

**Lancashire Traumatic Stress Service**

**TRAUMA SCREENING – QUESTIONNAIRE**

**NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**TRAUMATIC EVENT:** \_\_\_\_\_

**DATE OF EVENT:** \_\_\_\_\_

**INSTRUCTIONS:** Please consider the following reactions that sometimes occur after a traumatic event. This questionnaire is concerned with your personal reactions to the traumatic event. Please indicate whether or not you have experienced any of the following **AT LEAST TWICE IN THE PAST WEEK:**

ITEM	Yes, at least twice in the past week	No
1. Upsetting thoughts or memories about the event that have come into your mind against your will.		
2. Upsetting dreams about the event.		
3. Acting or feeling as though the event were happening again.		
4. Feeling upset by reminders of the event.		
5. Bodily reactions (such as fast heartbeat, stomach churning, sweatiness, dizziness) when reminded of the event.		
6. Difficulty falling or staying asleep.		
7. Irritability or outbursts of anger.		
8. Difficulty concentrating.		
9. Heightened awareness of potential dangers to yourself and others.		
10. Being jumpy or being startled at something unexpected.		