

Structured Trauma-Related Experiences and Symptoms Screener (STRESS)

Adult Self-Report

DATE _____ NAME _____ RECORD ID _____

AGE _____ SEX Male Female

RACE White/Caucasian Black/African American Asian American Indian or Alaska Native
 Native Hawaiian/Pacific Islander Other (Specify): _____

ETHNICITY Hispanic/Latino Non-Hispanic/Latino

PART 1 TRAUMA-RELATED EXPERIENCES

INSTRUCTIONS We are going to go through a list of very stressful or traumatic things that sometimes happen to people. Choose YES if the thing happened to you or NO if it has not happened to you. For each 'YES' response, follow the instructions to indicate about when the stressful or traumatic thing happened or started happening.

1. Have you ever been in a really bad storm or disaster, like a flood, earthquake, or hurricane? NO YES, PAST YEAR YES, 1+ YEARS AGO

2. Have you been in an actual war or combat zone? NO YES, PAST YEAR YES, 1+ YEARS AGO

3. Has a partner or spouse ever been in an actual war or combat zone? NO YES, PAST YEAR YES, 1+ YEARS AGO

4. Have you ever been in a serious fire or lost your home in a fire? NO YES, PAST YEAR YES, 1+ YEARS AGO

5. Have you ever been in a really bad accident NO YES, PAST YEAR YES, 1+ YEARS AGO

6. Have you ever had to stay in the hospital because you were really sick or badly injured? NO YES, PAST YEAR YES, 1+ YEARS AGO

7. Has anyone in your family (excluding your child) ever had to stay in the hospital because he/she was really sick or badly injured? NO YES, PAST YEAR YES, 1+ YEARS AGO

8. Have you lost a partner or spouse to death? NO YES, PAST YEAR YES, 1+ YEARS AGO

9. Have you ever seen or heard people in your neighborhood get badly hurt or killed? NO YES, PAST YEAR YES, 1+ YEARS AGO

10. Has anyone outside your family ever beaten you up or hit, punched, shoved, or kicked you? NO YES, PAST YEAR YES, 1+ YEARS AGO

11. Has anyone outside your family ever made you think he or she might hurt or kill you? NO YES, PAST YEAR YES, 1+ YEARS AGO

12. Has anyone outside your family ever made you think he or she might hurt or kill someone you love? NO YES, PAST YEAR YES, 1+ YEARS AGO

13. Has anyone outside your family ever forced you to have sex or engage in sexual behavior? NO YES, PAST YEAR YES, 1+ YEARS AGO

14. Has a partner or spouse ever beaten you up or hit, punched, shoved, or kicked you? NO YES, PAST YEAR YES, 1+ YEARS AGO

(Continued from Page 1)

Structured Trauma-Related Experiences and Symptoms Screener (STRESS)

15. Has a partner or spouse ever made you think he or she might badly hurt or kill you? NO YES, PAST YEAR YES, 1+ YEARS AGO

16. Has a partner or spouse ever made you think he or she might hurt or kill someone you love? NO YES, PAST YEAR YES, 1+ YEARS AGO

17. Has a partner or spouse ever forced you to have sex or engage in sexual behavior? NO YES, PAST YEAR YES, 1+ YEARS AGO

18. Has anyone else in your home or family ever beaten you up or hit, punched, shoved, or kicked you? NO YES, PAST YEAR YES, 1+ YEARS AGO

19. Has anyone else in your home or family ever made you think he or she might hurt or kill someone you NO YES, PAST YEAR YES, 1+ YEARS AGO

20. Has anyone else in your home or family ever forced you to have sex or engage in sexual behavior? NO YES, PAST YEAR YES, 1+ YEARS AGO

21. Did you know so much about how someone you loved died that you could picture it in your head? NO YES, PAST YEAR YES, 1+ YEARS AGO

22. Did anything else really stressful or traumatic happen during your adult life? *Specify* [] NO YES, PAST YEAR YES, 1+ YEARS AGO

As a parent (skip to #28 if you are not a parent)...

23. Has your child had to stay in the hospital because he or she was really sick or badly injured? NO YES, PAST YEAR YES, 1+ YEARS AGO

24. Has your child been diagnosed with a terminal or life-threatening illness? NO YES, PAST YEAR YES, 1+ YEARS AGO

25. Have you lost a child to death? NO YES, PAST YEAR YES, 1+ YEARS AGO

26. Has your child been physically assaulted or abused by someone? NO YES, PAST YEAR YES, 1+ YEARS AGO

27. Has your child been sexually assaulted or abused by someone? NO YES, PAST YEAR YES, 1+ YEARS AGO

As a child or teenager (17 years or younger)...

