

OFFICE ONLY ID: _____	Respondent: _____	Times @ Clinic _____	Date: _____	Time Period: _____
Assessor: _____	Vscale _____	VP1: <input type="checkbox"/> Y <input type="checkbox"/> N	VP2: <input type="checkbox"/> Y <input type="checkbox"/> N	VP3: <input type="checkbox"/> Y <input type="checkbox"/> N

Life Stressor Checklist – Revised
ETTN 2010 Version – Revised September, 2010 by Chandra Ghosh Ippen

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Note: While the form was originally developed to be a questionnaire, it has been revised to be administered as a clinical interview. Clinicians should ask the questions for each item and then ask follow-up questions as needed in order to be able to code the shaded items for each question.

For the question “how much does this continue to affect you?” please note that we are trying to capture negative impact. Most participants will answer in this way, but some may indicate that the event had a positive impact. If need be ask “how much does this continue to negatively affect you?” If the person indicates that the event affects them in a positive way and does not have a negative impact, mark “not at all.”

CTRP Introduction:

I am going to ask you about different stressful life events that you may have experienced, including being in a disaster like an earthquake or hurricane, witnessing an accident, and being physically assaulted. The reason we ask parents about these types of things is that as we work together to help your child, this may bring up memories about things you’ve been through. Although you have come here for help for your child, I want to be able to help and support you too, so it will help me if I understand a little bit about your life. If any of the questions I ask you make you feel uncomfortable, let me know. You can choose not to answer them or to take breaks.

1. Have you ever been in a serious disaster (for example, an earthquake, hurricane, tornado, large fire, or explosion)?																							YES NO	
How old were you when this happened? (<i>clinician mark all that apply</i>) []Unknown (<i>only check unknown if no estimate can be given</i>)																								
0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49
50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	+
<i>Clinician (write notes describing what happened)</i>																								
How much does this continue to affect you?										1 (not at all)				2 (a little)				3 (somewhat)				4 (a lot)		
<i>Clinician Code: Severity at time of disaster (what person experienced and/or disruption to life)</i>										No real impact on person				Mild				Moderate				Severe		

2. Have you ever seen a serious accident (for example, a bad car wreck or an on-the-job accident)?																							YES NO		
How old were you when this happened? (<i>clinician mark all that apply</i>) []Unknown (<i>only check unknown if no estimate can be given</i>)																									
0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	
25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	
50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	+	
<i>Clinician (write notes describing what happened)</i>																									
How much does this continue to affect you?										1 (not at all)				2 (a little)				3 (somewhat)				4 (a lot)			
<i>Clinician Code: Severity level (what person witnessed or knew about)</i>										Level of severity unknown		None/Mild (saw accident but to person's knowledge no medical treatment required)				Moderate (saw significant harm to others but no life threat to others)				Severe (e.g. saw severe injury or harm with potential life threat, car overturned, people taken away in ambulance)				Someone died	

3. Have you ever had a very serious accident or accident-related injury (for example, a bad car wreck or an on-the-job accident)?																							YES NO						
How old were you when this happened? (<i>clinician mark all that apply</i>) <input type="checkbox"/> Unknown (<i>only check unknown if no estimate can be given</i>)																													
0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24					
25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49					
50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	+					
<i>Clinician (write notes describing what happened)</i>																													
How much does this continue to affect you?										1 (not at all)				2 (a little)				3 (somewhat)				4 (a lot)							
<i>Clinician Code: Severity (harm to anyone involved in accident)</i>										No injuries				Mild injury or life threat				Moderate injury or life threat				Severe (requiring medical treatment) or great fear of threat to life				Someone died			

