Name: _____ Date: _____

POST-TRAUMATIC STRESS DISORDER (PTSD) SELF-TEST

Please complete the following self-test by checking the "Yes or "No" boxes next to each question and bring the results to your next session.

	Yes	No	Questions
1.	☐	☐	Have you experienced or witnessed a life-threatening event that caused intense fear, helplessness or horror?
Do you re-experience the event in any of the following ways?			
2.	☐	☐	Repeated, distressing memories and/or dreams?
3.	☐	☐	Acting or feeling as if the event were happening again (flashbacks or a sense of re-living it)?
4.	☐	☐	Intense physical and/or emotional distress when you are exposed to things that remind you of the event?
Do you avoid reminders of the event and feel numb, compared to the way you felt before?			
5.	☐	☐	Avoiding thoughts, feelings, or conversations about it?
6.	☐	☐	Avoiding activities, places, or people who remind you of it?
7.	☐	☐	Blanking on important parts of it?
8.	☐	☐	Losing interest in significant activities of your life?
9.	☐	☐	Feeling detached from other people?
10.	☐	☐	Feeling your range of emotions is restricted?
11.	☐	☐	Sensing that your future has shrunk (for example, you don't expect to have a career, marriage, children, or a normal life span)?
Are you troubled by any of the following?			
12.	☐	☐	Problems sleeping?
13.	☐	☐	Irritability or outbursts of anger?
14.	☐	☐	Problems concentrating?
15.	☐	☐	Feeling "on guard?"
16.	☐	☐	An exaggerated startle response?
Answered "Yes" to 4 or more above: Please elaborate on another piece of paper.			