28. Have you ever been in a really bad storm or disaster, like a flood, earthquake or hurricane? NO YES About how old were you? _____

29. Have you ever been in an actual war or combat zone? NO YES About how old were you? _____

30. Has a parent ever been in an actual war or combat zone? NO YES About how old were you? _____

31. Have you ever been in a serious fire or lost your home in a fire? NO YES About how old were you? _____

32. Have you ever been in a really bad accident? NO YES About how old were you? _____

Structured Trauma-Related Experiences and Symptoms Screener (STRESS)

(Continued from Page 2)

33. Have you ever had to stay in the hospital because you were really sick or badly injured? NO YES About how old were you? _____

34. Has anyone in your family ever had to stay in the hospital because he or she was really sick or badly injured? NO YES About how old were you? _____

35. Have you lost a parent or sibling to death? NO YES About how old were you? _____

36. Did you know so much about how someone you loved died that you could picture it in your head? NO YES About how old were you? _____

37. Have you ever seen or heard people in your neighborhood get badly hurt or killed? NO YES About how old were you? _____

38. Has anyone outside your family ever beaten you up or hit, punched, shoved, or kicked you? NO YES About how old were you? _____

39. Has anyone outside your family ever made you think he or she might hurt or kill you? NO YES About how old were you? _____

40. Has anyone outside your family ever made you think he or she might hurt or kill someone you love? NO YES About how old were you? _____

41. Has anyone outside your family ever forced you to have sex or engage in sexual behavior? NO YES About how old were you? _____

42. Has a parent ever beaten you up or hit, punched, shoved, or kicked you? NO YES About how old were you? _____

43. Has a parent ever made you think he or she might badly hurt or kill you? NO YES About how old were you? _____

44. Has a parent ever made you think he or she might hurt or kill someone you love? NO YES About how old were you? _____

45. Has a parent ever forced you to have sex or engage in sexual behavior? NO YES About how old were you? _____

46. Has anyone else in your home or family ever beaten you up or hit, punched, shoved, or kicked you? NO YES About how old were you? _____

47. Has anyone else in your home or family ever made you think he or she might hurt or kill someone you NO YES About how old were you? _____

48. Has anyone else in your home or family ever forced you to have sex or engage in sexual behavior? NO YES About how old were you? _____

49. Did you ever see or hear adults in your home beat each other up or hit, punch, shove, or kick each other? NO YES About how old were you? _____

50. Were you separated from a parent or someone you depended on for love or safety for an extended period of time? NO YES About how old were you? _____

Structured Trauma-Related Experiences and Symptoms Screener (STRESS)

(Continued from Page 3)

51. Was a parent ever arrested or put in jail? NO YES About how old were you? _____

52. Did anything else really stressful or traumatic happen during your childhood? Specify [_____] NO YES About how old were you? _____

If you said YES to any of the above questions, continue to PART 2 below

PART 2 SYMPTOMS & IMPAIRMENT

The next questions ask about problems some people have after very stressful or traumatic things happen to them. Please think about a very stressful or traumatic experience or experiences from the questions you just answered. Then answer these questions about how you have been thinking, feeling, or acting during a typical week of the past month.

53. How often did disturbing or unwanted thoughts or memories about what happened pop up into your NONE 1 DAY 2-3 DAYS MOST DAYS

54. When something reminded you about what happened, how often did it make your body feel tense, sweaty, or sick or you stomach or head hurt? NONE 1 DAY 2-3 DAYS MOST DAYS

55. In a typical week, how often was it hard to remember important parts of what happened? NONE 1 DAY 2-3 DAYS MOST DAYS

56. How often were you bored or just not interested in doing things you usually like to do? NONE 1 DAY 2-3 DAYS MOST DAYS

57. In a typical week, how often did you feel on edge, watchful, or on guard, just in case something bad might happen? NONE 1 DAY 2-3 DAYS MOST DAYS

58. How often did you have bad dreams or nightmares? NONE 1 DAY 2-3 DAYS MOST DAYS

59. How often did you try to keep your body from feeling ways that reminded you of what happened? NONE 1 DAY 2-3 DAYS MOST DAYS

60. How often did you think that you are a bad person or that something is terribly wrong about you? NONE 1 DAY 2-3 DAYS MOST DAYS

