## **Trauma Checklist Adult**

NAME	AGE	SEX	DATE	
	events or situations. Please make NO if you have not had that	•	nave experienc	ed of witnessed
1.Serious accident, fire or explo	osion			□ Yes □ No
2.Natural disaster (tornado, floo		□ Yes □ No		
3.Non-sexual assault by someo	□ Yes □ No			
4.Non-sexual assault by a stranger	ger			□ Yes □ No
5.Sexual assault by a family me	ember or someone you know			□ Yes □ No
6.Sexual assault by a stranger				□ Yes □ No
7.Military combat or a war zone	е			□ Yes □ No
8.Sexual contact before you we	□ Yes □ No			
9.Imprisonment				□ Yes □ No
10.Torture				□ Yes □ No
11.Life-threatening illness				□ Yes □ No
12.Other traumatic event				□ Yes □ No
13.If "other traumatic event" is	checked YES above; please write	what the event was	S	
14. Of the question to which yo (Please list the question #)	ou answered YES, which was the	worst		
15. Which of the above inciden (Please list the question #)	ces is the reason for which you ar	e currently seeking	treatment?	
Please check YES or NO re	egarding the event listed in qu	estion 15.		
Were you physically injured?				□ Yes □ No
Was someone else physically in	njured?			□ Yes □ No
Did you think your life was in o	langer?			□ Yes □ No
Did you think someone else's l	ife was in danger?			□ Yes □ No
Did you feel helpless?				□ Yes □ No
Did you feel terrified?				□ Yes □ No

## TRAUMA CHECKLIST ADULT

Not at all

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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:

Once per week or less/ a little bit/ one in a while

3	2 to 4 times per week/ somewhat/ half the time 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 tall	k about the traumatic e	vent					
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 aroun	d you					
11.	Feeling emotionally num	b (unable to cry or hav	e loving	feelings)				
12.	Feeling as if your future	hopes or plans will not	come tru	e				
13.	Having trouble falling or	staying asleep						
14.	Feeling irritable or havin	g fits or anger						
15.	Having trouble concentra	ating						
16.	Being overly alert							
17.	Being jumpy or easily sta	artled						
Please	mark YES or NO if the	problems above inter	fered wit	th the following:				
1.	Work	$\square$ Yes $\square$ No	6.	Family relationships	$\square$ Yes $\square$ No			
2.	Household duties	$\square$ Yes $\square$ No	7.	Sex life	$\square$ Yes $\square$ No			
3.	Friendships	$\square$ Yes $\square$ No	8.	General life satisfaction	□ Yes □ No			
4.	Fun/leisure activities	$\square$ Yes $\square$ No	9.	Overall functioning	□ Yes □ No			
5.	Schoolwork	□ Yes □ No						