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Core Clinical Characteristics (Baseline Assessment Form)

Child ID Number: -- Child's Initials:
Center ID Subcenter ID Child ID

First Middle Last

SYSTEM SCREENING INFORMATION

Complete the following.

1. Child's initials (Enter a dash if no middle initial)
First Middle Last

2. Child's date of birth: / /
Month Day Year

3. Child's gender:
1 = Male
2 = Female

4. Has this child been seen at another NCTSN network center(s) for a previous episode(s) of care?
0 = No
1 = Yes
If Yes: Was this child enrolled in the NCTSN's Core Data Set?
0 = No
1 = Yes

If Yes: STOP and e-mail NICON helpdesk (NICONhelp@icfi.com) for further instructions!

5. Has this child been seen at this center for a previous episode(s) of care?
0 = No
1 = Yes
If Yes: Was this child already enrolled in the NCTSN's Core Data Set?
0 = No. Click Submit to continue Enrollment
1 = Yes

If Yes: STOP, do not proceed with enrollment.

If Yes: GO to the Follow-up Assessment and create a Follow up Visit record.

BASELINE VISIT AND DEMOGRAPHIC INFORMATION

Complete the following.

1. Date of visit: / /
Month Day Year

Baseline Visit Information

2. Is this the child's first visit at this center for the current episode of care?
0 = No
If No: How many visits (including today's visit) has the child had at your center for the current episode of care? Number of visits _____
1 = Yes
3. From whom are you collecting information for this form? **(Check all that apply)**
- Parent
 - Other adult relative
 - Foster parent
 - Agency staff
 - Child/adolescent/self
 - Other, please specify: _____
4. Who is currently the legal guardian for this child? **(Select only one)**
- 1 = Parent
 - 2 = Other adult relative
 - 3 = State
 - 4 = Emancipated minor (self)
 - 98 = Other, please specify: _____
 - 99 = Unknown

Demographic Information

5. Child's ethnicity: **(Select only one)**
- 1 = Hispanic or Latino
 - 2 = Not Hispanic or Latino
 - 99 = Unknown
6. Child's race **(If multiracial, check all that apply)**
- American Indian or Alaska Native
 - Asian
 - Black/African American
 - Native Hawaiian or other Pacific Islander
 - White
 - Unknown
7. Was the child born in the United States?
- 0 = No
If No: In what country was the child born? _____
If No: Please complete the Refugee and Immigrant Families Supplement
 - 1 = Yes
 - 99 = Unknown

BASELINE VISIT AND DEMOGRAPHIC INFORMATION (CONTINUED)

8. Does the child have one or more siblings enrolled in the Core Data Set?

0 = No

1 = Yes

If Yes: How many? _____

If Yes: Please enter the ID numbers for the child's sibling(s) _____

99 = Unknown

9. Has anyone in the child's family been in the military since 2001?

0 = No

1 = Yes

If Yes: Please complete the Military Families Supplement

99 = Unknown

10. Please indicate health care and early intervention providers currently caring for this child (**Check all that apply**)

Pediatrician

Other medical doctor

Nurse practitioner

Nurse

Early interventionist (i.e. physical, speech, or occupational therapist)

Other, please specify: _____

11. Please indicate whether the child has any chronic or recurrent conditions that affect the child's ability to function. This may include asthma, diabetes, mental retardation, cerebral palsy, or fetal alcohol syndrome.

0 = Child does not have any medical problems or physical disabilities

1 = Child has medical problems or physical disabilities; however, they are managed well and do not interfere with the child's functioning

2 = Child's medical problems or physical disabilities cause stress to the child and/or family and interfere with functioning.

3 = Child's medical problems or physical difficulties are a significant source of distress to the child and/or family. Family spends significant time addressing child's problem, and the problem interferes with the family's ability to engage in activities due to the child's needs

If 1-3 selected: Please indicate the medical condition: _____

99 = Unknown

12. Please provide an identifier for the health care provider at your center currently caring for this child. _____

REFUGEE AND IMMIGRANT FAMILIES SUPPLEMENT

If the child was not born in the United States, as indicated by question 7 in the Baseline Visit and Demographic Information form above, complete the following questions.

1. In what month and year did the child first enter the United States?

Date of entry: _____ / _____
Month Year

Unknown

2. Was the child's mother born in the United States?

0 = No

If No: In what country was the child's mother born? _____

1 = Yes

99 = Unknown

3. Was the child's father born in the United States?

0 = No

If No: In what country was the child's father born? _____

1 = Yes

99 = Unknown

4. What is the country of origin of the child's family? _____

Unknown

5. Has the child ever had refugee or asylee status (meaning US government refugee status or formally going through a legal process to become an asylee because of fear of persecution in their country of origin)?

0 = No

1 = Yes

99 = Unknown

6. Has the child's parents ever had refugee or asylee status (meaning US government refugee status or formally going through a legal process to become an asylee because of fear of persecution in their country of origin)?