4. Was a close family member ever sent to jail?																							YES NO		
How old were you when this happened? (<i>clinician mark all that apply</i>) <input type="checkbox"/> Unknown (<i>only check unknown if no estimate can be given</i>)																									
0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	
25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	
50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	+	
<i>Clinician (write notes describing what happened)</i>																									
How much does this continue to affect you?										1 (not at all)				2 (a little)				3 (somewhat)				4 (a lot)			
<i>Clinician Code: Who was sent to jail (check all that apply)</i>										<input type="checkbox"/> Bio mom				<input type="checkbox"/> Other relative				<input type="checkbox"/> Bio dad				<input type="checkbox"/> Child's parent			
										<input type="checkbox"/> Other 1er caregiver				<input type="checkbox"/> Other partner before child's parent				<input type="checkbox"/> Grandparents				<input type="checkbox"/> Other partner after child's parent			
										<input type="checkbox"/> Sibling				<input type="checkbox"/> Other (<i>specify in notes</i>)											
<i>Clinician Code: What were they sent to jail for (check all that apply)</i>										Unknown				Violent crime				Drug related				Weapon used			
<i>Did this result in a significant separation from a 1er caregiver?</i>										No		<1 week		<1 month		<6 months		<1 year		___ years					

5. Have you ever been sent to jail?																								YES	NO
How old were you when this happened? (clinician mark all that apply) <input type="checkbox"/> Unknown (only check unknown if no estimate can be given)																									
0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	
25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	
50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	+	
Clinician (write notes describing what happened)																									
How much does this continue to affect you?												1 (not at all)			2 (a little)			3 (somewhat)			4 (a lot)				
Clinician Code: Did this happen during target child's life?												No			Yes										
Clinician Code: Did this happen during another child's life?												No			Yes →			Which Child:							
Clinician Code: What were they sent to jail for (check all that apply)												Unknown			Violent crime			Drug related			Weapon used				
Did this result in a significant separation from child?												No		<1 week		<1 month		<6 months		<1 year		___ years			

6. Were you ever placed in foster care or adopted?																								YES	NO
How old were you when this happened? (clinician mark all that apply) <input type="checkbox"/> Unknown (only check unknown if no estimate can be given)																									
0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	
Clinician (write notes describing what happened)																									
How much does this continue to affect you? (only code negative impact)												1 (not at all)			2 (a little)			3 (somewhat)			4 (a lot)				
Clinician Code: Number of placements? (include family of origin as 1, so minimum=2)																									
Clinician Code: Type of placement (check all that apply)												Institutional care/group home		Foster care – relative or friend		Foster care – unrelated		Adoption		Other (explain in notes)					
Clinician Code: (total length of separation(s) from caregiver)												Adopted Age _____		< 1 week		<1 month		<6 months		<1 year		Year+ or multiple significant separations			

7. Did your parents ever separate or divorce while you were living with them?																								YES	NO
How old were you when this happened? <i>(clinician mark all that apply)</i> <input type="checkbox"/> Unknown <i>(only check unknown if no estimate can be given)</i>																									
0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	
25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	
50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	+	
<i>Clinician (write notes describing what happened)</i>																									
How much does this continue to affect you?				1 (not at all)				2 (a little)				3 (somewhat)				4 (a lot)									
<i>Clinician Code: Level of contact with parents following divorce (check one for mom and dad)</i>																				Mom		Dad			
				Did not see																					
				Infrequent/uncertain contact																					
				Infrequent contact but scheduled (e.g. holidays)																					
				Regular contact																					
Lived with																									

8. Have you ever been separated or divorced?																								YES	NO
How old were you when this happened? <i>(clinician mark all that apply)</i> <input type="checkbox"/> Unknown <i>(only check unknown if no estimate can be given)</i>																									
0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	
25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	
50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	+	
<i>Clinician (write notes describing what happened)</i>																									
How much does this continue to affect you?				1 (not at all)				2 (a little)				3 (somewhat)				4 (a lot)									

9. Have you ever had serious money problems (for example, not enough money for food or a place to live)?																							YES NO				
How old were you when this happened? <i>(clinician mark all that apply)</i> <input type="checkbox"/> Unknown <i>(only check unknown if no estimate can be given)</i>																											
0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24			
25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49			
50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	+			
<i>Clinician (write notes describing what happened)</i>																											
How much does this continue to affect you?												1 (not at all)				2 (a little)				3 (somewhat)				4 (a lot)			

