

TRAUMA RESPONSE CHECKLIST

OVERVIEW

The following exercise is to be used in conjunction with our book, “*What Is PTSD? 3 Steps to Healing Trauma*” for best effect. Please visit www.WhatIsPTSD.com for additional resources.

The checklist below was developed as a brief screening instrument. It will not provide a diagnosis but rather an indicator for you to consider the areas of strain you have experienced after traumatic exposure. Read each of the statements and select the box that best applies to you in the past month.

Trauma Response Checklist

What happened? (Describe briefly- max 10-15 words)

Event Questions

1. Did you believe that the event could result in death or physical injury to you or another? Yes No
2. Did you feel intense fear, helplessness, or horror? Yes No

Read each statement and select the response that most closely identifies with your experience during the past four weeks.

Distress/Strain Questions

1. I have difficulty falling or staying asleep Yes No
2. I seem to be more irritable or angry Yes No

- 3. I have more difficulty concentrating Yes No
- 4. I feel more alert and watchful since the event Yes No
- 5. I startle easily (i.e., when I hear loud noises, sudden movements) Yes No

Steer Clear Questions

- 1. At times, I try to avoid thoughts or feelings related to the experience Yes No
- 2. Sometimes I try to avoid activities or situations that remind me of the event Yes No
- 3. I cannot remember all the important details of the event Yes No
- 4. I am not as interested in participating in activities as I was before the event Yes No
- 5. I am not as interested in participating in activities as I was before the event Yes No
- 6. I don't feel as happy or as sad as I used to before the event Yes No
- 7. I have withdrawn or been more detached from others since the event Yes No
- 8. I feel like I won't live as long as I thought I would since the event Yes No

Negative Interference Questions

- 1. I experience unwanted thoughts, images or sensitivity to the event(s) Yes No
- 2. I experience dreams or nightmares related to the event(s) Yes No
- 3. At times, I act or feel like the event is still happening Yes No
- 4. I feel emotionally upset when exposed to reminders of the event Yes No
- 5. I experience physical distress when exposed to reminders of events (i.e., body tension, nausea, rapid heart rate, shallow breathing, etc.) Yes No

Associated Disturbance Questions

- 1. I have more feelings of guilt since the event Yes No
- 2. I have the desire to harm myself or another Yes No
- 3. I feel very helpless or hopeless Yes No
- 4. I feel sadder since the event Yes No

5. I feel like nothing will be good again Yes No

6. I am drinking or using drugs more often since the event Yes No

7. I experience more headaches, muscle tension, nausea and fear since the event Yes No

Anything else you wish to add about your struggles?
