

Life Incidence of Traumatic Events - Student Form

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Name _____ Age _____ Grade _____ Date _____

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

Did this ever happen to you?			how many times	how old you were (first time)	how much it upset you then	how much it bothers you 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