10. Have you ever had a very serious physical or mental illness (for example, cancer, heart attack, serious operation, felt like killing yourself, hospitalized because of nerve problems)?																							YES NO												
How old were you when this happened? <i>(clinician mark all that apply)</i> <input type="checkbox"/> Unknown <i>(only check unknown if no estimate can be given)</i>																																			
0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24											
25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49											
50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	+											
<i>Clinician (write notes describing what happened)</i>																																			
How much does this continue to affect you?												1 (not at all)				2 (a little)				3 (somewhat)				4 (a lot)											
<i>Clinician Code (mark all that apply)</i>						Physical illness						Mental illness						Hospitalization for mental illness						Suicidal ideation						Suicide attempt					
<i>Clinician code (mark all that apply) Did illness affect care of child</i>												No				Yes Target child				Yes Other child (not target)															

11. Have you ever been emotionally abused or neglected (for example, being frequently shamed, embarrassed, ignored, or repeatedly told that you were “no good”)?																							YES	NO			
How old were you when this happened? (<i>clinician mark all that apply</i>)																											
[] Unknown (<i>only check unknown if no estimate can be given</i>)																											
0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24			
25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49			
50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	+			
<i>Clinician (write notes describing what happened)</i>																											
How much does this continue to affect you?												1 (not at all)				2 (a little)				3 (somewhat)				4 (a lot)			
<i>Clinician Code: People who did this (check all that apply)</i>												<input type="checkbox"/> Bio mom				<input type="checkbox"/> Teacher											
												<input type="checkbox"/> Bio dad				<input type="checkbox"/> Friend											
												<input type="checkbox"/> Other 1er caregiver				<input type="checkbox"/> Child's parent											
												<input type="checkbox"/> Other relative				<input type="checkbox"/> Other partner before child's parent											
												<input type="checkbox"/> Siblings				<input type="checkbox"/> Other partner after child's parent											
												<input type="checkbox"/> Other: (<i>specify</i>)															
<i>Clinician Code: Did target child see this?</i>												No				Yes				Unsure							

12. Have you ever been physically neglected (for example, not fed, not properly clothed, or left to take care of yourself when you were too young or ill)?																							YES	NO			
How old were you when this happened? (<i>clinician mark all that apply</i>)																											
[] Unknown (<i>only check unknown if no estimate can be given</i>)																											
0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24			
25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49			
50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	+			
<i>Clinician (write notes describing what happened)</i>																											
How much does this continue to affect you?												1 (not at all)				2 (a little)				3 (somewhat)				4 (a lot)			
<i>Clinician Code: People who did this (check all that apply)</i>												<input type="checkbox"/> Bio mom				<input type="checkbox"/> Teacher											
												<input type="checkbox"/> Bio dad				<input type="checkbox"/> Friend											
												<input type="checkbox"/> Other 1er caregiver				<input type="checkbox"/> Child's parent											
												<input type="checkbox"/> Other relative				<input type="checkbox"/> Other partner before child's parent											
												<input type="checkbox"/> Siblings				<input type="checkbox"/> Other partner after child's parent											
												<input type="checkbox"/> Other: (<i>specify</i>)															

13. WOMEN ONLY: Have you ever had an abortion or miscarriage (lost your baby)?																							YES	NO			
How old were you when this happened? (<i>clinician mark all that apply</i>) <input type="checkbox"/> Unknown (<i>only check unknown if no estimate can be given</i>)																											
0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24			
25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49			
50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	+			
<i>Clinician (write notes describing what happened)</i>																											
How much does this continue to affect you?												1 (not at all)				2 (a little)				3 (somewhat)				4 (a lot)			

14. Have you ever been separated from your child against your will (for example, the loss of custody or visitation, or kidnapping)?																							YES	NO											
How old were you when this happened? (<i>clinician mark all that apply</i>) <input type="checkbox"/> Unknown (<i>only check unknown if no estimate can be given</i>)																																			
0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24											
25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49											
50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	+											
<i>Clinician (write notes describing what happened)</i>																																			
How much does this continue to affect you?												1 (not at all)				2 (a little)				3 (somewhat)				4 (a lot)											
<i>Clinician Code: Which child (check all that apply)</i>												Target child				Younger sibling of target				Older sibling of target				Other (specify in notes)											
<i>Clinician code: Reason for separation (check all that apply)</i>												Immigration				Custody issues				Foster care				Kidnapping				Other							
<i>Clinician code: Length of separation (check all that apply)</i>												Ongoing				<1 week				<1 month				<6 months				< 1 year				Year+ or multiple significant separations			

