

POST-TRAUMATIC STRESS DISORDER SELF-TEST

If you suspect that you, or a loved one might suffer from post-traumatic stress disorder, complete the following self-test by clicking the "yes or "no" boxes next to each question. If you or a loved one has experienced trauma and has answered "yes" to some of these questions, discuss them with your doctor.

HOW CAN I TELL IF IT'S PTSD?

Yes	No	Have you, or a loved one experienced or witnessed a life-threatening event that caused intense fear, helplessness or horror?
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Do you, or a loved one re-experience the event in at least one of the following ways?

Yes	No	Repeated, distressing memories and/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, or a loved one avoid reminders of the event and feel numb, compared to the way you felt before, in three or more of the following ways:

Yes	No	Avoiding thoughts, feelings, or conversations about it?
Yes	No	Avoiding activities, places, or people who remind you of it?
Yes	No	Blanking on important parts of it?
Yes	No	Losing interest in significant activities of you life?
Yes	No	Feeling detached from other people?
Yes	No	Feeling your range of emotions is restricted?
Yes	No	Sensing that your future has shrunk (for example, you don't expect to have a career, marriage, children, or a normal life span)?

Are you, or a loved one troubled by two or more of the following:

Yes	No	Problems sleeping?
Yes	No	Irritability or outbursts of anger?
Yes	No	Problems concentrating?
Yes	No	Feeling "on guard"?
Yes	No	An exaggerated startle response?

Having more than one illness at the same time can make it difficult to diagnosis and treat the different conditions. Illnesses that sometimes complicate an anxiety disorder include depression and substance abuse. With this in mind, please take a minute to answer the following questions:

Yes	No	Have you, or a loved one experienced changes in sleeping or eating habits?
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More days than not, do you, or a loved one feel:

Yes	No	Sad or depressed?
Yes	No	Disinterested in life?
Yes	No	Worthless or guilty?

During the last year, has the use of alcohol or drugs:

Yes	No	Resulted in your failure to fulfill responsibilities with work, school, or family?
Yes	No	Placed you in a dangerous situation, such as driving a car under the influence?
Yes	No	Gotten you arrested?
Yes	No	Continued despite causing problems for you and/or your loved ones?