TRAUMA REACTION WORKSHEET

Please circle the answer that is most true for you. How often you have experienced each of the following in the last month or since the incident (whichever is most recent).

	Never	Occasionally	Fairly Often	Very Often
1 Insomnia (trouble getting to sleep)	0	1	2	3
2 Restless sleep	0	1	2	3
3 Nightmares	0	1	2	3
4 Waking up early in the morning and can't sleep	0	1	2	3
5 Weight loss	0	1	2	3
6 Feeling isolated from others	0	1	2	3
7 Lonliness	0	1	2	3
8 Low sex drive	0	1	2	3
9 Sadness	0	1	2	3
10 Flashbacks (sudden, vivid, distracting memories)	0	1	2	3
11 Spacing out (going away in your mind)	0	1	2	3
12 Headaches	0	1	2	3
13 Stomach problems	0	1	2	3
14 Uncontrollable crying	0	1	2	3
15 Anxiety attacks	0	1	2	3
16 Trouble controlling temper	0	1	2	3
17 Trouble getting along with others	0	1	2	3
18 Diziness	0	1	2	3
19 Passing out	0	1	2	3
20 Desire to physically hurt yourself	0	1	2	3
21 Desire to physically hurt others	0	1	2	3
22 Sexual problems	0	1	2	3
23 Sexual overactivity	0	1	2	3
24 Fear of men	0	1	2	3
25 Fear of women	0	1	2	3
26 Unnecessary or over-frequent washing	0	1	2	3
27 Feelings of inferiority	0	1	2	3
28 Feelings of guilt	0	1	2	3
29 Feelings that things are "unreal"	0	1	2	3
30 Memory problems	0	1	2	3
31 Feelings that you are not always in your body	0	1	2	3
32 Feeling tense all of the time	0	1	2	3
33 Having problems breathing	0	1	2	3

Any additional comments or concerns that you have at this time, please feel free to write them below:

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Name: ____ Date:_________________________