15. Has a baby or child of yours ever had a severe physical or mental handicap (for example, mentally retarded, birth defects, can't hear, see, walk)?																								YES	NO
How old were you when this happened? <i>(clinician mark all that apply)</i> <input type="checkbox"/> Unknown <i>(only check unknown if no estimate can be given)</i>																									
0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	
25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	
50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	+	
<i>Clinician (write notes describing what happened)</i>																									
How much does this continue to affect you?				1 (not at all)				2 (a little)				3 (somewhat)				4 (a lot)									
<i>Clinician Code: Which child (check all that apply)</i>				Target child				Younger sibling of target				Older sibling of target				Other (specify in notes)									
<i>Clinician Code: Does child live with target child?</i>				Is target child				Yes				No				Other (e.g. visits)									

16. Have you ever been responsible for taking care of someone close to you (not your child) who had a severe physical or mental handicap (for example, cancer, stroke, Alzheimer's disease, AIDS, nerve problems, can't hear, see, walk)?																								YES	NO
How old were you when this happened? <i>(clinician mark all that apply)</i> <input type="checkbox"/> Unknown <i>(only check unknown if no estimate can be given)</i>																									
0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	
25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	
50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	+	
<i>Clinician (write notes describing what happened)</i>																									
How much does this continue to affect you?				1 (not at all)				2 (a little)				3 (somewhat)				4 (a lot)									
<i>Clinician Code: People caregiver cared for (check all that apply)</i>				<input type="checkbox"/> Bio mom				<input type="checkbox"/> Sibling(s)																	
				<input type="checkbox"/> Bio dad				<input type="checkbox"/> Friend																	
				<input type="checkbox"/> Other 1er caregiver				<input type="checkbox"/> Child's parent																	
				<input type="checkbox"/> Grandparents				<input type="checkbox"/> Other partner before child's parent																	
				<input type="checkbox"/> Other relative				<input type="checkbox"/> Other partner after child's parent																	
				<input type="checkbox"/> Other: <i>(specify in notes)</i>																					

17. Has someone close to you died suddenly or unexpectedly (for example, an accident, sudden heart attack, murder or suicide)?																					YES NO			
How old were you when this happened? (<i>clinician mark all that apply</i>)																								
[] Unknown (<i>only check unknown if no estimate can be given</i>)																								
0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49
50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	+
<i>Clinician (write notes describing what happened)</i>																								
How much does this continue to affect you?										1 (not at all)			2 (a little)			3 (somewhat)			4 (a lot)					
<i>Clinician Code:</i> <i>How died:</i> <i>a) violence</i> <i>b) illness/health related</i> <i>c) accident</i> <i>d) drugs</i> <i>e) other (specify)</i>										Person					How died (use letter codes)					<i>Check if Witness Death?</i>		Age		
										<input type="checkbox"/> Biological mother														
										<input type="checkbox"/> Biological father														
										<input type="checkbox"/> Other 1er Caregiver														
										<input type="checkbox"/> Grandparents														
										<input type="checkbox"/> Other relative														
										<input type="checkbox"/> Sibling(s)														
										<input type="checkbox"/> Friend														
										<input type="checkbox"/> A child														
										<input type="checkbox"/> Target child's parent														
<input type="checkbox"/> Other partner before target child's parent																								
<input type="checkbox"/> Other partner after target child's parent																								
<input type="checkbox"/> Other (<i>specify in notes</i>)																								
<i>Clinician Code: Number of people who died suddenly</i>										# _____														
<i>Clinician Code: Did respondent lose a primary caregiver? IF YES -> Age</i>															No		Yes →		Age:					

