

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 | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 2. Having bad dreams or nightmares about the traumatic event | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 3. Reliving the traumatic event (acting as if it were happening again) | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 4. Feeling emotionally upset when you are reminded of the traumatic event | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 5. Experiencing physical reactions when reminded of the traumatic event (sweating, increased heart rate) | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 6. Trying not to think or talk about the traumatic event | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 7. Trying to avoid activities or people that remind you of the traumatic event | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 8. Not being able to remember an important part of the traumatic event | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 9. Having much less interest or participating much less often in important activities | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 10. Feeling distant or cut off from the people around you | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 11. Feeling emotionally numb (unable to cry or have loving feelings) | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 12. Feeling as if your future hopes or plans will not come true | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 13. Having trouble falling or staying asleep | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 14. Feeling irritable or having fits of anger | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 15. Having trouble concentrating | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 16. Being overly alert | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 17. Being jumpy or easily startled | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |

Please mark YES or NO if the problems above interfered with the following:

- | | | |
|------------------------------|---------------------------|--------------------------|
| 1. Work | <input type="radio"/> Yes | <input type="radio"/> No |
| 2. Household duties | <input type="radio"/> Yes | <input type="radio"/> No |
| 3. Friendships | <input type="radio"/> Yes | <input type="radio"/> No |
| 4. Fun/leisure activities | <input type="radio"/> Yes | <input type="radio"/> No |
| 5. Schoolwork | <input type="radio"/> Yes | <input type="radio"/> No |
| 6. Family relationships | <input type="radio"/> Yes | <input type="radio"/> No |
| 7. Sex life | <input type="radio"/> Yes | <input type="radio"/> No |
| 8. General life satisfaction | <input type="radio"/> Yes | <input type="radio"/> No |
| 9. Overall functioning | <input type="radio"/> Yes | <input type="radio"/> No |

Additional Comments