

If you suspect PTSD as a possible diagnosis, fill out this form and bring it with you to our next session. You may either check the boxes on line and then print the form, or print the form and fill it out by hand.

Yes No Have you experienced or witnessed a life-threatening event that caused intense fear, helplessness or horror?

Do you re-experience the event in at least one of the following ways?

Yes No Repeated, distressing memories and/or dreams?

Yes No Acting or feeling as if the event were happening again (flashbacks or a sense of reliving it)?

Yes No Intense physical and/or emotional distress when you are exposed to things that remind you of the event?

Do you avoid reminders of the event and feel numb, compared to the way you felt before, in three or more of the following ways:

Yes No Avoiding thoughts, feelings, or conversations about it?

Yes No Avoiding activities, places, or people who remind you of it?

Yes No Blanking on important parts of it?

Yes No Losing interest in significant activities of you life?

Yes No Feeling detached from other people?

Yes No Feeling your range of emotions is restricted?

Yes No Sensing that your future has shrunk (for example, you don't expect to have a career, marriage, children, or a normal life span)?

Are you troubled by two or more of the following:

Yes No Problems sleeping?

Yes No Irritability or outbursts of anger?

Yes No Problems concentrating?

Yes No Feeling "on guard"?