18. Has someone close to you died (do not include those who died suddenly or unexpectedly)?																							YES NO	
How old were you when this happened? (<i>clinician mark all that apply</i>)																								
[]Unknown (<i>only check unknown if no estimate can be given</i>)																								
0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49
50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	+
<i>Clinician (write notes describing what happened)</i>																								
How much does this continue to affect you?												1 (not at all)			2 (a little)			3 (somewhat)			4 (a lot)			
<i>Clinician Code:</i>	Person											How died (<i>if the way they died was sudden or unexpected code under item 17</i>)											Age	
	<input type="checkbox"/> Biological mother																							
	<input type="checkbox"/> Biological father																							
	<input type="checkbox"/> Other 1er Caregiver																							
	<input type="checkbox"/> Grandparents																							
	<input type="checkbox"/> Other relative																							
	<input type="checkbox"/> Sibling(s)																							
	<input type="checkbox"/> Friend																							
	<input type="checkbox"/> A child																							
	<input type="checkbox"/> Target child's parent																							
<input type="checkbox"/> Other partner before target child's parent																								
<input type="checkbox"/> Other partner after target child's parent																								
<input type="checkbox"/> Other (<i>specify in notes</i>)																								
<i>Clinician Code: Number of people who died</i>												# _____												
<i>Clinician Code: Did respondent lose a primary caregiver? IF YES -> Age</i>																No			Yes →			Age:		

20. Have you ever seen a robbery, mugging, or attack taking place?																							YES	NO
How old were you when this happened? (<i>clinician mark all that apply</i>) <input type="checkbox"/> Unknown (<i>only check unknown if no estimate can be given</i>)																								
0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49
50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	+
<i>Clinician (write notes describing what happened)</i>																								
How much does this continue to affect you?				1 (not at all)				2 (a little)				3 (somewhat)				4 (a lot)								
<i>Clinician Code: Who was mugged</i>				Stranger				Friend				Relative				Other (specify in notes)								
<i>Clinician Code: Severity (check all that apply)</i>				Weapon used				Person injured				Person died				Respondent threatened								

21. Have you ever been robbed, mugged, or physically attacked (not sexually) by someone you did not know?																							YES	NO
How old were you when this happened? (<i>clinician mark all that apply</i>) <input type="checkbox"/> Unknown (<i>only check unknown if no estimate can be given</i>)																								
0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49
50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	+
<i>Clinician (write notes describing what happened)</i>																								
How much does this continue to affect you?				1 (not at all)				2 (a little)				3 (somewhat)				4 (a lot)								
<i>Clinician Code: Severity (check all that apply)</i>				Weapon used				Mild injury				Moderate injury (pain last more than a day)				Serious injury (requiring medical treatment)								
<i>Clinician Code: Person's perception of danger</i>				No serious danger				Fear of mild injury				Fear of serious injury				Feared for life								

22. Before age 16, were you ever abused or physically attacked (not sexually) by someone you knew (for example, a parent, boyfriend, or husband hit, slapped, choked, burned, or beat you up)?																	YES NO	
How old were you when this happened? <i>(clinician mark all that apply)</i> <input type="checkbox"/> Unknown <i>(only check unknown if no estimate can be given)</i>																		
0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16		
<i>Clinician (write notes describing what happened)</i>																		
How much does this continue to affect you?			1 (not at all)			2 (a little)			3 (somewhat)			4 (a lot)						
			People involved						Chronicity <i>(use codes below)</i>				Severity <i>(use codes below)</i>					
<i>Clinician Code: People who did this (check all that apply but only one category per person)</i>			<input type="checkbox"/> Bio mom															
			<input type="checkbox"/> Bio dad															
			<input type="checkbox"/> Other 1er caregiver															
			<input type="checkbox"/> Parent's boyfriend/girlfriend															
			<input type="checkbox"/> Grandparent															
			<input type="checkbox"/> Sibling(s)															
			<input type="checkbox"/> Friend															
			<input type="checkbox"/> Target child's parent															
			<input type="checkbox"/> Other boyfriend/girlfriend/partner															
			<input type="checkbox"/> Adult relative															
			<input type="checkbox"/> Child relative															
<input type="checkbox"/> Teacher																		
<input type="checkbox"/> Other: <i>(specify in notes)</i>																		
<i>Clinician Code Overall: Chronicity</i>			a) 1x			b) Few times			c) Occasional			d) Frequent			e) Other (specify in notes)			
<i>Clinician Code Overall: Severity</i>			a) Mild (no injuries)			b) Moderate (mild injuries)			c) Serious (significant injuries)			d) Threat of death or actual death			e) Other (specify in notes)			

