Please complete this form and show it to your doctor or other healthcare professional.

**Do you have Post Traumatic Stress Disorder?**

1. Have you experienced or witnessed an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of yourself or others?  
   - YES  
   - NO

2. When this event happened, did you feel intense fear, helplessness, or horror?  
   - YES  
   - NO

3. Do you experience recurrent and intrusive distressing memories, images, or thoughts of the event?  
   - YES  
   - NO

4. Do you experience recurrent distressing dreams of the event?  
   - YES  
   - NO

5. Do you sometimes act or feel as if the event were happening again?  
   - YES  
   - NO

6. Do you feel very distressed or anxious when you see or hear something that reminds you of the event?  
   - YES  
   - NO

7. Do you get strong physical sensations of anxiety (like racing heart, rapid breathing, sweating) when you see or hear something that reminds you of the event?  
   - YES  
   - NO

8. Do you go out of your way to avoid thoughts, feelings, or conversations associated with the event?  
   - YES  
   - NO

9. Do you go out of your way to avoid activities, places, or people that arouse recollections of the event?  
   - YES  
   - NO

10. Are you unable to recall an important aspect of the event?  
    - YES  
    - NO

11. Have you lost interest in significant activities?  
    - YES  
    - NO
12. Do you feel detached or estranged from others?  YES  NO
13. Do you feel emotionally "numb", or like you are unable to feel certain feelings?  YES  NO
14. Do you have a sense that your future will be bleak or short?  YES  NO
15. Do you have difficulty falling or staying asleep?  YES  NO
16. Do you have irritability or outbursts of anger?  YES  NO
17. Do you have difficulty concentrating?  YES  NO
18. Are you constantly "on guard" or watchful for danger?  YES  NO
19. Are you "jumpy" or do you get startled easily?  YES  NO
20. Have you experienced these problems for more than one month?  YES  NO
21. Do these problems cause you to feel very distressed, anxious, or upset?  YES  NO
22. Do these problems impair your social, occupational, or other important areas of functioning?  YES  NO

You might have Post Traumatic Stress Disorder if all of the following are true:

- You answered YES to items 1 and 2
- You answered YES to at least one of items 3-7
- You answered YES to at least three of items 8-14
- You answered YES to at least two of items 15-19
- You answered YES to item 20
- You answered YES to at least one of items 21 or 22

Note: This questionnaire is for informational purposes only and is not intended to function as a psychological or psychiatric assessment. Diagnosis of psychiatric disorders requires a careful evaluation by a trained professional.

To get help for this condition or to receive a comprehensive assessment, please call The Institute of Living's Anxiety Disorders Center at (860) 545-7685.