

Structured Trauma-Related Experiences and Symptoms Screener (STRESS)

Adult Self-Report (Symptoms Only Version)

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 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 (B1). How often did disturbing or unwanted thoughts or memories about what happened pop up into your mind?	<input type="checkbox"/> NONE	<input type="checkbox"/> 1 DAY	<input type="checkbox"/> 2-3 DAYS	<input type="checkbox"/> MOST DAYS
54 (B5). 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?	<input type="checkbox"/> NONE	<input type="checkbox"/> 1 DAY	<input type="checkbox"/> 2-3 DAYS	<input type="checkbox"/> MOST DAYS
55 (D1). In a typical week, how often was it hard to remember important parts of what happened?	<input type="checkbox"/> NONE	<input type="checkbox"/> 1 DAY	<input type="checkbox"/> 2-3 DAYS	<input type="checkbox"/> MOST DAYS
56 (D5). How often were you bored or just not interested in doing things you usually like to do?	<input type="checkbox"/> NONE	<input type="checkbox"/> 1 DAY	<input type="checkbox"/> 2-3 DAYS	<input type="checkbox"/> MOST DAYS
57 (E3). In a typical week, how often did you feel on edge, watchful, or on guard, just in case something bad might happen?	<input type="checkbox"/> NONE	<input type="checkbox"/> 1 DAY	<input type="checkbox"/> 2-3 DAYS	<input type="checkbox"/> MOST DAYS
58 (B2). How often did you have bad dreams or nightmares?	<input type="checkbox"/> NONE	<input type="checkbox"/> 1 DAY	<input type="checkbox"/> 2-3 DAYS	<input type="checkbox"/> MOST DAYS
59 (C1). How often did you try to keep your body from feeling ways that reminded you of what happened?	<input type="checkbox"/> NONE	<input type="checkbox"/> 1 DAY	<input type="checkbox"/> 2-3 DAYS	<input type="checkbox"/> MOST DAYS
60 (D2a). How often did you think that you are a bad person or that something is terribly wrong about you?	<input type="checkbox"/> NONE	<input type="checkbox"/> 1 DAY	<input type="checkbox"/> 2-3 DAYS	<input type="checkbox"/> MOST DAYS
61 (D2b). How often did you think the world is a bad or very dangerous place, or that people can't be trusted?	<input type="checkbox"/> NONE	<input type="checkbox"/> 1 DAY	<input type="checkbox"/> 2-3 DAYS	<input type="checkbox"/> MOST DAYS
62 (D6). In a typical week, how often did you feel lonely or emotionally distant and cut-off from other people?	<input type="checkbox"/> NONE	<input type="checkbox"/> 1 DAY	<input type="checkbox"/> 2-3 DAYS	<input type="checkbox"/> MOST DAYS
63 (E4). How often did you get really scared or upset when you heard or saw something you were not expecting to happen?	<input type="checkbox"/> NONE	<input type="checkbox"/> 1 DAY	<input type="checkbox"/> 2-3 DAYS	<input type="checkbox"/> MOST DAYS
64 (B3a). How often did memories about what happened make you lose track of time or forget where you were?	<input type="checkbox"/> NONE	<input type="checkbox"/> 1 DAY	<input type="checkbox"/> 2-3 DAYS	<input type="checkbox"/> MOST DAYS