0 = No

1 = Yes

99 = Unknown

7. Did the child ever live in a refugee or detention camp?

0 = No

1 = Yes

If Yes: For how months did the child live in a refugee/detention camp(s)? Months: ____

99 = Unknown

8. How well do the child's parent(s)/primary caregiver(s) speak English? **(Select only one. Please respond with respect to the parent/caregiver who is most proficient in English.)**

1 = Speaks English well

2 = Speaks some English

3 = Speaks little or no English

99 = Unknown

9. How well does the child speak English (for a child of his/her age)? **(Select only one)**

1 = Speaks English well

2 = Speaks some English

3 = Speaks little or no English

99 = Unknown

MILITARY FAMILIES SUPPLEMENT

If the child has a family member(s) who served in the military since 2001, as indicated by question 9 in the Baseline Visit and Demographic Information form above, complete the following questions.

1. Has anyone in the child's family served in the military in the last year?

0 = No

1 = Yes

99 = Unknown

2. Has anyone in the child's family been in combat?

0 = No

1 = Yes

99 = Unknown

3. What is the relationship of that person (service member) to the child? (Check all that apply)

Mother

Father

Brother/Sister

Cousin

Uncle/Aunt

Grandparent

Other, please specify: _____

Answer the following questions for each family member indicated in question 3 above.

4. What was the service member's component and branch of services? (Check all that apply)

Reserve

National Guard

Army

Air Force

Navy

Marine Corps

Coast Guard

5. Did the service member experience any of the following? (Check all that apply)

Deployed in support of Combat Operations (e.g., Iraq or Afghanistan)

If Yes: How many times was this person deployed to Combat Operations?

1 = Once

2 = Twice

3 = Three times

4 = Four times

5 = Five or more times

99 = Unknown

If Yes: To what degree has the family member's deployment distressed the child?

1 = Not at all

2 = Minimally

3 = Moderately

4 = Severely

99 = Unknown

Physically injured during Combat Operations
If Yes: Indicate the type of injury(s): (Check all that apply)

Amputation
 Traumatic Brain Injury (TBI)/Blast-Related Concussion
 Burns
 Other, please specify: _____

Developed combat stress symptoms/difficulties adjusting following deployment, including PTSD, depression, or suicidal thoughts

Died or was killed
If Yes: What was the nature of the death?

1 = Killed in combat
2 = Accidental death
3 = Medical condition or illness
4 = Suicide
5 = Other, please specify: _____
99 = Unknown

BRIEF INTERVENTION SERVICES INFORMATION

Brief Intervention refers to the number of sessions that a child/family may receive. If a child/family is receiving 3–6 sessions, then complete the following.

1. Is this child/family receiving brief intervention services?
0 = No
1 = Yes

If Yes: Please press the Add Entry button and complete the requested information for EACH episode of care where the child/family receives brief intervention services. A new entry is required for each type of treatment and each different set of start/stop dates.

1. What treatment component(s) is the child/family receiving for this brief episode of care?
(Check all that apply)

- Screening
- Assessment
- Case Consultation
- Case Management
- Child and Family Traumatic Stress Intervention (CFTSI)
- Psychological First Aid (PFA)
- Skills for Psychological Recovery
- Acute Crisis Response and Management
- Referral Services
- Psycho-education
- Safety Planning
- Individual Therapy
- Family Therapy
- Group Therapy
- Support Group
- Other, please specify: _____

2. Date this brief episode of care began: / /
Month Day Year

NOTE: Answer question 3 after the child/family has completed the selected treatment component(s).

3. Did this child/family complete the treatment component(s) offered during this brief episode of care?
0 = No, left treatment before completing

If No: Date left treatment: / /
Month Day Year

1 = Yes, completed treatment

If Yes: Date completed treatment: / /
Month Day Year

NCTSN BREAKTHROUGH SERIES/LEARNING COLLABORATIVES

Complete the following.

1. Is this child/family receiving a treatment from a therapist participating in a breakthrough series or learning collaborative for that treatment?

0 = No

1 = Yes

If Yes: Please press the Add Entry button and complete the requested information for **EACH** treatment the child/family is receiving through a breakthrough series or learning collaborative. A new entry is required for each type of treatment and each different set of start/stop dates.

1. What treatment is this child/family receiving through a therapist participating in a breakthrough series or other learning collaborative? (Select only one)

1 = Trauma-Focused Cognitive Behavior Therapy (TF-CBT)

2 = Life Skills/Life Stories

3 = Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)

4 = Trauma Adaptive Recovery Group Education and Therapy TARGET (TARGET)

5 = Trauma Systems Therapy (TST)

6 = Child Parent Psychotherapy (CPP)

7 = Cognitive-Behavioral Intervention for Trauma in Schools (CBITS)

98 = Other, please specify name of treatment: _____

2. Date this treatment began: / /
Month Day Year

NOTE: Complete question 3 after the child/family has terminated this treatment.

