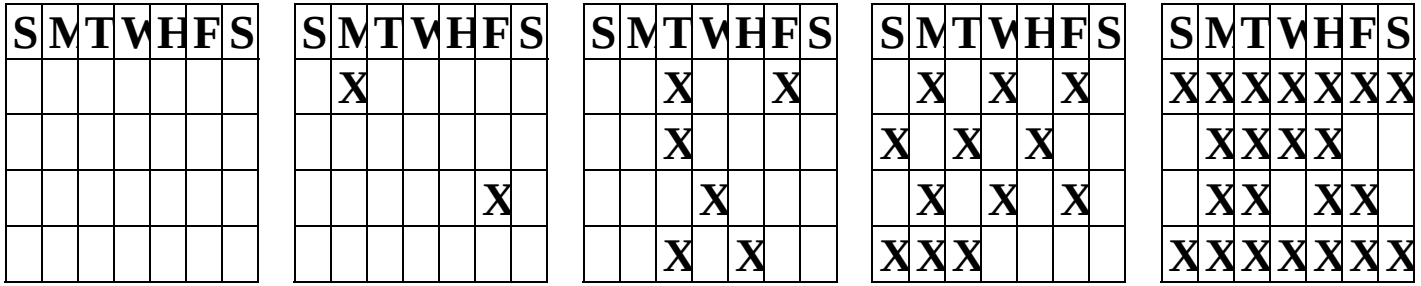
HOW MUCH OF THE TIME DURING THE PAST MONTH	**None**	**Little**	**Some**	**Much**	**Most**
1_{D4} I watch out for danger or things that I am afraid of.	0	1	2	3	4
2_{B4} When something reminds me of what happened, I get very upset, afraid, or sad.	0	1	2	3	4
3_{B1} I have upsetting thoughts, pictures, or sounds of what happened come into my mind when I do not want them to.	0	1	2	3	4
4_{D2} I feel grouchy, angry or mad.	0	1	2	3	4
5_{B2} I have dreams about what happened or other bad dreams.	0	1	2	3	4
6_{B3} I feel like I am back at the time when the bad thing happened, living through it again.	0	1	2	3	4
7_{C4} I feel like staying by myself and not being with my friends.	0	1	2	3	4

HOW MUCH OF THE TIME DURING THE PAST MONTH	None	Little	Some	Much	Most
8_{C5} I feel alone inside and not close to other people.	0	1	2	3	4
9_{C1} I try not to talk about, think about, or have feelings about what happened.	0	1	2	3	4
10_{C6} I have trouble feeling happiness or love.	0	1	2	3	4
11_{C6} I have trouble feeling sadness or anger.	0	1	2	3	4
12_{D5} I feel jumpy or startle easily, like when I hear a loud noise or when something surprises me.	0	1	2	3	4
13_{D1} I have trouble going to sleep or I wake up often during the night.	0	1	2	3	4
14_{AF} I think that some part of what happened is my fault.	0	1	2	3	4
15_{C3} I have trouble remembering important parts of what happened.	0	1	2	3	4
16_{D3} I have trouble concentrating or paying attention.	0	1	2	3	4
17_{C2} I try to stay away from people, places, or things that make me remember what happened.	0	1	2	3	4
18_{B5} When something reminds me of what happened, I have strong feelings in my body, like my heart beats fast, my head aches, or my stomach aches.	0	1	2	3	4
19_{C7} I think that I will not live a long life.	0	1	2	3	4
20_{AF} I am afraid that the bad thing will happen again.	0	1	2	3	4

FREQUENCY RATING SHEET

HOW OFTEN OR HOW MUCH OF THE TIME DURING THE PAST MONTH, THAT IS SINCE _____, DOES THE PROBLEM HAPPEN?

0	1	2	3	4
NONE	**LITTLE**	**SOME**	**MUCH**	**MOST**



NEVER	TWO TIMES A MONTH	1-2 TIMES A WEEK	2-3 TIMES EACH WEEK	ALMOST EVERY DAY