61. How often did you think the world is a bad or very dangerous place, or that people can't be trusted? NONE 1 DAY 2-3 DAYS MOST DAYS

62. In a typical week, how often did you feel lonely or emotionally distant and cut-off from other people? NONE 1 DAY 2-3 DAYS MOST DAYS

63. How often did you get really scared or upset when you heard or saw something you were not expecting to happen? NONE 1 DAY 2-3 DAYS MOST DAYS

64. How often did memories about what happened make you lose track of time or forget where you were? NONE 1 DAY 2-3 DAYS MOST DAYS

65. How often did you feel like the extremely upsetting experience was happening now or like you were reliving it right now? NONE 1 DAY 2-3 DAYS MOST DAYS

Structured Trauma-Related Experiences and Symptoms Screener (STRESS)

(Continued from Page 4)

66. In a typical week, how often did you think that a part of what happened was your fault or guilty that you were to blame for what happened? NONE 1 DAY 2-3 DAYS MOST DAYS

67. In a typical week, how often did you think that a part of what happened was somebody else's fault and that they were to blame for what happened? NONE 1 DAY 2-3 DAYS MOST DAYS

68. How often did you feel really irritable or angry, or blow up and become really aggressive? NONE 1 DAY 2-3 DAYS MOST DAYS

69. How often did you feel like you could not focus or concentrate your mind when you were trying to pay attention? NONE 1 DAY 2-3 DAYS MOST DAYS

70. How often did you get really upset when you saw, heard, or felt something like what happened? NONE 1 DAY 2-3 DAYS MOST DAYS

71. How often did you try to avoid or get away from people, places, activities, or situations that reminded you of what happened? NONE 1 DAY 2-3 DAYS MOST DAYS

72. How often did you feel really scared, sad, or guilty for most of the day? NONE 1 DAY 2-3 DAYS MOST DAYS

73. How often did you do things that you or other people think are dangerous or not safe? NONE 1 DAY 2-3 DAYS MOST DAYS

74. In a typical week, how often did you wake up in the middle of the night and have trouble falling back to sleep? NONE 1 DAY 2-3 DAYS MOST DAYS

75. How often was it hard for you to feel happiness or love? NONE 1 DAY 2-3 DAYS MOST DAYS

76. How often did it feel like you didn't know yourself or your own body, like you were seeing a stranger when you looked in the mirror? NONE 1 DAY 2-3 DAYS MOST DAYS

77. How often did you feel like people or places around you seemed totally strange, like you were in a dream even though you were awake? NONE 1 DAY 2-3 DAYS MOST DAYS

Since the stressful or traumatic thing or things happened, is it harder to...

78. Spend time with friends and family NO YES

79. Get along with co-workers or colleagues NO YES

80. Do household tasks and run errands NO YES

81. Get along with people you live with NO YES

82. Get your tasks done at work or school NO YES

83. Be a good parent for your child(ren) (if applicable) NO YES

Structured Trauma-Related Experiences and Symptoms Screener (STRESS)

(Continued from Page 5)

YOU ARE FINISHED

SCORING - ADMINISTRATORS ONLY

≥ 1 Adulthood Event (YES on items 1-27) ≥ 1 Childhood Event (YES on items 28-52)

PTSD Symptom Severity (Sum items 53-77 with None = 0, 1 Day = 1, 2-3 Days = 2, Most Days = 3. **NOTE.** Count whichever score is higher for the following sets of items: [items 60 and 61] [items 64 and 65] [items 66 and 67])

Intrusion Symptom Criterion B Met ≥ 1 of the following items with scores of ≥ 2 - 53, 54, 58, 64, 65, 70)

Avoidance Symptom Criterion C Met ≥ 1 of the following items with scores ≥ 2 - items 59, 71)

Negative Changes in Mood & Cognitions Criterion D Met ≥ 2 of the following items with scores ≥ 2 - items 55, 56, [60 -or- 61] 62, [66 -or- 67], 72, 75)

Alterations in Arousal & Reactivity Criterion E Met ≥ 2 of the following items with scores ≥ 2 - items 57, 63, 68, 69, 73, 74)

Evidence of functional Impairment ≥ 1 of the following items: 78, 79, 80, 81, 82, 83)

Evidence of Dissociative Symptoms (item 76 or 77 with score of ≥ 2)

Full PTSD Likely (Symptom Criteria B, C, D, and E met) OR **Partial PTSD Likely** (≥ 1 Symptom Criteria met)

NOTES: