

Trauma Checklist Adult

NAME _____ AGE _____ SEX _____ DATE _____

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

1. Serious accident, fire or explosion Yes No
2. Natural disaster (tornado, flood, hurricane, major earthquake) Yes No
3. Non-sexual assault by someone you know (physically attacked/injured) Yes 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 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 | <input type="checkbox"/> Yes <input type="checkbox"/> No | 6. Family relationships | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Household duties | <input type="checkbox"/> Yes <input type="checkbox"/> No | 7. Sex life | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Friendships | <input type="checkbox"/> Yes <input type="checkbox"/> No | 8. General life satisfaction | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Fun/leisure activities | <input type="checkbox"/> Yes <input type="checkbox"/> No | 9. Overall functioning | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Schoolwork | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |