Red Willow
COUNSELING & RECOVERY

Trauma Checklist Adult

NAME_____**AGE**_____**SEX**_____**DATE**

Below is a list of traumatic events or situations. Please mark YES if you have experienced of witnessed the following events or mark NO if you have not had that experience.

1.Serious accident, fire or explosion ☐ Yes ☐ No

2.Natural disaster (tornado, flood, hurricane, major earthquake) ☐ Yes ☐ No

3.Non-sexual assault by someone you know (physically attacked/injured) ☐ Yes ☐ No

4.Non-sexual assault by a stranger ☐ Yes ☐ No

5.Sexual assault by a family member or someone you know ☐ Yes ☐ No

6.Sexual assault by a stranger ☐ Yes ☐ No

7.Military combat or a war zone ☐ Yes ☐ No

8.Sexual contact before you were age 18 with someone who was 5 or more years older than you ☐ Yes ☐ No

9.Imprisonment ☐ Yes ☐ No

10.Torture ☐ Yes ☐ No

11.Life-threatening illness ☐ Yes ☐ No

12.Other traumatic event ☐ Yes ☐ No

13.If "other traumatic event" is checked YES above; please write what the event was _____

14. Of the question to which you answered YES, which was the worst (Please list the question #) _____

15. Which of the above incidences is the reason for which you are currently seeking treatment? (Please list the question #) _____

Please check YES or NO regarding the event listed in question 15.

Were you physically injured? ☐ Yes ☐ No

Was someone else physically injured? ☐ Yes ☐ No

Did you think your life was in danger? ☐ Yes ☐ No

Did you think someone else's life was in danger? ☐ Yes ☐ No

Did you feel helpless? ☐ Yes ☐ No

Did you feel terrified? ☐ Yes ☐ No

TRAUMA CHECKLIST ADULT

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:

0 Not at all
1 Once per week or less/ a little bit/ one in a while
2 2 to 4 times per week/ somewhat/ half the time
3 3 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
__2. Having bad dreams or nightmares about the traumatic event
__3. Reliving the traumatic event (acting as if it were happening again)
__4. Feeling emotionally upset when you are reminded of the traumatic event
__5. Experiencing physical reactions when reminded of the traumatic event (sweating, increased heart rate)
__6. Trying not to think or talk about the traumatic event
__7. Trying to avoid activities or people that remind you of the traumatic event
__8. Not being able to remember an important part of the traumatic event
__9. Having much less interest or participating much less often in important activities
__10. Feeling distant or cut off from the people around you
__11. Feeling emotionally numb (unable to cry or have loving feelings)
__12. Feeling as if your future hopes or plans will not come true
__13. Having trouble falling or staying asleep
__14. Feeling irritable or having fits or anger
__15. Having trouble concentrating
__16. Being overly alert
__17. Being jumpy or easily startled

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

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