3. Did this child/family complete this treatment?

0 = No, left this treatment before completing

If No: Date left this treatment: / /
Month Day Year

1 = Yes, completed treatment

If Yes: Date completed this treatment: / /
Month Day Year

INSURANCE INFORMATION AND DOMESTIC ENVIRONMENT

Insurance Information

1. Is the child currently covered by any type of public or private health insurance?
 0 = No (If no, skip to Question 3)
 1 = Yes
If Yes: Specify type below in Question 2
 99 = Unknown

2. Type of public or private health insurance currently covering the child **(Check all that apply)**
 - Public:
 - Medicare
 - Medicaid
 - Indian health service
 - Children’s health insurance program (CHIP)
 - Other public, please specify: _____
 - Private:
 - HMO
 - PPO
 - Fee-for-service
 - Other private, please specify: _____

3. Is the child’s parent/guardian covered by any type of insurance?
 0 = No (If no, skip to Question 5)
 1 = Yes
If Yes: Specify type below in Question 4
 99 = Unknown

4. Type of public or private health insurance currently covering the child’s parent/guardian **(Check all that apply)**
 - Public:
 - Medicare
 - Medicaid
 - Indian health service
 - Children’s health insurance program (CHIP)
 - Other public, please specify: _____
 - Private:
 - HMO
 - PPO
 - Fee-for-service
 - Other private, please specify: _____

Domestic Environment

5. Where is the child’s current primary residence? (Select only one)

1 = Independent (alone or with peers)	7 = Correctional facility
2 = Home (With parent(s))	8 = Homeless
3 = With relatives or other family	9 = Shelter
4 = Regular foster care	99 = Unknown
5 = Treatment foster care	98 = Other, please specify _____
6 = Residential treatment center	

6. How many months has the child been living in above setting?
_____(Enter number of months or "0" if less than one month)
Or, circle one of the following options:
1 = Entire life
99 = Unknown

DOMESTIC ENVIRONMENT DETAILS

If 'Home with parent(s)' or 'With relatives or other family' is selected for primary residence on the Insurance Information and Domestic Environment form at Baseline complete the following questions.

1. What types of adults live in the home with the child? (Check all that apply)
- Mother (Biological or adopted)
 - Father (Biological or adopted)
 - Parent's partner/significant other
 - Grandparent
 - Other adult relative
 - Other adult non-relative
 - Unknown
 - Other, please specify: _____
2. Total number of adults (18 years of age or older) living in child's home: _____
Or, circle the following if unknown: 99 = Unknown
3. Total number of children younger than 18 years of age (including client) living in child's home: _____
Or, circle the following if unknown: 99 = Unknown
4. Please specify ZIP code of child's current residence: - (5 digit zip code)
Or, circle the following if unknown: 99 = Unknown
5. Primary language spoken at home: (Select only one)
- 1 = English
 - 2 = Spanish
 - 3 = French
 - 4 = Mandarin
 - 5 = Cantonese
 - 6 = Navaho
 - 7 = Japanese
 - 8 = Korean
 - 9 = Russian
 - 99 = Unknown
 - 98 = Other, please specify: _____
6. What is the total income for the child's household for the past year, before taxes and including all sources:
\$ _____(US\$)
Or, circle the following if unknown: 99 = Unknown

FAMILY ASSESSMENT MODULE – FAMILY APGAR

The following 5 questions are designed to be completed by the child’s caregiver.

The following questions have been designed to help us better understand you and your family. You should feel free to ask questions about any item in the questionnaire. Answer each question as “almost always”, “sometimes”, or “hardly ever”. Family is defined as the individual(s) with whom you usually live.

1. I am satisfied with the help that I receive from my family when something is troubling me.	0 = Hardly ever 1 = Some of the time 2 = Almost always 99 = Unknown
2. I am satisfied with the way my family discusses items of common interest and shares problem solving with me.	0 = Hardly ever 1 = Some of the time 2 = Almost always 99 = Unknown
3. I find that my family accepts my wishes to take on new activities or make changes in my life-style.	0 = Hardly ever 1 = Some of the time 2 = Almost always 99 = Unknown
4. I am satisfied with the way my family expresses affection and response to my feelings such as anger, sorrow, and love.	0 = Hardly ever 1 = Some of the time 2 = Almost always 99 = Unknown
5. I am satisfied with the amount of time my family and I spend together.	0 = Hardly ever 1 = Some of the time 2 = Almost always 99 = Unknown

INDICATORS OF SEVERITY OF PROBLEMS

This section relates to the types of problems and experiences ‘child’ might have displayed. Indicate if the child experienced these types of problems within the past month (*within the last 30 days*). Please answer each question. **This section should be completed for children ages 6 and older.**

All responses should be the Indicator of Severity for problems experienced **within the past month**.

