Name ________________________________ **Date**__________

Trauma Screening Questionnaire

Many people have been exposed to violence in some form, both as children and as adults; and some people may have witnessed violence against someone else (for example, someone being beaten). We have found that it is important to discuss with individuals who come here their experiences as victims or witnesses of violence.

Following are a few questions about things that you may have seen or experienced at different points in your life. Please try to answer the following questions about your entire lifetime experience, including when you were a child. There are fourteen questions. All of them can be answered with a “yes” or ‘”no.”

You don’t have to answer any questions you don’t want to, and you can stop answering the questions at any time you like. The clinician you meet with for your session is willing and available to discuss any concerns you may have about any of the questions.

In your lifetime have you ever:

1. Been in, injured by, or seen a bad accident? ☐Yes ☐No

2. Been in a fire, flood, or other disaster? ☐Yes ☐ No

3. Had a life threatening illness? ☐Yes ☐ No

4. Witnessed or experienced violence? ☐Yes ☐ No

5. Personally experienced physical or verbal abuse? ☐Yes ☐ No

6. Been touched in a sexual manner against your will? ☐Yes ☐ No

7. Been forced to have sex against your will? ☐ Yes ☐ No

8. Witnessed or experienced the serious illness or death of a spouse, child, close friend or family member? ☐Yes ☐ No

9. Witnessed the death, or a dead body, of someone who is not a close friend or family member? ☐Yes ☐ No

10. Been in a war zone? ☐Yes ☐ No

11. Been kidnapped or held against your will? ☐Yes ☐ No

12. Do you feel that you have ever been discriminated against or harmed because of your:

	Currently		In the past	
Culture	☐Yes	☐No	☐Yes	☐No
Skin color	☐Yes	☐No	☐Yes	☐No
Race	☐Yes	☐No	☐Yes	☐No
Gender	☐Yes	☐No	☐Yes	☐No
Religion	☐Yes	☐No	☐Yes	☐No
Sexual orientation	☐Yes	☐No	☐Yes	☐No
Disability	☐Yes	☐No	☐Yes	☐No
Age	☐Yes	☐No	☐Yes	☐No

13. If you answered Yes to any of the above questions 1-12, have you been re-experiencing the event in a distressing way in the past month? (Examples include dreams, intense recollections, flashbacks, physical reactions)

☐Yes ☐No

14. Is there anything else that you have experienced and would like to discuss with your clinician?

☐Yes ☐ No