23. After age 16, were you ever abused or physically attacked (not sexually) by someone you knew (for example, a parent, boyfriend, or husband hit, slapped, choked, burned, or beat you up)?																							YES NO	
How old were you when this happened? (clinician mark all that apply)																								
<input type="checkbox"/> Unknown (only check unknown if no estimate can be given)																								
16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40
41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	+
Clinician (write notes describing what happened)																								
How much does this continue to affect you?												1 (not at all)			2 (a little)			3 (somewhat)			4 (a lot)			
												Chronicity (use codes below)			Severity (use codes below)									
Clinician Code: People who did this (check all that apply but only one category per person)												<input type="checkbox"/> Bio mom												
												<input type="checkbox"/> Bio dad												
												<input type="checkbox"/> Other 1er caregiver												
												<input type="checkbox"/> Parent's boyfriend/girlfriend												
												<input type="checkbox"/> Grandparent												
												<input type="checkbox"/> Sibling(s)												
												<input type="checkbox"/> Friend												
												<input type="checkbox"/> Target child's parent												
												<input type="checkbox"/> Other boyfriend/girlfriend/partner before target child's parent												
												<input type="checkbox"/> Other boyfriend/girlfriend/partner after target child's parent												
												<input type="checkbox"/> Adult relative												
												<input type="checkbox"/> Child relative (under age 18)												
<input type="checkbox"/> Teacher																								
<input type="checkbox"/> Other: (specify in notes)																								
Clinician Code Overall: Chronicity						a) 1x			b) Few times			c) Occasional			d) Frequent			e) Other (specify in notes)						
Clinician Code Overall: Severity						a) Mild (no injuries)			b) Moderate (mild injuries)			c) Serious (significant injuries)			d) Threat of death or actual death			e) Other (specify in notes)						

24. Have you ever been bothered or harassed by sexual remarks, jokes, or demands for sexual favors by someone <i>at work or school</i> (for example, a co-worker, a boss, a customer, another student, a teacher)?																							YES NO	
How old were you when this happened? (<i>clinician mark all that apply</i>) <input type="checkbox"/> Unknown (<i>only check unknown if no estimate can be given</i>)																								
0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49
50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	+
<i>Clinician (write notes describing what happened)</i>																								
How much does this continue to affect you?												1 (not at all)			2 (a little)			3 (somewhat)			4 (a lot)			

25. Before age 16, were you ever <u>touched</u> or made to <u>touch someone else</u> in a sexual way because he/she forced you in some way or threatened to harm you if you didn't?																	YES		NO											
How old were you when this happened? (clinician mark all that apply)																														
[] Unknown (only check unknown if no estimate can be given)																														
0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16														
Clinician (write notes describing what happened)																														
How much does this continue to affect you?															1 (not at all)				2 (a little)				3 (somewhat)				4 (a lot)			
															People Involved												Chronicity (use codes below)			
Clinician Code: People who did this (check all that apply but only one category per person)															<input type="checkbox"/> Bio mom															
															<input type="checkbox"/> Bio dad															
															<input type="checkbox"/> Other 1er caregiver															
															<input type="checkbox"/> Parent's boyfriend/girlfriend															
															<input type="checkbox"/> Grandparent															
															<input type="checkbox"/> Sibling(s)															
															<input type="checkbox"/> Friend															
															<input type="checkbox"/> Target child's parent															
															<input type="checkbox"/> Other boyfriend/girlfriend/partner before target child's parent															
															<input type="checkbox"/> Other boyfriend/girlfriend/partner after target child's parent															
															<input type="checkbox"/> Friend (child)															
															<input type="checkbox"/> Adult relative															
															<input type="checkbox"/> Child relative															
															<input type="checkbox"/> Another child															
<input type="checkbox"/> Adult known to respondent																														
<input type="checkbox"/> Adult stranger																														
<input type="checkbox"/> Teacher																														
<input type="checkbox"/> Other: (specify in notes)																														
Clinician Code Overall: Chronicity															a) 1x			b) Few times			c) Occasional			d) Frequent			e) Other (specify in notes)			

