Life Incidence of Traumatic Events - Parent Form

Your Name_____ Child's Name_____ Date_____

Please circle **No** or **Yes** to show which things have happened **to your child**. **If Yes**, also fill in the rest of the line.

Did this ever happen to him/her?			how many times	how old s/he was (first time)	how much it upset him/her **then**	how much it bothers him/her **now**
No	Yes	been in a car accident	_____	_____	none some lots	none some lots
No	Yes	been hurt in another kind of accident or sick in the hospital	_____	_____	none some lots	none some lots
No	Yes	seen someone else get hurt	_____	_____	none some lots	none some lots
No	Yes	someone in the family in the hospital (hurt or sick)	_____	_____	none some lots	none some lots
No	Yes	someone in the family died	_____	_____	none some lots	none some lots
No	Yes	friend very sick, hurt or died	_____	_____	none some lots	none some lots
No	Yes	been in a fire	_____	_____	none some lots	none some lots
No	Yes	been in a hurricane, tornado, flood, or mudslide (circle which)	_____	_____	none some lots	none some lots
No	Yes	parents (or grown-ups) broke things or hurt each other	_____	_____	none some lots	none some lots
No	Yes	parents separated or divorced	_____	_____	none some lots	none some lots
No	Yes	been taken away from family	_____	_____	none some lots	none some lots
No	Yes	been hit, whipped, beaten, or hurt by someone	_____	_____	none some lots	none some lots
No	Yes	been tied up, or locked in a small space	_____	_____	none some lots	none some lots
No	Yes	been made to do sex things	_____	_____	none some lots	none some lots
No	Yes	been threatened (someone said they would do something bad)	_____	_____	none some lots	none some lots
No	Yes	been robbed (or house robbed)	_____	_____	none some lots	none some lots
No	Yes	other scary or upsetting event (what was it?_____)	_____	_____	none some lots	none some lots