Revised Child Impact of Events Scale

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

Name:

Date:

		Not at all	Rarely	Some- times	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 waves of strong feelings about it	[]	[]	[]	[]
4.	Do you stay away from reminders of it (e.g. places or situations)	[]	[]	[]	[]
5.	Do you try not talk about it	[]	[]	[]	[]
6.	Do pictures about it pop into your mind?	[]	[]	[]	[]
7.	Do other things keep making you think about it?	[]	[]	[]	[]
8.	Do you try not to think about it?	[]	[]	[]	[]

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