26. Before age 16, did you ever have sex (oral, anal, genital) when you didn't want to because someone forced you in some way or threatened to harm you if you didn't?																	YES NO		
How old were you when this happened? (clinician mark all that apply)																			
[] Unknown (only check unknown if no estimate can be given)																			
0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16			
Clinician (write notes describing what happened)																			
How much does this continue to affect you?										1 (not at all)			2 (a little)		3 (somewhat)		4 (a lot)		
Clinician Code: People who did this (check all that apply but only one category per person)										People Involved								Chronicity (use codes below)	
										<input type="checkbox"/> Bio mom									
										<input type="checkbox"/> Bio dad									
										<input type="checkbox"/> Other 1er caregiver									
										<input type="checkbox"/> Parent's boyfriend/girlfriend									
										<input type="checkbox"/> Grandparent									
										<input type="checkbox"/> Sibling(s)									
										<input type="checkbox"/> Friend									
										<input type="checkbox"/> Target child's parent									
										<input type="checkbox"/> Other boyfriend/girlfriend/partner before target child's parent									
										<input type="checkbox"/> Other boyfriend/girlfriend/partner after target child's parent									
										<input type="checkbox"/> Friend (child)									
										<input type="checkbox"/> Adult relative									
										<input type="checkbox"/> Child relative									
										<input type="checkbox"/> Another child									
<input type="checkbox"/> Adult known to respondent																			
<input type="checkbox"/> Adult stranger																			
<input type="checkbox"/> Teacher																			
<input type="checkbox"/> Other: (specify in notes)																			
Clinician Code Overall: Chronicity										a) 1x		b) Few times		c) Occasional		d) Frequent		e) Other (specify in notes)	

27. After age 16, were you ever <u>touched</u> or made to <u>touch someone else in a sexual way</u> because he/she forced you in some way or threatened to harm you if you didn't?																							YES	NO
How old were you when this happened? (clinician mark all that apply)																								
[] Unknown (only check unknown if no estimate can be given)																								
16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40
41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	+
Clinician (write notes describing what happened)																								
How much does this continue to affect you?												1 (not at all)	2 (a little)	3 (somewhat)	4 (a lot)									
												People Involved						Chronicity (use codes below)						
Clinician Code: People who did this (check all that apply but only one category per person)												<input type="checkbox"/> Bio mom												
												<input type="checkbox"/> Bio dad												
												<input type="checkbox"/> Other 1er caregiver												
												<input type="checkbox"/> Parent's boyfriend/girlfriend												
												<input type="checkbox"/> Grandparent												
												<input type="checkbox"/> Sibling(s)												
												<input type="checkbox"/> Friend												
												<input type="checkbox"/> Target child's parent												
												<input type="checkbox"/> Other boyfriend/girlfriend/partner before target child's parent												
												<input type="checkbox"/> Other boyfriend/girlfriend/partner after target child's parent												
												<input type="checkbox"/> Friend (child)												
												<input type="checkbox"/> Adult relative												
												<input type="checkbox"/> Child relative (under age 18)												
												<input type="checkbox"/> Another child (under age 18)												
												<input type="checkbox"/> Adult known to respondent												
<input type="checkbox"/> Adult stranger																								
<input type="checkbox"/> Teacher																								
<input type="checkbox"/> Other: (specify in notes)																								
Clinician Code Overall: Chronicity												a) 1x	b) Few times	c) Occasional	d) Frequent	e) Other (specify in notes)								

