Ocean
Trauma Counselling

Child Outcome Measures

Date of completion	
Childs name	
Parent / Guardian Name	

RCADS-PARENT

The questions below are to be completed by the child's parent/guardian. RCADS questionnaire helps to establish a baseline on what you consider are the presenting issues for your child.

Please mark the box to indicate how often each issue occurs

	Never	Sometimes	Often	Always
My child worries about things				
My child feels sad or empty				
When my child has a problem, they get a funny feeling in their stomach				
My child worries when they think they have done poorly at something				
My child feels afraid of being alone at home				
Nothing is much fun for my child anymore				
My child feels scared when taking a test				
My child worries when they think someone is angry with them				
My child worries about being away from me				
My child is bothered by bad or silly thoughts or pictures in their mind				
My child has trouble sleeping				
My child worries about doing badly at school work				
My child worries that something awful will happen to someone in the family				
My child suddenly feels as if they can't breathe when there is no reason for this				
My child had problems with their appetite				
My child must keep checking that they have done things right (e.g. the door is locked)				
My child feels scared to sleep on their own				

My child had trouble going to school in the mornings because of feeling nervous or afraid				
My child had no energy for things				
My child worries about looking foolish				
My child is tired a lot				
My child worries that bad things will happen to them				
My child can't seem to get bad or silly thoughts out of their head				
When my child has a problem, their heart beats really fast				
My child cannot think clearly				
My child suddenly starts to tremble or shake when there is no reason for this				
My child worries that something bad will happen to them				
When my child has a problem, they feel shaky				
My child feels worthless				
My child worries about making mistakes				
My child must think special thoughts(like numbers or words) to stop bad things from happening				
My child worries what other people think of them				
My child is afraid of being in crowded places				
All of a sudden, my child will feel really scared for no reason				
My child worries about what is going to happen				
My child suddenly becomes dizzy or faint when there is no reason for this				
My child thinks about death				
My child feels afraid if they have to talk in front of the class				
My child's heart suddenly starts to beat too quickly for no reason				
My child feels like they don't want to move a lot of the time				
My child worries that they will suddenly get a scared feeling when there is nothing to be afraid of				
My child feels afraid that they will make a fool of themselves in front ofpeople				
My child had to do some things in				

just the right way to stop bad things from happening				
My child worries when in bed at night				
My child would feel scared if they had to stay away from home overnight				
My child feels restless				

Trauma Screening- to be completed by parents / guardians. (CATS-C)

(*Only complete if a trauma or traumatic events have occurred, for example, death of someone close, abuse, witnessing domestic violence etc.*)

CATS-C		***How often have the following affected your child in the last 2 weeks? Answer to the best of your ability***	Never	Once in a while	Half the time	Almost always
1.	Upsetting thoughts or images about a stressful event, or re-enacting a stressful event in play		☐	☐	☐	☐
2.	Having bad dreams related to a stressful event		☐	☐	☐	☐
3.	Acting, playing or feeling as if a stressful event is happening right now		☐	☐	☐	☐
4.	Feeling very emotionally upset when reminded of a stressful event		☐	☐	☐	☐
5.	Strong physical reactions when reminded of stressful event		☐	☐	☐	☐
6.	Trying not to remember, think about or have feeling about a stressful event		☐	☐	☐	☐
7.	Avoiding anything that is a reminder of a stressful event		☐	☐	☐	☐
8.	Not being able to remember an important part of a stressful event		☐	☐	☐	☐
9.	Negative changes in how they think about self, other or the world after the stressful event		☐	☐	☐	☐
10.	Thinking a stressful event happened because they, or someone else, did something wrong or did not do enough to stop it		☐	☐	☐	☐
11.	Having very negative emotional states		☐	☐	☐	☐
12.	Losing interest in activities they used to enjoy before the event		☐	☐	☐	☐
13.	Feeling distant or cut off from people around them		☐	☐	☐	☐
14.	Not showing positive feelings		☐	☐	☐	☐
15.	Being irritable or having angry outbursts without good reason and taking it out on other people or things		☐	☐	☐	☐
16.	Risky behaviour or behaviour that could be harmful to them		☐	☐	☐	☐
17.	Being overly alert or on guard		☐	☐	☐	☐
18.	Being jumpy or easily startled		☐	☐	☐	☐
19.	Problems with concentration		☐	☐	☐	☐
20.	Trouble falling or staying asleep		☐	☐	☐	☐

Have the problems above interfered with the following?

1. Getting along with others Yes No
2. Hobbies/fun Yes No
3. School Yes No
4. Family relationships Yes No
5. General happiness Yes No

Please provide an overview of the trauma/ traumatic event(s) your child has experienced. *What happened? How did it happen? How did it affect your child at the time? What are your child'scurrent feelings and thoughts about the event(s)? Is this something you/ your child wants to address in therapy?*