CLINICAL TRAUMA CHECKLIST

DATE _____

№	ACTIVITIES	✓
1	Repetitive, disturbing or unwanted memories of a stressful experience?	
2	Repetitive or disturbing dreams of a stressful experience?	
3	Do you suddenly feel or act as if you are reliving a stressful experience?	
4	Do you feel angry when something reminds you of a stressful experience?	
5	Do you have strong physical reactions when something reminds you of a stressful experience? (For example, pounding heartbeat, trouble breathing, sweating)	
6	Do you avoid memories, thoughts or feelings related to an experience that has greatly impacted you?	
7	Do you avoid external things that remind you of a stressful experience? (For example people, places, conversations, activities, objects or other situations)	
8	Do you have difficulty remembering important facts related to a very shocking experience?	
9	Do you have difficulty concentrating?	
10	Do you have trouble falling asleep or staying asleep?	

IMPORTANT TO KEEP IN MIND FOR THE ADMINISTRATION OF THIS QUESTIONNAIRE

TO DISCUSS THE IMPACT OF TRAUMA, THESE CRITERIA MUST BE MET ON A 3-5 DAY PER WEEK BASIS, OVER A 3-MONTH PERIOD.

ADMINISTER THIS TOOL FROM DAILY OBSERVATION FOR AT LEAST 2 WEEKS. IF IT'S NOT YOURSELF, YOU CAN ASK THESE QUESTIONS TO THE PERSON YOU'RE CONCERNED ABOUT.

DELIVER THE RESULTS TO YOUR TRUSTED PSYCHOLOGY OR PSYCHIATRY PROFESSIONAL TO GUARANTEE THE RESULTS AND FIND LEARN ABOUT HOW TO PROCEED.

TAKE NOTE OF ANY EVENT THAT YOU CONSIDER OF INTEREST TO THE PROFESSIONAL

THIS QUESTIONNAIRE CAN BE ADMINISTERED TO ANYONE OVER 12 YEARS OLD.