

# ADULT Traumatic Events Screening Part 1

• Mental Health			
In the past 90 days (3 months) has the person had a significant period in which they experienced:			
1. serious depression (feelings of sadness, hopelessness, loss of interest, change in appetite or sleep patterns, difficulty with daily activities?)	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> not provided
2. serious anxiety or tension (uptight, worried, unable to relax?)	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> not provided
3. prescribed medication for psychological/emotional problems?	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> not provided
4. thought of harming yourself?	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> not provided
5. hallucinations (heard/seen things others don't hear or see?)	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> not provided
6. attempted suicide	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> not provided
• Substance Use			
During the past 12 months has the person:			
7. been preoccupied with drinking alcohol and/or using other drugs?	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> not provided
8. tried to stop drinking alcohol and/or using other drugs but couldn't	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> not provided
9. had problems caused by drinking alcohol and/or using other drugs but kept using?	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> not provided
10. need to drink or use more to get the same effect they used to?	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> not provided
11. used more drugs and/or alcohol than they intended?	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> not provided
12. experienced periods of time when their thinking speeds up and they have trouble keeping up with their thoughts?	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> not provided
• Gambling			
During the past 12 months have they:			
13. felt the need to bet more and more money?	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> not provided
14. lied to the people important to them about how much they gamble?	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> not provided
• Children and Adolescents			
During the past 12 months have they:			
15. felt angry, sad, hopeless, or nervous?	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> not provided
16. had a change in eating, sleeping, or school performance?	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> not provided
17. spending less times with friends, care less about appearance, and/or spending more time alone?	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> not provided
18. getting into trouble for acting up, fighting, setting fires?	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> not provided
19. experienced a traumatic event and continue to feel scared?	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> not provided

20. using alcohol, inhalants, or other drugs?	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> not provided
21. misusing over-the-counter or prescription medications?	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> not provided
22. currently taking any medications, including over-the-counter? <i>(If yes, specific medications listed in the Client Assessment Record (CAR))</i>	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> not provided

• Additional Information						
Primary referral source:						
Secondary referral source:						
Currently homeless?				<input type="checkbox"/> yes	<input type="checkbox"/> no	How long?
Been homeless any time in the past 3 years?				<input type="checkbox"/> yes	<input type="checkbox"/> no	How many times?
Race: (check all that apply)	<input type="checkbox"/> American Indian	<input type="checkbox"/> Black or African American	<input type="checkbox"/> Asian	<input type="checkbox"/> Native Hawaiian or Pacific Islander	<input type="checkbox"/> White	<input type="checkbox"/> Other
Ethnicity	<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Other				
Anyone the person would like to include in their services or treatment planning?						
Primary or preferred language:						
Other languages spoken:						

## Traumatic Events Screening **Part 2** (required for all intakes)

Listed below are a number of difficult or stressful things that sometimes happen to people. For each event, check one or more of the boxes to the right to indicate the person's experiences.

Be sure to consider the person's entire life (growing up as well as adulthood) as you go through the list of events.

<b>This section does not produce a numerical score.</b>	Happened to me	Witness to it	Learned about it	Not sure	Doesn't apply
	<b>A. Natural disaster</b> (i.e., flood, hurricane, tornado, or earthquake)				
<b>B. Fire or explosion</b>					
<b>C. Transportation Accident</b> (i.e., car accident, train wreck, or plane crash)					
<b>D. Serious accident</b> at work, home, or during recreational activity					
<b>E. Exposure to toxic substances</b> (i.e., dangerous chemicals or radiation)					
<b>F. Physical assault</b> (i.e., being attacked, hit, slapped, or beaten)					
<b>G. Assault with a weapon</b> (i.e., shot, stabbed, threat with knife, bomb, or gun)					

H. <b>Sexual assault</b> (i.e., rape, attempted rape, forced to perform any sexual act through force or threat of harm)					
I. <b>Other</b> unwanted or uncomfortable sexual experience					
J. <b>Combat or exposure to a war zone</b> (in the military or as a civilian)					
K. <b>Captivity</b> (i.e., kidnapped, abducted, hostage, or prisoner of war)					
L. <b>Life-threatening illness or injury</b>					
M. <b>Severe Human Suffering</b>					
N. <b>Sudden violent death</b> (i.e., suicide or homicide)					
O. <b>Sudden unexpected death of someone close to you</b>					
P. <b>Serious injury, harm, or death you caused someone else</b>					
Q. <b>Any other traumatic event or experience</b>					

## Traumatic Events Screening **Part 2B** (required for all intakes)

Below is a list of difficulties people sometimes have after stressful life events. Please read each item and then indicate how distressing each item has been for the person **DURING THE PAST SEVEN DAYS** with respect to information provided on the previous page—how much were they distressed or bothered by these events?

Score 1–4 depending on severity	<b>0</b> =not at all	<b>1</b> =a little bit	<b>2</b> =moderate	<b>3</b> =quite a bit	<b>4</b> =extremely
1. Any reminder brought back feelings about it					
2. I had trouble staying asleep					
3. Other things kept making me think about it					
4. I felt irritable and angry					
5. I avoided letting myself get upset when I thought or was reminded of it					

6. I thought about it when I didn't mean to					
7. I felt as if it hadn't happened or wasn't real					
8. I stayed away from reminders about it					
9. Pictures about it popped into my mind					
10. I was jumpy and easily startled					
11. I tried not to think about it					
12. I was aware that I still had a lot of feelings about it but didn't deal with them.					
13. My feelings about it were kind of numb					
14. I found myself acting or feeling as if I was back at that time					
15. I had trouble falling asleep					
16. I had waves of strong feelings about it					
17. I tried to remove it from my memory					
18. I had trouble concentrating					
19. Reminders of it caused me to have physical reactions, such as sweating, nausea, or trouble breathing					
20. I had dreams about it					
21. I felt watchful or on guard					
22. I tried not to talk about it					

### Scoring

Overall Total = \_\_\_\_\_ (total of ALL items)

0–21 • mild–no trauma

22–43 • moderate trauma

44–65 • Severe Trauma

66–88 • Profound Trauma

Avoidance Subscale = average of items 5 7 8 11 12 13 17 22—Total: \_\_\_\_\_/8=

**Intrusion Subscale = average of items 1 2 3 6 9 14 16 20—Total: \_\_\_\_/8=**

**Hyperarousal Subscale = average of items 4 10 15 18 19 21—Total: \_\_\_\_/6=**