PDS

Please indicate how many of the following events you have witnessed or experienced:

- Accident or fire □
- Natural diaster □
- Nonsexual assault (known assailant) □
- Nonsexual assault (unknown assailant) □
- Sexual assault (known assailant) □
- Sexual assault (unknown assailant) □
- Combat or war zone □
- Sexual abuse □
- Imprisonment □
- Torture □
- Life-threatening illness □
- Other □

Please indicate which of the above events has disturbed you **most** in the past month and briefly describe the event in the space provided.

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Please refer to the above event when answering the following questions.

1. Was there any physical injury to yourself as a result of the event? Yes / No
2. Was there any physical injury to someone else as a result of the event? Yes / No

3. Did you feel that your life or someone else's life was in danger at the time of this event? Yes / No
4. Did you have a feeling of helplessness or terror at the time of the event? Yes / No

The following items refer to the frequency with which you have experienced these symptoms in the past month:

0	1	2	3
Once in a while	**Some of the time**	**Half the time**	**Almost always**
Once a week or less	**2 times / week**	**3 – 4 times / week**	**5 + times / week**

1. Having upsetting thoughts or images about the traumatic event that came into your head when you didn't want them to
2. Having bad dreams or nightmares about the traumatic event
3. Reliving the traumatic event, acting or feeling as if it was happening again
4. Feeling emotionally upset when you were reminded of the traumatic event (eg feeling scared, sad, angry, guilty etc)
5. Experiencing physical reactions when you were reminded of the traumatic event (eg breaking out in a sweat, heart beating fast)
6. Trying not to think about, or have feelings about the traumatic event
7. Trying to avoid activities, people or places that remind you of the traumatic event
8. In ability to recall an important aspect of the trauma
9. Having much less interest or participating much less often in important activities
10. Feeling distant or cut off from people around you
11. Feeling emotionally numb (for example being unable to cry or unable to have loving feelings)
12. Feeling as if your future plans or hopes will not come true (for example you will not have a career, marriage, children or a long life)
13. Having trouble falling or staying asleep

14. Feeling irritable or having fits of anger
15. Having trouble concentrating (for example drifting in and out of conversations, losing track of a story on television, forgetting what you read)
16. Being overly alert (for example checking to see who is around you , being uncomfortable with your back to a door etc)
17. Being jumpy and easily startled (for example when someone walks up behind you)

Please indicate whether your symptoms have interfered with the following areas within the past month :

1.	Work	Yes / No
2.	Household duties	Yes / No
3.	Friendships	Yes / No
4.	Family relationships	Yes / No
5.	Fun and leisure activities	Yes / No
6.	Schoolwork	Yes / No
7.	Sex life	Yes / No
8.	General satisfaction with life	Yes / No
9.	Overall level of functioning	Yes / No