

Trauma Screen and PTSD-DSM5 Checklist-Adult

Name: _____

Date: _____

Stressful or scary events happen to many people. Below is a list of stressful and scary events that sometimes happen. Mark YES if it happened to you. Mark No if it didn't happen to you.

- | | | |
|--|------------------------------|-----------------------------|
| 1. Serious natural disaster like a flood, tornado, hurricane, earthquake, or fire. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Serious accident or injury like a car/bike crash, dog bite, sports injury. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Robbed by threat, force or weapon. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Slapped, punched, or beat up in your family. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Slapped, punched, or beat up by someone not in your family. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Seeing someone in your family get slapped, punched or beat up. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Seeing someone in the community get slapped, punched or beat up. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. Someone older touching your private parts when they shouldn't. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9. Someone forcing or pressuring sex, or when you couldn't say no. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 10. Someone close to you dying suddenly or violently. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 11. Attacked, stabbed, shot at or hurt badly. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 12. Seeing someone attacked, stabbed, shot at, hurt badly or killed. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 13. Stressful or scary medical procedure. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 14. Being around war. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 15. Other stressful or scary event? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Describe: _____

Which one is bothering you the most now? _____

If you marked "YES" to any stressful or scary events, then turn the page and answer the next questions.

Mark 0, 1, 2 or 3 for how often the following things have bothered you in the last two weeks:

0 Never / 1 Once in a while / 2 Half the time / 3 Almost always

1. Upsetting memories about a stressful event that pop into your head unplanned or when you are reminded.	0	1	2	3
2. Bad dreams related to a stressful event that feels like it is happening in the dream.	0	1	2	3
3. Acting or feeling as if the stressful event is happening right now.	0	1	2	3
4. Feeling very emotionally upset when you are reminded of a stressful event.	0	1	2	3
5. Strong physical reactions when reminded of a stressful event (sweating, heart beating fast).	0	1	2	3
6. Trying not to remember, talk about or have feelings about a stressful event.	0	1	2	3
7. Avoiding activities, people, places or things that remind you of a stressful event.	0	1	2	3
8. Not being able to remember an important part of a stressful event.	0	1	2	3
9. Negative changes in how you think about yourself, others or the world after a stressful event.	0	1	2	3
10. Thinking a stressful event happened because you or someone else did something wrong or did not do enough to stop it.	0	1	2	3
11. Having a very negative emotional state (afraid, angry, guilty, ashamed).	0	1	2	3
12. Losing interest in activities you used to enjoy before a stressful event.	0	1	2	3
13. Feeling distant or cut off from people around you.	0	1	2	3
14. Not being able to have positive feelings (being happy, having loving feelings).	0	1	2	3
15. Feeling irritable or having angry outbursts without a good reason and taking it out on other people or things.	0	1	2	3
16. Risky behavior or behavior that could hurt you.	0	1	2	3
17. Being overly alert or on guard.	0	1	2	3
18. Being jumpy or easily startled.	0	1	2	3
19. Problems with concentration.	0	1	2	3
20. Trouble falling or staying asleep.	0	1	2	3

Total _____
Clinical = 21+

Please mark "YES" or "NO" if the problems you marked interfered with:

- | | | | | | |
|------------------------------|------------------------------|-----------------------------|-------------------------|------------------------------|-----------------------------|
| 1. Getting along with others | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 4. Family relationships | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Hobbies/Fun | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 5. General happiness | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. School or work | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |