

**Post-Traumatic Stress Disorder Screening Tool**

This is a screening measure to help you determine whether you might have post-traumatic stress disorder (PTSD) that needs professional attention. This screening tool is not designed to make a diagnosis of PTSD but to be shared with your primary care physician or mental health professional to inform further conversations about diagnosis and treatment.

**Directions:**

1. Complete the provided form
2. Print out the results
3. Share them with your health care provider to determine a diagnosis

**Are you troubled by the following?**

|  |  |
| --- | --- |
| **Yes  No** | You have experienced or witnessed a life-threatening event. |

**Do you have intrusions about the event in at least one of the following ways?**

|  |  |
| --- | --- |
| **Yes  No** | Repeated, distressing memories, or dreams |
| **Yes  No** | Acting or feeling as if the event were happening again (flashbacks or a sense of reliving it) |
| **Yes  No** | Intense physical and/or emotional distress when you are exposed to things that remind you of the event |

**Do you avoid things that remind you of the event in at least one of the following ways?**

|  |  |
| --- | --- |
| **☐ Yes ☐ No** | Avoiding thoughts, feelings, or conversations about it |
| **☐ Yes ☐ No** | Avoiding activities and places or people who remind you of it |
| **Since the event, do you have negative thoughts and mood associated with the event in at least 2 of the following ways?** | |
| **☐ Yes ☐ No** | Blanking on important parts of it |
| **☐ Yes ☐ No** | Negative beliefs about oneself, others and the world and about the cause or consequences of the event |
| **☐ Yes ☐ No** | Feeling detached from other people |
| **☐ Yes ☐ No** | Inability to feel positive emotions |
| **☐ Yes ☐ No** | Persistent negative emotional state |

**Are you troubled by at least two of the following?**

|  |  |
| --- | --- |
| **Yes  No** | Problems sleeping |
| **Yes  No** | Irritability or outbursts of anger |
| **Yes  No** | Reckless or self-destructive behavior |
| **Yes  No** | Problems concentrating |
| **Yes  No** | Feeling "on guard" |
| **Yes  No** | An exaggerated startle response |

Please print this completed form and share it with your health care provider to determine diagnoses.

For more information, visit us at www.adaa.org or contact us at [information@adaa.org](mailto:information@adaa.org)

Reference: American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing