POST-TRAUMATIC STRESS DISORDER CHECKLIST

DATE _____

Briefly identify the worst episode you have ever experienced.

How long has it been? (if you are not sure you can write an approximate period)

Was there actual or threatened death, serious injury, or sexual violence?

How do I experience it? : It happened directly to you - You witnessed it - I knew it happened to a family member or close person - I was exposed repeatedly as part of my job (for example, paramedic, police, military, emergency personnel)

If the event involved the death of a close family member or close friend, was it due to some type of accident or violence, or was it due to natural causes?

Second, with this event in mind, read each of the problems on the next page and then check if applicable

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№	ACTIVITIES	☑
1	Repetitive, disturbing or unwanted memories of the stressful experience?	
2	Repetitive and disturbing dreams from the stressful experience?	
3	Do you suddenly feel or act as if the stressful experience is really happening? (As if he was actually reliving the experience)	
4	Do you feel angry when something reminds you of that stressful experience?	
5	Do you have strong physical reactions when something reminds you of that stressful experience? (For example, pounding heartbeat, trouble breathing, sweating)	
6	Do you avoid memories, thoughts or feelings related to the stressful experience?	
7	Do you avoid external things that remind you of the stressful experience? (For example people, places, conversations, activities, objects or other situations)	
8	Do you have trouble remembering important facts from the stressful experience?	
9	Do you have strong negative beliefs about yourself, other people, or the world (for example, if you have thoughts like: I am bad, there is something seriously wrong with me, I can't trust anyone, our world is extremely dangerous)?	

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№	ACTIVITIES	✓
10	Do you blame yourself or someone else for the stressful experience or what happened after it?	
11	Do you have strong negative feelings such as fear, horror, anger, guilt or shame?	
12	Have you lost interest in activities you enjoyed?	
13	Have you felt distant or separated from other people?	
14	Do you have difficulty experiencing positive feelings (for example, being unable to feel happy or have feelings of love for people close to you)?	
15	Do you have irritable behavior, angry outbursts, aggressive behavior?	
16	Do you take a lot of risks or want to do things that could cause harm?	
17	Are you “on alert” or vigilant or on guard?	
18	Do you feel nervous or scared easily?	
19	Do you have difficulty concentrating?	
20	Do you have trouble falling asleep or staying asleep?	

IMPORTANT TO KEEP IN MIND FOR THE ADMINISTRATION OF THIS QUESTIONNAIRE

TO SPEAK OF AN ONSET OF PTSD, AT LEAST 10 OF THESE CRITERIA MUST BE PRESENT ON A DAILY BASIS. ADMINISTER THIS TOOL FROM DAILY OBSERVATION FOR AT LEAST 1 WEEK. IF IT'S NOT YOURSELF, YOU CAN ASK THESE QUESTIONS TO THE PERSON YOU'RE WORRIED ABOUT. DELIVER THE RESULTS TO YOUR TRUSTED PSYCHOLOGIST OR PSYCHIATRIST AS SOON AS THE WEEK OF OBSERVATION HAS PASSED SINCE PTSD CAN BE A GATEWAY DISORDER TO MORE COMPLEX CLINICAL DISORDERS. TAKE NOTE OF ANY EVENT THAT YOU CONSIDER OF INTEREST TO THE PROFESSIONAL

THIS QUESTIONNAIRE CAN BE ADMINISTERED TO ANYONE OVER 10 YEARS OLD.