Trauma Screening Questionnaire

Consider the following reactions which sometimes occur after a traumatic event. This questionnaire is concerned with your personal reactions to the traumatic event which happened a few weeks ago.

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| **Indicate whether or not you have experienced any of the following at least twice in the past week:** | **Yes, at least twice in the past week** | **No** |
| 1. Upsetting thoughts or memories about the event that have come into your mind against your will. |  |  |
| 2. Upsetting dreams about the event. |  |  |
| 3. Acting or feeling as though the event were happening again. |  |  |
| 4. Feeling upset by reminders of the event. |  |  |
| 5. Bodily reactions (such as fast heartbeat, stomach churning,  sweatiness, dizziness) when reminded of the event. |  |  |
| 6. Difficulty falling or staying asleep. |  |  |
| 7. Irritability or outbursts of anger. |  |  |
| 8. Difficulty concentrating. |  |  |
| 9. Heightened awareness of potential dangers to yourself and others. |  |  |
| 10. Being jumpy or being startled at something unexpected. |  |  |