

# Ranking Your Trauma Symptoms PTSD Worksheet

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Practitioner's Name: \_\_\_\_\_

**Instructions:** Fill out the following chart to the best of your ability, noting your typical trauma-related symptoms, their frequency and duration (how long they typically last). There is no right or wrong answer.

**Frequency:** 0 = never 1 = rarely 2 = often 3 = very often 4 = all the time

**Duration:** 1 = several seconds 2 = several minutes 3 = a few hours 4 = a day 5 = several days 6 = more than a week

Question	Yes	No	Frequency	Duration
Are you jumpy and easily startled?	<input type="checkbox"/>	<input type="checkbox"/>		
Do you have disturbing memories?	<input type="checkbox"/>	<input type="checkbox"/>		
Are you "super alert" or "watchful and guarded"?	<input type="checkbox"/>	<input type="checkbox"/>		
Do you have disturbing thoughts?	<input type="checkbox"/>	<input type="checkbox"/>		
Do you have difficulties concentrating?	<input type="checkbox"/>	<input type="checkbox"/>		
Do you have intense disturbing feelings?	<input type="checkbox"/>	<input type="checkbox"/>		
Are you feeling irritable or angry?	<input type="checkbox"/>	<input type="checkbox"/>		
Do you have repeated disturbing dreams?	<input type="checkbox"/>	<input type="checkbox"/>		
Do you have flashbacks?	<input type="checkbox"/>	<input type="checkbox"/>		
Do you have problems with falling and remaining asleep?	<input type="checkbox"/>	<input type="checkbox"/>		

Are you suddenly acting as if a traumatic experience is happening?	<input type="checkbox"/>	<input type="checkbox"/>		
Do you feel like you don't have a future?	<input type="checkbox"/>	<input type="checkbox"/>		
Do you have physical solid reactions (heart pounding, trouble breathing)	<input type="checkbox"/>	<input type="checkbox"/>		
Do you feel distant and cut off from other people?	<input type="checkbox"/>	<input type="checkbox"/>		
Are you avoiding thinking or talking about the trauma?	<input type="checkbox"/>	<input type="checkbox"/>		
Do you show a loss of interest in activities that you used to enjoy?	<input type="checkbox"/>	<input type="checkbox"/>		
Do you have problems remembering important parts of the trauma?	<input type="checkbox"/>	<input type="checkbox"/>		
Are you avoiding activities or situations because they remind you of the trauma?	<input type="checkbox"/>	<input type="checkbox"/>		
Are you seeing yourself and others in more negative ways than you did before the trauma?	<input type="checkbox"/>	<input type="checkbox"/>		
Are you taking more risks or doing things that may cause you or others harm?	<input type="checkbox"/>	<input type="checkbox"/>		
Are you blaming yourself or others for the trauma?	<input type="checkbox"/>	<input type="checkbox"/>		
Are you having difficulties experiencing positive feelings?	<input type="checkbox"/>	<input type="checkbox"/>		
Have you hallucinated and are anxious you might again?	<input type="checkbox"/>	<input type="checkbox"/>		
Do you have intrusive thoughts?	<input type="checkbox"/>	<input type="checkbox"/>		
Are you having nightmares?	<input type="checkbox"/>	<input type="checkbox"/>		
Are you emotionally distressed after being exposed to traumatic reminders?	<input type="checkbox"/>	<input type="checkbox"/>		

Are you feeling isolated?	<input type="checkbox"/>	<input type="checkbox"/>		
Are you experiencing depersonalization symptoms?	<input type="checkbox"/>	<input type="checkbox"/>		
Are you experiencing derealization symptoms?	<input type="checkbox"/>	<input type="checkbox"/>		

Reference:

Mandić, T., PhD. (2019). Understand Your Trauma. In *The PTSD Workbook* (p. 8). Between Sessions Resources.