

Trauma History Screen (THS) Parent Version

Name: _____ ID: _____
Date: _____ Child's DOB: _____
Relationship to child: _____

	Directions: Read each item. If it never happened, enter 0 and ask about the next item. If it has happened, ask about how many times it has happened, and then how much the parent thinks it affected the child when it happened, and now.	How many times did this happen? 0=Never	When this happened, how much did it affect your child ?					How much does this still affect your child ?				
			Not at all	A little bit	Moderately	Quite a bit	Extremely	Not at all	A little bit	Moderately	Quite a bit	Extremely
1	Has your child ever been in or seen a really bad accident?		1	2	3	4	5	1	2	3	4	5
2	Has someone your child knows ever been so badly injured or sick that he/she almost died?		1	2	3	4	5	1	2	3	4	5
3	Has someone your child knows ever died?		1	2	3	4	5	1	2	3	4	5
4	Has your child ever been so sick that you or the doctor thought he/she might die?		1	2	3	4	5	1	2	3	4	5
5	Has your child ever been unexpectedly separated from someone who he/she depends on for love or security for more than a few days?		1	2	3	4	5	1	2	3	4	5
6	Has someone close to your child ever tried to hurt or kill him/herself?		1	2	3	4	5	1	2	3	4	5
7	Has someone ever physically hurt your child or threatened to hurt your child?		1	2	3	4	5	1	2	3	4	5
8	Has your child ever been robbed or seen someone he/she cares about get robbed?		1	2	3	4	5	1	2	3	4	5
9	Has anyone ever kidnapped your child?		1	2	3	4	5	1	2	3	4	5
10	Has your child ever been in or seen a hurricane, earthquake, tornado, or bad fire?		1	2	3	4	5	1	2	3	4	5
11	Has your child ever been attacked by a dog or other animal?		1	2	3	4	5	1	2	3	4	5
12	Has your child ever seen or heard people physically fighting or threatening to hurt each other? (in or outside of the family)		1	2	3	4	5	1	2	3	4	5
13	Has your child ever seen a family member arrested or in jail?		1	2	3	4	5	1	2	3	4	5
14	Has there ever been a time in your child's life when he/she did not have the right care (e.g. food, clothing, place to live)?		1	2	3	4	5	1	2	3	4	5
15	Has someone ever made your child see or do something sexual?		1	2	3	4	5	1	2	3	4	5
16	Has your child ever seen or heard someone else being forced to do something sexual?		1	2	3	4	5	1	2	3	4	5
17	Has your child ever watched people using drugs, like smoking drugs or using needles?		1	2	3	4	5	1	2	3	4	5
18	Has something else happened to your child that was very scary or where somebody could have been hurt or killed? Specify: _____		1	2	3	4	5	1	2	3	4	5

Response Scale for THS

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