<table>
<thead>
<tr>
<th>Event</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serious accident, fire or explosion</td>
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<td></td>
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<tr>
<td>Natural disaster (tornado, flood, hurricane, major earthquake)</td>
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<tr>
<td>Non-sexual assault by someone you know (physically attacked/injured)</td>
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<tr>
<td>Non-sexual assault by a stranger</td>
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<tr>
<td>Sexual assault by a family member or someone you know</td>
<td></td>
<td></td>
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<tr>
<td>Sexual assault by a stranger</td>
<td></td>
<td></td>
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<tr>
<td>Military combat or a war zone</td>
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<tr>
<td>Sexual contact before you were age 18 with someone who was 5 or more years older than you</td>
<td></td>
<td></td>
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<tr>
<td>Imprisonment</td>
<td></td>
<td></td>
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<tr>
<td>Torture</td>
<td></td>
<td></td>
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<tr>
<td>Life-threatening illness</td>
<td></td>
<td></td>
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<tr>
<td>Other traumatic event</td>
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</tbody>
</table>

If “other traumatic event” is checked YES above; please write what the event was: __________________________________________

14. Of the question to which you answered YES, which was the worst
    (Please list the question #)

    15. Which of the above incidences is the reason for which you are currently seeking treatment?
        (Please list the question #)

Please check YES or NO regarding the event listed in question 15.

- Were you physically injured?  
  [ ] Yes  [ ] No

- Was someone else physically injured?  
  [ ] Yes  [ ] No

- Did you think your life was in danger?  
  [ ] Yes  [ ] No

- Did you think someone else’s life was in danger?  
  [ ] Yes  [ ] No

- Did you feel helpless?  
  [ ] Yes  [ ] No

- Did you feel terrified?  
  [ ] Yes  [ ] No
TRAUMA CHECKLIST ADULT

Below is a list of problems that people sometimes have after experiencing a traumatic event. Please rate on a scale from 0-3 how much or how often these following things have occurred to you:

0  Not at all
1  Once per week or less/ a little bit/ one in a while
2  2 to 4 times per week/ somewhat/ half the time
3  3 5 or more times per week/ very much/ almost always

__1. Having upsetting thought or images about the traumatic event that come into your head when you did not want them to
__2. Having bad dreams or nightmares about the traumatic event
__3. Reliving the traumatic event (acting as if it were happening again)
__4. Feeling emotionally upset when you are reminded of the traumatic event
__5. Experiencing physical reactions when reminded of the traumatic event (sweating, increased heart rate)
__6. Trying not to think or talk about the traumatic event
__7. Trying to avoid activities or people that remind you of the traumatic event
__8. Not being able to remember an important part of the traumatic event
__9. Having much less interest or participating much less often in important activities
__10. Feeling distant or cut off from the people around you
__11. Feeling emotionally numb (unable to cry or have loving feelings)
__12. Feeling as if your future hopes or plans will not come true
__13. Having trouble falling or staying asleep
__14. Feeling irritable or having fits or anger
__15. Having trouble concentrating
__16. Being overly alert
__17. Being jumpy or easily startled

Please mark YES or NO if the problems above interfered with the following:

1. Work          □ Yes □ No          6. Family relationships   □ Yes □ No
2. Household duties □ Yes □ No      7. Sex life              □ Yes □ No
3. Friendships    □ Yes □ No         8. General life satisfaction □ Yes □ No
4. Fun/leisure activities □ Yes □ No  9. Overall functioning □ Yes □ No
5. Schoolwork     □ Yes □ No

Trauma Checklist Adult