

PTSD / Trauma-Related Symptom Questionnaire

Complete only if trauma-related symptoms are relevant. You do not need to describe graphic details on this form.

Patient name:	_____	Date of birth:	_____
Date completed:	_____	Appointment date:	_____

Choice and privacy

You may write only what feels necessary. Tell your clinician if completing this form increases distress or makes you feel unsafe.

Brief description or type of event, if you choose to provide it: _____

Approximate age or date: _____

During the past month, how often have you experienced the following?

Symptom or experience	Not at all	Several days	More than half	Nearly every day
Unwanted memories, images, or thoughts about the event	☐	☐	☐	☐
Disturbing dreams related to the event	☐	☐	☐	☐
Feeling or acting as if the event were happening again	☐	☐	☐	☐
Strong emotional distress when reminded	☐	☐	☐	☐
Physical reactions when reminded	☐	☐	☐	☐
Avoiding memories, thoughts, or feelings related to the event	☐	☐	☐	☐
Avoiding people, places, conversations, or activities that remind you	☐	☐	☐	☐
Difficulty remembering important parts of the event	☐	☐	☐	☐
Persistent negative beliefs about yourself, others, safety, trust, or the world	☐	☐	☐	☐
Blaming yourself or others in a way that causes distress	☐	☐	☐	☐
Persistent fear, guilt, shame, anger, or horror	☐	☐	☐	☐
Loss of interest or feeling detached from others	☐	☐	☐	☐
Difficulty experiencing positive emotions	☐	☐	☐	☐

Symptom or experience	Not at all	Several days	More than half	Nearly every day
Irritability, anger outbursts, or reckless behavior	☐	☐	☐	☐
Being overly alert, watchful, or easily startled	☐	☐	☐	☐
Difficulty concentrating	☐	☐	☐	☐
Difficulty falling or staying asleep	☐	☐	☐	☐

PTSD / Trauma-Related Symptom Questionnaire — continued

Current impact and stabilization

Item	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme
Interference with work or school	☐	☐	☐	☐	☐
Interference with relationships	☐	☐	☐	☐	☐
Interference with sleep	☐	☐	☐	☐	☐
Interference with leaving home or daily activities	☐	☐	☐	☐	☐
Use of alcohol, cannabis, medication, or another substance to cope	☐	☐	☐	☐	☐
Feeling disconnected, unreal, numb, or outside your body	☐	☐	☐	☐	☐

Question	No	Yes	Unsure
Are you currently in contact with the person or situation associated with the trauma?	☐	☐	☐
Do you currently feel unsafe in your home or relationship?	☐	☐	☐
Have you recently had suicide thoughts, self-harm urges, or dangerous impulsive behavior?	☐	☐	☐
Do you have grounding or coping skills that help you return to the present?	☐	☐	☐
Do you have at least one supportive person or safe place?	☐	☐	☐

Known triggers:

Grounding strategies, supports, or activities that help:

What would help you feel safer during treatment?
