REVISED CHILD IMPACT OF EVENTS SCALE

Below is a list of comments made by children after stressful life events. Please check each item showing how frequently these comments were true for you *during* the past 7 days. If they did not occur during that time, please check the "not at all" box.

Child's name:_____________________________________Date:_______________

	0 Not at all	1 Rarely	3 Sometimes	5 Often
1. Do you think about it, even when you don't mean to?				
2. Do you try to remove it from your memory?				
3. Do you have difficulties paying attention or concentrating?				
4. Do you have waves of strong feelings about it?				
5. Do you startle more easily, or feel more nervous than you did before it happened?				
6. Do you stay away from reminders of it (e.g., places or situations)?				
7. Do you try not to talk about it?				
8. Do pictures about it pop into your mind?				
9. Do other things keep making you think about it?				
10. Do you try not to think about it?				
11. Do you get easily irritable?				
12. Are you alert and watchful even when there is no obvious need to be?				
13. Do you have sleep problems?				

Office use only: I: ________ Av:________ Ar:________ RS:________

Children and War Foundation, 1998
RCP: 10/05