PTSD Symptom Scale (PSS)

Name Sample, Patient Date 2014/03/07 (Side One)

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.

	Yes	No
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 write what the event was Suspendisse ornare convallis

14. Of the question to which you answered YES, which was the worst 5

(Please list the question #)

15. Which of the above incidences is the reason for which you are currently seeking treatment? 5

(Please list the question #)

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.

	Yes	No
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

Please complete both sides of this document if you answered YES to any of the first series of questions (1-14).