PTSD Symptom Scale (PSS)

Name	Date	(Side One)				
Below is a list of traumatic events or situations. Please mark YES if you have experienced or witnessed the following events or mark NO if you have not had that experience.						
1. Serious accident, fire or explosion		\square Yes \square No				
2. Natural disaster (tornado, flood, hurricane, major earthquake)		\square Yes \square No				
3. Non-sexual assault by someone you know (physically attacked	/injured)	\square Yes \square No				
4. Non-sexual assault by a stranger		\square Yes \square No				
5. Sexual assault by a family member or someone you know		\square Yes \square No				
6. Sexual assault by a stranger		\square Yes \square No				
7. Military combat or a war zone		\square Yes \square No				
8. Sexual contact before you were age 18 with someone who was	5 or more years older than you	\square Yes \square No				
9. Imprisonment		\square Yes \square No				
10. Torture		\square Yes \square No				
11. Life-threatening illness		\square Yes \square No				
12. Other traumatic event		\square Yes \square No				
13. If "other traumatic event" is checked YES above; please write	e what the event was					
14. Of the question to which you answered YES, which was the v	vorst					
(Please list the question #)						
15. Which of the above incidences is the reason for which you are	e currently seeking treatment?					
(Please list the question #)						
If you answered NO to all of the above questions, STOP If you answered YES to any of the above questions, please	complete the rest of the form					
Please check YES or NO regarding the event listed in qu	estion 15.					
Were you physically injured?		□ Yes □ No				
Was someone else physically injured?		\square Yes \square No				
Did you think your life was in danger?		\square Yes \square No				
Did you think someone else's life was in danger?		\square Yes \square No				
Did you feel helpless?		\square Yes \square No				
Did you feel terrified?		□ Yes □ No				
Please complete both sides of this document if you answered YES to any of the first series of questions (1-14).						

PTSD Symptom Scale (PSS)

(Side 2)

Below is a list of problems that people sometimes have after experiencing a traumatic event. Please rate on a scale from 0-3 how much or how often these following things have occurred to you in the last two weeks:

- 0 Not at all
- Once per week or less/ a little bit/ one in a while
- 2 to 4 times per week/ somewhat/ half the time
- 3 to 5 or more times per week/ very much/ almost always

1.	Having upsetting thought or images about the traumatic event that come into your head when you did not want them to		1	2	3
2.	Having bad dreams or nightmares about the traumatic event		1	2	3
3.	Reliving the traumatic event (acting as if it were happening again)		1	2	3
4.	Feeling emotionally upset when you are reminded of the traumatic event		1	2	3
5.	Experiencing physical reactions when reminded of the traumatic event (sweating, increased heart rate)	0	1	2	3
6.	Trying not to think or talk about the traumatic event	0	1	2	3
7.	Trying to avoid activities or people that remind you of the traumatic event	0	1	2	3
8.	Not being able to remember an important part of the traumatic event	0	1	2	3
9.	Having much less interest or participating much less often in important activities	0	1	2	3
10.	Feeling distant or cut off from the people around you	0	1	2	3
11.	. Feeling emotionally numb (unable to cry or have loving feelings)		1	2	3
12.	Feeling as if your future hopes or plans will not come true	0	1	2	3
13.	Having trouble falling or staying asleep	0	1	2	3
14.	Feeling irritable or having fits of anger	0	1	2	3
15.	Having trouble concentrating	0	1	2	3
16.	Being overly alert	0	1	2	3
17.	Being jumpy or easily startled	0	1	2	3

Please mark YES or NO if the problems above interfered with the following:

1.	Work	\square Yes \square No	6.	Family relationships	\square Yes \square No
2.	Household duties	\square Yes \square No	7.	Sex life	\square Yes \square No
3.	Friendships	\square Yes \square No	8.	General life satisfaction	\square Yes \square No
4.	Fun/leisure activities	\square Yes \square No	9.	Overall functioning	\square Yes \square No
5.	Schoolwork	□ Yes □ No			