

PTSD Symptom Scale (PSS)

Name:

Date Accomplished:

Instructions: Below is a list of traumatic events or situations. Please mark YES if you have experienced or 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 describe 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 #)

Instructions:

- 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 |

Instructions: 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 in the last two weeks:

- **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 or having fits of 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
2. Household duties	☐ Yes	☐ No
3. Friendships	☐ Yes	☐ No
4. Fun/leisure activities	☐ Yes	☐ No
5. Schoolwork	☐ Yes	☐ No
6. Family relationships	☐ Yes	☐ No
7. Sex life	☐ Yes	☐ No
8. General life satisfaction	☐ Yes	☐ No
9. Overall functioning	☐ Yes	☐ No

Additional Comments