GEORGE HULL CENTRE
FOR CHILDREN & FAMILIES
Changing the trajectory of children's mental health.

CASTER™ (Child and Adolescent Screener for Traumatic Events and Response)

Parent/Caregiver Report (Children ages 0-5) © 2021 The George Hull Centre

Child's Name_____ **Client ID** _____
(FIRST and LAST Name)

Today's Date _____ **Child's Birthdate** _____ **Child's Age** _____ **Child's Gender**_____
(dd/mm/yyyy) **(dd/mm/yyyy)**

Your Name_____ **Relationship to Child**_____
(FIRST and LAST Name)

Please review the racial and ethnic categories list at the back of this document and indicate which category best describes your CHILD's racial or ethnic group by filling in the blue circle(s). You can choose more than one option.

Stressful experiences can impact a child's health and development. The CASTER helps us understand more about your child's past experiences and their current thoughts, feelings, and behaviours.

Section One contains a list of potentially traumatic events that some people have experienced. To the best of your knowledge, please indicate if these events have ever happened to your child by choosing either **Yes** or **No** for each event.

If you answer **Yes** to an event, please then indicate ***how much*** that experience is currently affecting your child, as follows:

Not at All if the event does not currently affect your child at all.
Somewhat if the event currently affects your child somewhat.
Very Much if the event currently affects your child very much.

For example, if your child experienced a serious accident, and it affects them very much currently:

		No	Yes	*Not at All*	*Somewhat*	*Very Much*
10	Serious accident or injury for your child	O	●	O	O	●

Section Two contains a list of different thoughts, feelings, or behaviours. Some of these are common for children who are the same age as your child, whereas others may be related to upsetting events that have happened to your child. To the best of your knowledge, please tell us how often your child has experienced these **during the past 6 months**:

N = Never during the past 6 months
S = Sometimes during the past 6 months
O = Often during the past 6 months

For example, if your child has experienced problems falling asleep sometimes in the past 6 months:

During the past 6 months*, how often has your child experienced the following? *Circle which applies.

N = Never (past 6 months only) **S = Sometimes (past 6 months only)** **O = Often (past 6 months only)**

1	Problems falling asleep	*N*	(*S*)	*O*

Section Two has three additional questions. These questions tell us about important changes that your child may have experienced. Please tell us how many changes your child has experienced.
For example, if both parents and a stepfather have been primary caregivers for your child, you would select "3" for the following question:

Since birth, how many *TIMES* has a parent/important caregiver (e.g., stepparent, foster parent, grandparent) left your child's life in a significant way?		*1*	*2*	(*3*)	*4*	*5*	*6*	*7*	*8*	*9*	*10*	*11+*

Please ask for assistance if there are any questions about completing this form. Thank you.

SECTION ONE

Child Name or Client ID_____

CASTER™ Parent/Caregiver Report (Children ages 0-5)

	Has your child ever experienced any of the following?	**Check which applies**		**If Yes, please check how this experience currently affects your child**		
	Environmental/Living Conditions	*No*	*Yes*	*Not at All*	*Somewhat*	*Very Much*
1	Serious fire or natural disaster (e.g., flood, earthquake, forest fire)	O	O	O	O	O
2	Public health or environmental crisis (e.g., unsafe drinking water, chemical spill, disease/pandemic)	O	O	O	O	O
3	Major family move(s) (e.g., to a new community, home, country, or multiple moves)	O	O	O	O	O
4	Lived somewhere that felt dangerous, stressful, or unsafe	O	O	O	O	O
	Health, Injury, or Loss	*No*	*Yes*	*Not at All*	*Somewhat*	*Very Much*
5	Serious accident, injury, illness or scary medical procedure for your child	O	O	O	O	O
6	Serious accident, injury or illness happened to someone close to your child	O	O	O	O	O
7	Death of someone close to your child	O	O	O	O	O
	Life in the Community	*No*	*Yes*	*Not at All*	*Somewhat*	*Very Much*
8	Treated badly or unfairly because of race, gender, religion, sexual orientation, place of birth, abilities, or appearance	O	O	O	O	O
9	Seriously hurt, threatened, or bullied	O	O	O	O	O
10	Saw or heard serious violence or injury outside of the home	O	O	O	O	O
11	Saw or heard someone close to them stopped, confronted, detained, or arrested by law enforcement	O	O	O	O	O
	Life in the Family	*No*	*Yes*	*Not at All*	*Somewhat*	*Very Much*
12	Physically or emotionally hurt by parent/caregiver or other family member	O	O	O	O	O
13	Not enough food, appropriate or clean clothing, or other basic needs	O	O	O	O	O
14	Not enough affection, attention, or comfort from a parent/caregiver	O	O	O	O	O
15	Saw or heard serious conflict or violence between family members	O	O	O	O	O
16	Serious parental conflict, separation, and/or divorce	O	O	O	O	O
17	Serious financial trouble for the family (now or in the past)	O	O	O	O	O
18	Close family member with drug or alcohol problem or serious mental concerns	O	O	O	O	O
19	Significant separation from parent/caregiver or close family member	O	O	O	O	O
	Other	*No*	*Yes*	*Not at All*	*Somewhat*	*Very Much*
20	Exposed to, made to do, or had sexual things done to them	O	O	O	O	O
21	Heard about the serious harm or abuse of someone close to them	O	O	O	O	O
22	Other events that were scary, upsetting, or hurtful (please describe below) List: _____	O	O	O	O	O

SECTION TWO

Child Name or Client ID_____

CASTER™ Parent/Caregiver Report (Children ages 0-5)

During the past 6 months,* how often has your child experienced the following? *Circle which applies.