1. Academic problems (e.g., Problems with school work or grades)	0 = Not a problem 1 = Somewhat/sometimes a problem 2 = Very much/often a problem 99 = Unknown
2. Behavior problems in school or daycare (e.g., Getting into trouble, detention, suspension, expulsion)	0 = Not a problem 1 = Somewhat/sometimes a problem 2 = Very much/often a problem 99 = Unknown
3. Problems with skipping school or daycare (e.g., Where he/she skipped at least 4 days in the past month, or skipped parts of the day on at least half of the school days)	0 = Not a problem 1 = Somewhat/sometimes a problem 2 = Very much/often a problem 99 = Unknown
4. Behavior problems at home or community (e.g., Violent or aggressive behavior; breaking rules, fighting, destroying property, or other dangerous or illegal behavior)	0 = Not a problem 1 = Somewhat/sometimes a problem 2 = Very much/often a problem 99 = Unknown
5. Suicidality (e.g., Thinking about killing himself/herself or attempting to do so)	0 = Not a problem 1 = Somewhat/sometimes a problem 2 = Very much/often a problem 99 = Unknown
6. Other self-injurious behaviors (e.g., Cutting him/herself, pulling out his/her own hair)	0 = Not a problem 1 = Somewhat/sometimes a problem 2 = Very much/often a problem 99 = Unknown
7. Developmentally inappropriate sexualized behaviors (e.g., Saying or doing things about sex that children his/her age do not usually know)	0 = Not a problem 1 = Somewhat/sometimes a problem 2 = Very much/often a problem 99 = Unknown
8. Alcohol use (e.g., Use of alcohol)	0 = Not a problem 1 = Somewhat/sometimes a problem 2 = Very much/often a problem 99 = Unknown
9. Substance use (e.g., Use of illicit drugs or misuse of prescription medication)	0 = Not a problem 1 = Somewhat/sometimes a problem 2 = Very much/often a problem 99 = Unknown
10. Attachment problems (e.g., Difficulty forming and maintaining trusting relationships with other people)	0 = Not a problem 1 = Somewhat/sometimes a problem 2 = Very much/often a problem 99 = Unknown
11. Criminal activity (e.g., Activities that have resulted in being stopped by the police or arrested)	0 = Not a problem 1 = Somewhat/sometimes a problem 2 = Very much/often a problem 99 = Unknown

INDICATORS OF SEVERITY OF PROBLEMS (CONTINUED)

12. Running away from home (e.g., Staying away for at least one night)	0 = Not a problem 1 = Somewhat/sometimes a problem 2 = Very much/often a problem 99 = Unknown
13. Prostitution (e.g., Exchanging sex for money, drugs or other resources)	0 = Not a problem 1 = Somewhat/sometimes a problem 2 = Very much/often a problem 99 = Unknown
14. Child has other medical problems or disabilities (e.g., Chronic or recurrent condition that affects the child's ability to function)	0 = Not a problem 1 = Somewhat/sometimes a problem 2 = Very much/often a problem 99 = Unknown

15. Has the child ever talked about committing suicide?
 0 = No
 1 = Yes
If Yes: In the past 3 months, has the child talked about committing suicide?
 0 = No
 1 = Yes
 99 = Unknown
 99 = Unknown

16. Has the child ever attempted suicide?
 0 = No
 1 = Yes
If Yes: In the past 3 months, has the child attempted suicide?
 0 = No
 1 = Yes
 99 = Unknown
 99 = Unknown

YOUNG CHILD INDICATORS OF SEVERITY OF PROBLEMS

This section relates to the types of problems and experiences ‘child’ might have displayed. Indicate if the child experienced these types of problems within the past month (*within the last 30 days*). Please answer each question. This section should be completed for children younger than age 6.

All responses should be the Indicator of Severity for problems experienced **within the past month**.

1. Immediate Risk – Child’s current risk of self-harm

0	No current self injurious behaviors
1	Mild risk of self injury due to dysregulated behaviors (i.e. climbing high furniture, etc.)
2	Moderate problems with dangerous or self injurious behaviors, e.g. running from caregivers, pulls own hair, or head banging.
3	Severe problems with dangerous and self injurious behaviors, e.g. child runs into street, tries to hang or injury self or talks about wanting to kill themselves even though their understanding of death is not complete
99	Unknown/unable to rate

2. Emotional Regulation – Child’s ability: 1) to have developmentally appropriate control over emotions (including joy, excitement, anger, sadness, and fear); 2) to be comforted, and 3) to regulate the intensity of emotional expression particularly when faced with frustration.

0	No evidence of regulatory problems.
1	Mild problems with emotional regulation. Child may be difficult to choose or may require more structure and support than other children. in coping with frustration and difficult emotions.
2	Moderate problems with emotion regulation that may include: 1) difficulties with transitions; 2) severe irritability including extreme or prolonged tantrums; 3) low frustration tolerance; 4) age inappropriate ability to delay gratification. Problems interview with child’s developmental functioning and may require consistent adult intervention.
3	Profound problems with emotional regulation that place the child’s safety, well-being and/or development at risk.
99	Unknown/unable to rate

3. Feeding – Issues with feeding (e.g. difficulty sucking, chewing or swallowing, sensory food aversions, symptoms of failure to thrive, overeating and/or Pica)