28. After age 16, did you ever have sex (oral, anal, genital) when you didn't want to because someone forced you in some way or threatened to harm you if you didn't?																							YES	NO
How old were you when this happened? (clinician mark all that apply)																								
[] Unknown (only check unknown if no estimate can be given)																								
16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40
41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	+
Clinician (write notes describing what happened)																								
How much does this continue to affect you?												1 (not at all)	2 (a little)	3 (somewhat)	4 (a lot)									
												People Involved						Chronicity (use codes below)						
Clinician Code: People who did this (check all that apply but only one category per person)												<input type="checkbox"/> Bio mom												
												<input type="checkbox"/> Bio dad												
												<input type="checkbox"/> Other 1er caregiver												
												<input type="checkbox"/> Parent's boyfriend/girlfriend												
												<input type="checkbox"/> Grandparent												
												<input type="checkbox"/> Sibling(s)												
												<input type="checkbox"/> Friend												
												<input type="checkbox"/> Target child's parent												
												<input type="checkbox"/> Other boyfriend/girlfriend/partner before target child's parent												
												<input type="checkbox"/> Other boyfriend/girlfriend/partner after target child's parent												
												<input type="checkbox"/> Friend (child)												
												<input type="checkbox"/> Adult relative												
												<input type="checkbox"/> Child relative (under age 18)												
												<input type="checkbox"/> Another child (under age 18)												
<input type="checkbox"/> Adult known to respondent																								
<input type="checkbox"/> Adult stranger																								
<input type="checkbox"/> Teacher																								
<input type="checkbox"/> Other: (specify in notes)																								
Clinician Code Overall: Chronicity												a) 1x	b) Few times	c) Occasional	d) Frequent	e) Other (specify in notes)								

29. Have you ever been directly exposed to war, armed conflict, or terrorism (were there soldiers or others fighting or hurting people near where you lived)?																							YES NO				
How old were you when this happened? (<i>clinician mark all that apply</i>) <input type="checkbox"/> Unknown (<i>only check unknown if no estimate can be given</i>)																											
0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24			
25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49			
50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	+			
<i>Clinician (write notes describing what happened)</i>																											
How much does this continue to affect you?				1 (not at all)				2 (a little)				3 (somewhat)				4 (a lot)											
<i>Clinician Code: Person's own experience (check all that apply)</i>				Damage to own property				Injured				Threatened				Had to hide				Had to fight				Had to flee			
<i>Clinician Code: What person witnessed plus harm to others (mark all that apply)</i>				Family members injured				Family members died				Friends injured				Friends died											
				Saw people injured				Saw people die				Other specify in notes)															

30. Have you ever had to leave where you were living and move to another location (country, state, or city) because you could not pay for basic needs, like food clothing or shelter, or because you felt unsafe?																							YES NO	
How old were you when this happened? (<i>clinician mark all that apply</i>) <input type="checkbox"/> Unknown (<i>only check unknown if no estimate can be given</i>)																								
0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49
50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	+
<i>Clinician (write notes describing what happened)</i>																								
How much does this continue to affect you?				1 (not at all)				2 (a little)				3 (somewhat)				4 (a lot)								
<i>Clinician Code: Reason for leaving (check all that apply)</i>				Economic				Safety – related to DV				Safety related to war/terrorism				Safety Other (specify in notes)								

31. Are there any events we did not include that you would like to mention?																							YES NO		
What was the event? <i>(clinician write notes describing what happened)</i>																									
How old were you when this happened? <i>(clinician mark all that apply)</i> <input type="checkbox"/> Unknown <i>(only check unknown if no estimate can be given)</i>																									
0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	
25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	
50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	+	
How much does this continue to affect you?										1 (not at all)				2 (a little)				3 (somewhat)				4 (a lot)			

32. Have any of the events mentioned above ever happened to someone close to you so that even though you didn't experience the event yourself, you were seriously disturbed by it?																							YES NO		
What was the event? <i>(clinician write notes describing what happened)</i>																									
How old were you when this happened? <i>(clinician mark all that apply)</i> <input type="checkbox"/> Unknown <i>(only check unknown if no estimate can be given)</i>																									
0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	
25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	
50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	+	
How much does this continue to affect you?										1 (not at all)				2 (a little)				3 (somewhat)				4 (a lot)			
<i>Clinician Code: Number of events happening to others</i>																									
<i>Clinician Code: People who did this (check all that apply)</i>												<input type="checkbox"/> Bio mom						<input type="checkbox"/> Target child's parent							
												<input type="checkbox"/> Bio dad						<input type="checkbox"/> Other partner before child's parent							
												<input type="checkbox"/> Other 1er caregiver						<input type="checkbox"/> Other partner after child's parent							
												<input type="checkbox"/> Grandparent						<input type="checkbox"/> Target child							
												<input type="checkbox"/> Sibling(s)						<input type="checkbox"/> Other child							
												<input type="checkbox"/> Other relative						<input type="checkbox"/> Other: <i>(specify under notes)</i>							