N = Never (past 6 months only) **S = Sometimes** (past 6 months only) **O = Often** (past 6 months only)

1	Problems sleeping (e.g., falling asleep, staying asleep, not wanting to sleep on their own)	*N*	*S*	*O*
2	Nightmares	*N*	*S*	*O*
3	Difficulty eating (e.g., refusing to eat, eating too much or too little)	*N*	*S*	*O*
4	Significant weight gain or loss	*N*	*S*	*O*
5	Easily bothered by certain sounds, smells, sights, tastes, or textures	*N*	*S*	*O*
6	Overly sensitive to being touched	*N*	*S*	*O*
7	Difficulty being soothed or comforted	*N*	*S*	*O*
8	Easily startled (e.g., "jumpy" in response to touch, sound, or being approached)	*N*	*S*	*O*
9	Overly passive (e.g., quiet, still, or not reacting)	*N*	*S*	*O*
10	Headaches, stomach-aches, or body aches	*N*	*S*	*O*
11	Does not speak in certain places or situations (e.g., outside the home)	*N*	*S*	*O*
12	"Tuning out" or appearing like they are in a daze	*N*	*S*	*O*
13	Unable to do things that they used to be able to do (e.g., toileting, dressing, feeding, talking)	*N*	*S*	*O*
14	Playing with, smearing, and/or withholding feces (poo)	*N*	*S*	*O*
15	Refusing to bathe or shower	*N*	*S*	*O*
16	Tantrums or outbursts	*N*	*S*	*O*
17	Excessive crying or screaming	*N*	*S*	*O*
18	Running away from parent/caregiver	*N*	*S*	*O*
19	Overly comfortable with people they don't know	*N*	*S*	*O*
20	Prefers to be alone	*N*	*S*	*O*
21	Difficulty interacting with other children	*N*	*S*	*O*
22	Refusing to go to school, childcare, or programs	*N*	*S*	*O*
23	Struggles to follow routines and/or meet expectations at home, school, childcare, or programs	*N*	*S*	*O*
24	Overly clingy or has difficulty separating from adults	*N*	*S*	*O*
25	Overly nervous, anxious, or tense	*N*	*S*	*O*
26	Overly watchful for signs of danger	*N*	*S*	*O*
27	Afraid of specific people, places, or situations (please list)_____	*N*	*S*	*O*
28	Overly sad	*N*	*S*	*O*
29	Overly angry	*N*	*S*	*O*
30	Taking or hiding food and/or other things	*N*	*S*	*O*
31	Harming self (e.g., hitting or biting themselves, banging head, picking at skin)	*N*	*S*	*O*
32	Harming or threatening to harm other people	*N*	*S*	*O*
33	Harming animals	*N*	*S*	*O*
34	Destructive behaviours (e.g., breaking things, smashing things)	*N*	*S*	*O*
35	Sexual language or behaviours	*N*	*S*	*O*
36	Extreme difficulty sitting still and/or paying attention	*N*	*S*	*O*
37	Excessive self-soothing behaviours (e.g., rocking, twisting/chewing hair, thumb sucking)	*N*	*S*	*O*
38	Scary or upsetting past event shows up in their play, stories, or art	*N*	*S*	*O*
39	Seems to have difficulty remembering scary or upsetting past event	*N*	*S*	*O*
40	Blaming themselves for scary or upsetting past event	*N*	*S*	*O*
41	Feeling they are bad or unlovable	*N*	*S*	*O*

Other concerns (Please describe below)				
42		*Never*	*Sometimes*	*Often*

Additional Questions												
43	Since birth, how many *TIMES* has a parent/important caregiver (e.g., stepparent, foster parent, grandparent) left your child's life in a significant way?	*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*	*11+*
44	Since birth, how many *TIMES* has your child lived away from parents/important caregivers (e.g., foster care, group home, with extended family)?	*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*	*11+*
45	Since birth, how many *DIFFERENT* childcare arrangements or schools has your child attended?	*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10+*	

Ethnographic and Racial Categories

- **Asian**
  - East (e.g., Chinese, Japanese, Korean)
  - South (e.g., Indian, Pakistani, Sri Lankan)
  - South East (e.g., Malaysian, Filipino, Vietnamese)
  - European (e.g., English, German, Turkish, Russian)
  - North American (e.g., Canadian, American)
  - Caribbean (e.g., Guyanese, Chinese Jamaican)
  - Other: _____

- **Black**
  - African (e.g., Ghanaian, Kenyan, Somali)
  - Caribbean (e.g., Barbadian, Jamaican)
  - Latin American (e.g., Brazilian, Colombian)
  - European (e.g., English, Spanish, French)
  - North American (e.g., Canadian, American)
  - Other: _____

- **Indigenous**
  - First Nations
  - Inuit
  - Metis
  - Other: _____

- **Latin American**
  - European Origin (e.g., Spanish, French, German)
  - Indigenous (e.g., Peruvian, Bolivian, Guatemalan)
  - Mixed Origins (e.g., Indigenous and European, Black and European)
  - Other: _____

- **Middle Eastern, West Asian** (e.g., Egyptian, Iranian, Lebanese, Afghan, Israeli, Turkish)

- **White**
  - European Origin (e.g., English, Italian, Portuguese, Russian, Australian, NZ)
  - North American (Canadian, American)
  - Other: _____

- **Multi-racial/multi-ethnic**: please specify (e.g., Black – African and White North American)
  _____

- **Others**: _____

- **Prefer not to answer**

- **Do not know**