Child's Name

Please indicate whether any of these things have happened to you **since the accident.**

1. Do you have lots of thoughts or memories about the accident that you don't want to have?	Yes ○	No ○
2. Do you have bad dreams about the accident?	Yes ○	No ○
3. Do you feel or act as if the accident is about to happen again?	Yes ○	No ○
4. Do you have bodily reactions (such as a fast-beating heart, stomach churning, sweating and feeling dizzy) when reminded of the accident?	Yes ○	No ○
5. Do you have trouble falling or staying asleep?	Yes ○	No ○
6. Do you feel grumpy or lose your temper?	Yes ○	No ○
7. Do you feel upset by reminders of the accident?	Yes ○	No ○
8. Do you have a hard time paying attention?	Yes ○	No ○
9. Are you on the "look-out" for possible dangerous things that might happen to yourself and others?	Yes ○	No ○
10. When things happen by surprise or all of a sudden, does it make you "jump"?	Yes ○	No ○