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Forensic, Child, Adolescent, and Adult Psychiatry

INDIVIDUAL & FAMILY PSYCHOPHARMACOLOGIC TREATMENT OF:

- MOOD AND ANXIETY DISORDERS • OBSESSIVE-COMPULSIVE DISORDER
- PERVASIVE DEVELOPMENTAL DISORDERS/AUTISM • MENTAL RETARDATION
- ATTENTION DEFICIT DISORDER • TOURETTE'S DISORDER • TRAUMATIC PSYCHIATRY
- TRAUMATIC BRAIN INJURY • POST-TRAUMATIC STRESS DISORDER • CHRONIC PAIN MANAGEMENT
- WORKERS' COMPENSATION

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SCREENING QUESTIONNAIRE FOR

POST-TRAUMATIC STRESS DISORDER

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BY STANLEY L. GOODMAN, M.D.

POST-TRAUMATIC STRESS DISORDER

Answer if your case involves an accident, injury, or other stressful and/or traumatic event

1. Do you have repeated and uncomfortable thoughts about the event(s)? ☐ Yes ☐ No
   If so, describe one or two of your actual repeated and uncomfortable thoughts:
   ____

2. Does any one particular thought or idea trigger memories of the event? ☐ Yes ☐ No
   If so, state what particular thought or idea will do this:
   ____

3. How long after the event(s) did these thoughts begin to occur? (Month/Year) _______________
   At first, how many times did these thoughts occur? _____ times/day; _____ times/month
   Now, how many times do these thoughts occur? _____ times/day; _____ times/month

4. Have you had recurring dreams about the event(s)? ☐Yes ☐ No
   If so, describe one of your actual recurring dreams:
   ____

5. Did these dreams ever wake you up? ☐ Yes ☐ No
   How long after the event(s) did these dreams begin to occur? (Month/Year) _______________
   At first, how many times did these dreams occur? _____ times/day; _____ times/month
   Now, how many times do these dreams occur? _____ times/day; _____ times/month

6. Have you had recurring nightmares about the event(s)? ☐ Yes ☐ No
   If so, describe one of your most frightening recurring nightmares:
   ____

7. Did these nightmares ever wake you up? ☐ Yes ☐ No
   How long after the event(s) did these nightmares begin to occur? (Month/Year) _______________
   At first, how many times did these nightmares occur? _____ times/day; _____ times/month
   Now, how many times do these nightmares occur? _____ times/day; _____ times/month

8. Have you had the feeling the event(s) was happening all over again? ☐ Yes ☐ No
   (For instance if, afterwards, you were at or near the event site. Or, if it was a car accident, you were driving the same car again.)

9. Do you avoid activities similar to those in which you were involved at the time of the event, because they remind you of the event? ☐ Yes ☐ No
   Which activities? ____________________

10. If the event was an automobile accident, do you --
☐ No longer drive? ☐ Drive less? ☐ Drive, but now are very nervous about it?

11. Since the event, do you feel less interested in activities you once enjoyed? ☐ Yes ☐ No
If so, which? ☐ Work ☐ Hobbies ☐ Family activities ☐ Socializing with friends
Others: ______________________________

12. Since the event, have you lost the ability to feel emotions of any kind? ☐ Yes ☐ No
If so, which? ☐ Tenderness ☐ Closeness with people ☐ Sexual feelings
Others: ______________________________

13. Does this loss of feeling/emotions cause you relationship problems? ☐ Yes ☐ No
If so, with whom? ☐ Wife/Husband ☐ Significant other ☐ Children
☐ Parents ☐ Co-Workers ☐ Supervisor(s)
Others: ______________________________

14. *Since the event* --
Do you suddenly become irritable? ☐ Yes ☐ No
Do you have sudden outbursts of temper? ☐ Yes ☐ No
Have you *felt* like hitting someone? ☐ Yes ☐ No
Have you *actually* hit anyone? ☐ Yes ☐ No

If so, how many months after the event did these feelings begin? ______________
If you have actually hit someone, what was their relationship to you? ______________
Briefly state the circumstances: ______________________________

15. *Since the event* --
Do you have feelings of being especially alert? ☐ Yes ☐ No
Do you startle easily when there is a noise? ☐ Yes ☐ No

Do you have difficulty concentrating? ☐ Yes ☐ No
If so, is this because thoughts of the event come to mind? ☐ Yes ☐ No

Do you have difficulty falling asleep? ☐ Yes ☐ No
Do you have difficulty staying asleep? ☐ Yes ☐ No

16. *Since the event* --
Have you had the desire to take sudden trips? ☐ Yes ☐ No
Have you had the desire to leave work/family for periods of time? ☐ Yes ☐ No
Have you actually left home or work for a time? ☐ Yes ☐ No
Have you actually left work for a time? ☐ Yes ☐ No

State why you think you have these feelings: ______________________________

[Revised: 3/2003]