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 | | | |