0	No evidence of any feeding problems.
1	Child has minor feeding problems; however, problems have not interfered with the child’s functioning or the parent-child relationship.
2	Child has moderate symptoms of feeding problems
3	Child’s feeding problems have become so significant that the child has had medical problems associated with feeding issues
99	Unknown/unable to rate

4. Child Sleep Problems – Problems with sleep including insomnia, frequent awakening, and nightmares.

0	No evidence of sleep disturbance.
1	Mild sleep disruption, including occasional nightmares or difficulty falling asleep, i.e., mild insomnia of up to 1 hour.
2	Moderate sleep disturbance including frequent (at least once per week to nearly daily) resistance to going to bed, difficulty falling asleep, or nightmares. May include insomnia for up to 2 hours each night or frequent awakening with difficulty falling back asleep.
3	Severe sleep disturbance that could include daily sleep problems, including difficulty falling asleep, awakening in the night. The child has less than 4 hours of sleep per night or has day/night reversal.
99	Unknown/unable to rate

5. Play – Consider child’s developmental age when considering the child’s ability to engage in age appropriate play.

0	Child demonstrates age appropriate play.
1	Child demonstrates age appropriate play most of the time or is responsive to adult prompts to play.
2	Child demonstrates moderate problems with age appropriate play (e.g. child shows little interest or enjoyment in playing with peers or adults, child does not explore toys for significant length of time).
3	Child does not demonstrate age appropriate play skills. Child does not often respond to or engage in play activities with adults or peers, s/he does not explore or uses toys in a way that is appropriate for their age.
99	Unknown/unable to rate

6. Preschool/Childcare – Child’s behavior in preschool and/or childcare.

NA	Not applicable, child not in preschool or daycare
0	No evidence of problems with functioning in current preschool or childcare environment.
1	Mild problems with functioning in current preschool or daycare environment.
2	Moderate problems with functioning in current preschool or daycare environment. Child has difficulties with behavior in this setting creating significant concerns or problems for others.
3	Profound problems with functioning in current preschool or daycare environment. Child has been removed or is at immediate risk of being removed from program due to behaviors or unmet needs.
99	Unknown/unable to rate

7. Social functioning – Child difficulties with social skills and relationships.

0	No evidence of problems and/or child has developmentally appropriate social functioning.
1	Minor problems in social relationships. (i.e. Infants may be slow to respond to or engage adults, toddlers may need support to interact positively with peers and toddlers and preschoolers may be withdrawn or aggressive.)
2	Moderate problems with social relationships. (i.e. Infants and toddlers may be disengaged from adults or peers, hard to soothe, and show difficulty in focusing on toys in social situations. Preschoolers may hit, bite or having difficulty sharing and taking turns even when adults offer support.)
3	Severe disruptions in social relationships. (i.e. Infants and toddlers show limited ability to signal needs or express pleasure. Infants, toddlers, preschoolers are consistently withdrawn and unresponsive to familiar adults. Preschoolers show no joy or sustained interaction with peers or adults, and/or aggression, and or may be place themselves or others at risk.)
99	Unknown/unable to rate

8. Aggression – Aggressive behaviors include biting, hitting, kicking, throwing toys and other objects

0	No evidence of aggressive behaviors.
1	Mild concerns but does not interfere with functioning; adults are able to manage challenging behaviors.
2	Clear evidence of aggressive behavior. Behavior is persistent, and caregiver’s attempts to change behavior have not been successful.
3	Significant challenges with aggressive behaviors, characterized as dangerous and involves threat of harm to others or problems in more than one life domain that significantly threatens child’s growth and development.
99	Unknown/unable to rate

9. Sexualized behaviors –Sexualized behavior includes both age-inappropriate talking or acting out in sexualize ways.

0	No evidence of problems with sexualized talk or behaviors.
1	Some evidence of sexualize talk or behavior. Child may exhibit occasional inappropriate sexual language or behavior or engages in behaviors that mimic sexualized behaviors.
2	Moderate problems with sexualized behavior, Child may exhibit more frequent masturbation than is age appropriate, may frequently use sexualized language or say or do things related sex that children his/her age do not usually know
3	Significant problems with sexualize behaviors. Child exhibits sexual behaviors that indicates exposure to sexual activity or possible victimization and may try to touch other children.
99	Unknown/unable to rate

10. Child attachment difficulties - Item should be rated within the context of the child's significant parental or caregiver relationships.

