PTSD Symptom Scale (PSS)

Name _____Date_____ (Side One)

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 #)	_____	

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 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

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:

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 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	0	1	2	3
2. Having bad dreams or nightmares about the traumatic event	0	1	2	3
3. Reliving the traumatic event (acting as if it were happening again)	0	1	2	3
4. Feeling emotionally upset when you are reminded of the traumatic event	0	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)	0	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 of having fits or 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	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				