Trauma Checklist Adult

NAME	ACE	SEX	DATE
	AGE	SLA	DAIL

Below is a list of traumatic events or situations. Please mark YES if you have experienced of witnessed the following events or mark NO if you have not had that experience.

1.Serious accident, fire or explosion	\Box Yes \Box No	
2.Natural disaster (tornado, flood, hurricane, major earthquake)	□ Yes □ No	
3.Non-sexual assault by someone you know (physically attacked/injured)	\Box Yes \Box No	
4.Non-sexual assault by a stranger	□ Yes □ No	
5.Sexual assault by a family member or someone you know	□ Yes □ No	
6.Sexual assault by a stranger	□ Yes □ No	
7. Military combat or a war zone	□ Yes □ No	
8.Sexual contact before you were age 18 with someone who was 5 or more years older than you	🗆 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		
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	\Box Yes \Box No	6.	Family relationships	\Box Yes \Box No
2.	Household duties	🗆 Yes 🗆 No	7.	Sex life	\Box Yes \Box No
3.	Friendships	\Box Yes \Box No	8.	General life satisfaction	\Box Yes \Box No
4.	Fun/leisure activities	\Box Yes \Box No	9.	Overall functioning	\Box Yes \Box No
5.	Schoolwork	\Box Yes \Box No			