0	No evidence of attachment problems. Child appears able to respond to caregiver cues in a consistent, appropriate manner, and child seeks age-appropriate contact with caregiver for both nurturing and safety needs. Child experiences a sense of security and trust within his/her attachment relationships.
1	Mild problems with attachment. Child may have difficulty accurately reading caregiver efforts to provide attention and nurturance; may be inconsistent in response; or may be occasionally needy. Child may have mild problems with separation (e.g., anxious/clingy behaviors in the absence of obvious cues of danger) or may avoid contact with caregiver in age-inappropriate way.
2	Moderate problems with attachment. Child may consistently misinterpret cues, act in an overly needy way, or ignore/avoid contact even when distressed. Child may have ongoing difficulties with separation, may consistently avoid contact with caregivers.
3	Severe problems with attachment. Child is unable to form attachment relationships with others (e.g., chronic dismissive/avoidant/detached behavior in care giving relationships) OR child presents with diffuse emotional/physical boundaries leading to indiscriminate friendliness with others. Child is considered at ongoing risk due to the nature of his/her attachment behaviors. A child who meets the criteria for an Attachment Disorder in DSM-IV would be rated here.
99	Unknown/unable to rate

11. Developmental concerns –Problems may occur in cognitive, receptive language, expressive language, motor, or social domains

0	Child meets or exceeds all developmental milestones.
1	Child is close to meeting all developmental milestones. Circle domain(s) that needs further consideration: <ul style="list-style-type: none"> • Cognitive • Receptive Language • Expressive Language • Motor • Social
2	Child has some problems with immaturity or delay in meeting developmental milestones. Problems occasionally interfere with child’s ability to function. Circle domain(s) that needs further consideration: <ul style="list-style-type: none"> • Cognitive • Receptive Language • Expressive Language • Motor • Social
3	Significant difficulties or unevenness with development. Developmental delays significantly impair child’s functioning. Circle domain(s) that needs further consideration: <ul style="list-style-type: none"> • Cognitive • Receptive Language • Expressive Language • Motor • Social
99	Unknown/unable to rate

12. Atypical behaviors - Includes mouthing after 1 year, head banging, smelling objects, spinning, twirling, hand flapping, finger-flicking, rocking, toe walking, staring at lights, or repetitive and bizarre verbalizations

0	No evidence of atypical behaviors in the infant/child
1	Child engages in atypical behaviors at times
2	Clear evidence of atypical behaviors reported by caregivers that are observed on an ongoing basis
3	Clear evidence of atypical behaviors that are consistently present and interfere with the infants/child’s functioning on a regular basis
99	Unknown/unable to rate

SERVICES RECEIVED IN PAST MONTH

BASELINE INSTRUCTIONS: Has the child received any of these services or been placed in any of the following (excluding today's visit) within the past month (*within the past 30 days*)? These may include services provided by your Center as well as services provided by any other clinician, setting or sector.

1. Inpatient psychiatric unit or a hospital for mental health problems	0 = No 1 = Yes 99 = Unknown
2. Residential treatment center (A self-contained treatment facility where the child lives and goes to school)	0 = No 1 = Yes 99 = Unknown
3. Detention center, training school, jail, or prison	0 = No 1 = Yes 99 = Unknown
4. Group home (A group residence in a community setting)	0 = No 1 = Yes 99 = Unknown
5. Treatment foster care (Placement with foster parents who receive special training and supervision to help children with problems)	0 = No 1 = Yes 99 = Unknown
6. Probation officer or court counselor	0 = No 1 = Yes 99 = Unknown
7. Day treatment program (A day program that includes a focus on therapy and may also provide education while the child is there)	0 = No 1 = Yes 99 = Unknown
8. Case management or care coordination (Someone who helps the child get the kinds of services he/she needs)	0 = No 1 = Yes 99 = Unknown
9. In-home counseling (Services, therapy, or treatment provided in the child's home)	0 = No 1 = Yes 99 = Unknown
10. Outpatient therapy (From psychologist, social worker, therapist, or other counselor)	0 = No 1 = Yes 99 = Unknown
11. Outpatient treatment from a psychiatrist	0 = No 1 = Yes 99 = Unknown
12. Primary care physician/pediatrician for symptoms related to trauma or emotional/behavioral problems. (Excluding emergency room)	0 = No 1 = Yes 99 = Unknown
13. School counselor, school psychologist, or school social worker (For behavioral or emotional problems)	0 = No 1 = Yes 99 = Unknown
14. Special class, special school or Early Intervention Services (Part C or B) (For all or part of the day)	0 = No 1 = Yes 99 = Unknown
15. Child welfare (excluding foster care)	0 = No 1 = Yes 99 = Unknown
16. Social services other than child welfare (e.g., TANF, food stamps, child care)	0 = No 1 = Yes 99 = Unknown
17. Foster care (Placement in kinship or non-relative foster care)	0 = No 1 = Yes 99 = Unknown

SERVICES RECEIVED IN PAST MONTH (CONTINUED)

18. Therapeutic recreation services or mentor	0 = No 1 = Yes 99 = Unknown
19. Hospital emergency room (For problems related to trauma or emotional or behavioral problems)	0 = No 1 = Yes 99 = Unknown
20. Self-help groups (e.g., AA, NA)	0 = No 1 = Yes 99 = Unknown
21. Medication management	0 = No 1 = Yes 99 = Unknown
22. Home Visiting	0 = No 1 = Yes 99 = Unknown
23. Head Start Program and service coordination	0 = No 1 = Yes 99 = Unknown
24. Parent education and skill-building programs	0 = No 1 = Yes 99 = Unknown
25. Peer support / therapy	0 = No 1 = Yes 99 = Unknown
26. 'Wraparound' services	0 = No 1 = Yes 99 = Unknown
27. Other, Specify _____	0 = No 1 = Yes 99 = Unknown

28. If the child received outpatient therapy / treatment, please indicate which of the following treatment modalities were received (check all that apply):

Attachment-based therapy	
Behavioral therapy	
Cognitive therapy	
Cognitive behavioral therapy	
Expressive therapies (drawing, movement, theater)	
Family therapy	
Narrative therapy	
Phase-oriented trauma treatment	
Play therapy	
Psychoanalysis	
Psychodynamic psychotherapy	
Social skills training	
Solution-focused therapy	
Stress management / relaxation training	
Supportive therapy	

SERVICES RECEIVED IN PAST YEAR

BASELINE INSTRUCTIONS: Has the child received any of these services or been placed in any of the following (excluding today's visit) within the past year (*within the past 12 months*)? If so, were the services received in response to the child's trauma? These may include services provided by your Center as well as services provided by any other clinician, setting or sector.

Service	Service received by child?	Service received in response to child's trauma?
1. Inpatient psychiatric unit or a hospital for mental health problems	0 = No 1 = Yes 99 = Unknown	0 = No 1 = Yes 99 = Unknown
2. Residential treatment center (A self-contained treatment facility where the child lives and goes to school)	0 = No 1 = Yes 99 = Unknown	0 = No 1 = Yes 99 = Unknown
3. Detention center, training school, jail, or prison	0 = No 1 = Yes 99 = Unknown	0 = No 1 = Yes 99 = Unknown
4. Group home (A group residence in a community setting)	0 = No 1 = Yes 99 = Unknown	0 = No 1 = Yes 99 = Unknown
5. Treatment foster care (Placement with foster parents who receive special training and supervision to help children with problems)	0 = No 1 = Yes 99 = Unknown	0 = No 1 = Yes 99 = Unknown
6. Probation officer or court counselor	0 = No 1 = Yes 99 = Unknown	0 = No 1 = Yes 99 = Unknown
7. Day treatment program (A day program that includes a focus on therapy and may also provide education while the child is there)	0 = No 1 = Yes 99 = Unknown	0 = No 1 = Yes 99 = Unknown
8. Case management or care coordination (Someone who helps the child get the kinds of services he/she needs)	0 = No 1 = Yes 99 = Unknown	0 = No 1 = Yes 99 = Unknown
9. In-home counseling (Services, therapy, or treatment provided in the child's home)	0 = No 1 = Yes 99 = Unknown	0 = No 1 = Yes 99 = Unknown
10. Outpatient therapy (From psychologist, social worker, therapist, or other counselor)	0 = No 1 = Yes 99 = Unknown	0 = No 1 = Yes 99 = Unknown
11. Outpatient treatment from a psychiatrist	0 = No 1 = Yes 99 = Unknown	0 = No 1 = Yes 99 = Unknown
12. Primary care physician/pediatrician for symptoms related to trauma or emotional/behavioral problems. (Excluding emergency room)	0 = No 1 = Yes 99 = Unknown	0 = No 1 = Yes 99 = Unknown
13. School counselor, school psychologist, or school social worker (For behavioral or emotional problems)	0 = No 1 = Yes 99 = Unknown	0 = No 1 = Yes 99 = Unknown
14. Special class, special school or Early Intervention Services (Part C or B) (For all or part of the day)	0 = No 1 = Yes 99 = Unknown	0 = No 1 = Yes 99 = Unknown
15. Child welfare (excluding foster care)	0 = No 1 = Yes 99 = Unknown	0 = No 1 = Yes 99 = Unknown

SERVICES RECEIVED IN PAST YEAR (CONTINUED)

Service	Service received by child?	Service received in response to child's trauma?
16. Social services other than child welfare (e.g., TANF, food stamps, child care)	0 = No 1 = Yes 99 = Unknown	0 = No 1 = Yes 99 = Unknown
17. Foster care (Placement in kinship or non-relative foster care)	0 = No 1 = Yes 99 = Unknown	0 = No 1 = Yes 99 = Unknown
18. Therapeutic recreation services or mentor	0 = No 1 = Yes 99 = Unknown	0 = No 1 = Yes 99 = Unknown
19. Hospital emergency room (For problems related to trauma or emotional or behavioral problems)	0 = No 1 = Yes 99 = Unknown	0 = No 1 = Yes 99 = Unknown
20. Self-help groups (e.g., AA, NA)	0 = No 1 = Yes 99 = Unknown	0 = No 1 = Yes 99 = Unknown
21. Medication management	0 = No 1 = Yes 99 = Unknown	0 = No 1 = Yes 99 = Unknown
22. Home Visiting	0 = No 1 = Yes 99 = Unknown	0 = No 1 = Yes 99 = Unknown
23. Head Start Program and service coordination	0 = No 1 = Yes 99 = Unknown	0 = No 1 = Yes 99 = Unknown
24. Parent education and skill-building programs	0 = No 1 = Yes 99 = Unknown	0 = No 1 = Yes 99 = Unknown
25. Peer support / therapy	0 = No 1 = Yes 99 = Unknown	0 = No 1 = Yes 99 = Unknown
26. 'Wraparound' services	0 = No 1 = Yes 99 = Unknown	0 = No 1 = Yes 99 = Unknown
27. Other, Specify _____	0 = No 1 = Yes 99 = Unknown	0 = No 1 = Yes 99 = Unknown

28. If the child received outpatient therapy / treatment, please indicate which of the following treatment modalities were received (check all that apply):

Attachment-based therapy	
Behavioral therapy	
Cognitive therapy	
Cognitive behavioral therapy	
Expressive therapies (drawing, movement, theater)	
Family therapy	
Narrative therapy	
Phase-oriented trauma treatment	

Child ID Number: --
Center ID Subcenter ID Child ID

**Core Clinical Characteristics
 (Baseline Assessment Form)**

Play therapy	
Psychoanalysis	
Psychodynamic psychotherapy	
Social skills training	
Solution-focused therapy	
Stress management / relaxation training	
Supportive therapy	

CLINICAL EVALUATION

Based on your clinical evaluation, for questions 1-21 please check each problem/symptom/disorder currently displayed by the child. For question 22 please indicate the *primary* problems/symptom/disorder currently displayed by the child.

Clinical Problems, Symptoms, and Disorders	Child has/exhibits this problem? (Answer all that apply)		
1. Acute stress disorder	0 = No	1 = Probable	2 = Definite
2. Post traumatic stress disorder	0 = No	1 = Probable	2 = Definite
3. Traumatic/complicated grief	0 = No	1 = Probable	2 = Definite
4. Dissociation	0 = No	1 = Probable	2 = Definite
5. Somatization	0 = No	1 = Probable	2 = Definite
6. Generalized anxiety	0 = No	1 = Probable	2 = Definite
7. Separation disorder	0 = No	1 = Probable	2 = Definite
8. Panic disorder	0 = No	1 = Probable	2 = Definite
9. Phobic disorder	0 = No	1 = Probable	2 = Definite
10. Obsessive compulsive disorder	0 = No	1 = Probable	2 = Definite
11. Depression	0 = No	1 = Probable	2 = Definite
12. Attachment problems	0 = No	1 = Probable	2 = Definite
13. Sexual behavioral problems	0 = No	1 = Probable	2 = Definite
14. Oppositional defiant disorder	0 = No	1 = Probable	2 = Definite
15. Conduct disorder	0 = No	1 = Probable	2 = Definite
16. General behavioral problems	0 = No	1 = Probable	2 = Definite
17. Attention deficit hyperactivity disorder	0 = No	1 = Probable	2 = Definite
18. Suicidality	0 = No	1 = Probable	2 = Definite
19. Substance abuse	0 = No	1 = Probable	2 = Definite
20. Sleep disorder	0 = No	1 = Probable	2 = Definite
21. Adjustment disorder	0 = No	1 = Probable	2 = Definite
22. Disorders of infancy, childhood, or adolescence NOS	0 = No	1 = Probable	2 = Definite
23. Feeding disorder of infancy or early childhood	0 = No	1 = Probable	2 = Definite

24. Are there any other additional problems currently displayed by this child?
Please specify: _____

25. Please indicate the *primary* problem/symptom/disorder currently displayed by this child. (Select only one)
- 1 = Acute stress disorder
 - 2 = Post traumatic stress disorder
 - 3 = Traumatic/complicated grief
 - 4 = Dissociation
 - 5 = Somatization
 - 6 = Generalized anxiety
 - 7 = Separation disorder
 - 8 = Panic disorder
 - 9 = Phobic disorder
 - 10 = Obsessive compulsive disorder
 - 11 = Depression
 - 12 = Attachment problems
 - 13 = Sexual behavioral problems
 - 14 = Oppositional defiant disorder
 - 15 = Conduct disorder
 - 16 = General behavioral problems
 - 17 = Attention deficit hyperactivity disorder
 - 18 = Suicidality

- 19 = Substance abuse
- 20 = Sleep disorder
- 21 = Adjustment disorder
- 22 = Disorders of infancy, childhood, or adolescence NOS
- 23 = Feeding disorder of infancy or early childhood
- 24 = Other

26. Please rate the child and caregiving system

- 0 = Resilient
- 1 = Average adaptive, could benefit from education or information on post-trauma adjustment
- 2 = Risk of disturbance and intervention recommended
- 3 = Disturbance and need of intensive intervention
- 99 = Unknown

27. Please rate the family's resources (income and other resources available to address family needs)

- 0 = Family has financial resources necessary to meet needs
- 1 = Family has financial resources necessary to meet most needs; however, some limitations exist
- 2 = Family has financial difficulties that limit their ability to meet significant family needs
- 3 = Family experiencing financial hardship, poverty
- 99 = Unknown