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65 (B3b). How often did you feel like the extremely upsetting experience was happening now or like you were reliving it right now?	<input type="checkbox"/> NONE	<input type="checkbox"/> 1 DAY	<input type="checkbox"/> 2-3 DAYS	<input type="checkbox"/> MOST DAYS
66 (D3a). 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?	<input type="checkbox"/> NONE	<input type="checkbox"/> 1 DAY	<input type="checkbox"/> 2-3 DAYS	<input type="checkbox"/> MOST DAYS
67 (D3b). 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?	<input type="checkbox"/> NONE	<input type="checkbox"/> 1 DAY	<input type="checkbox"/> 2-3 DAYS	<input type="checkbox"/> MOST DAYS
68 (E1). How often did you feel really irritable or angry, or blow up and become really aggressive?	<input type="checkbox"/> NONE	<input type="checkbox"/> 1 DAY	<input type="checkbox"/> 2-3 DAYS	<input type="checkbox"/> MOST DAYS
69 (E5). How often did you feel like you could not focus or concentrate your mind when you were trying to pay attention?	<input type="checkbox"/> NONE	<input type="checkbox"/> 1 DAY	<input type="checkbox"/> 2-3 DAYS	<input type="checkbox"/> MOST DAYS
70 (B4). How often did you get really upset when you saw, heard, or felt something like what happened?	<input type="checkbox"/> NONE	<input type="checkbox"/> 1 DAY	<input type="checkbox"/> 2-3 DAYS	<input type="checkbox"/> MOST DAYS
71 (C2). How often did you try to avoid or get away from people, places, activities, or situations that reminded you of what happened?	<input type="checkbox"/> NONE	<input type="checkbox"/> 1 DAY	<input type="checkbox"/> 2-3 DAYS	<input type="checkbox"/> MOST DAYS
72 (D4). How often did you feel really scared, sad, or guilty for most of the day?	<input type="checkbox"/> NONE	<input type="checkbox"/> 1 DAY	<input type="checkbox"/> 2-3 DAYS	<input type="checkbox"/> MOST DAYS
73 (E2). How often did you do things that you or other people think are dangerous or not safe?	<input type="checkbox"/> NONE	<input type="checkbox"/> 1 DAY	<input type="checkbox"/> 2-3 DAYS	<input type="checkbox"/> MOST DAYS
74 (E6). In a typical week, how often did you wake up in the middle of the night and have trouble falling back to sleep?	<input type="checkbox"/> NONE	<input type="checkbox"/> 1 DAY	<input type="checkbox"/> 2-3 DAYS	<input type="checkbox"/> MOST DAYS
75 (D7). How often was it hard for you to feel happiness or love?	<input type="checkbox"/> NONE	<input type="checkbox"/> 1 DAY	<input type="checkbox"/> 2-3 DAYS	<input type="checkbox"/> MOST DAYS
76 (DS1). 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?	<input type="checkbox"/> NONE	<input type="checkbox"/> 1 DAY	<input type="checkbox"/> 2-3 DAYS	<input type="checkbox"/> MOST DAYS
77 (DS2). 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?	<input type="checkbox"/> NONE	<input type="checkbox"/> 1 DAY	<input type="checkbox"/> 2-3 DAYS	<input type="checkbox"/> MOST DAYS

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

78. Spend time with friends and family	<input type="checkbox"/> NO	<input type="checkbox"/> YES
79. Get along with co-workers or colleagues	<input type="checkbox"/> NO	<input type="checkbox"/> YES
80. Do household tasks and run errands	<input type="checkbox"/> NO	<input type="checkbox"/> YES
81. Get along with people you live with	<input type="checkbox"/> NO	<input type="checkbox"/> YES

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82. Get your tasks done at work or school NO YES
83. Be a good parent for your child(ren) (if applicable) NO YES

YOU ARE FINISHED

SCORING - ADMINISTRATORS ONLY

PTSD Symptom Severity (Sum items 53-77 with None = 0, 1 Day = 1, 2-3 Days = 2, Most Days = 3.
NOTE. For evaluating criteria, count whichever score is higher for the sets of items in brackets below.

- Intrusion Symptom Criterion B Met:** ≥ 1 of the following items with scores of ≥ 2 - 53 (B1), 54 (B5), 58 (B2), [64 (B3a) -or- 65 (B3b)] 70 (B4)
- Avoidance Symptom Criterion C Met:** ≥ 1 of the following items with scores ≥ 2 - items 59 (C1), 71 (C2)
- Negative Changes in Mood & Cognitions Criterion D Met:** ≥ 2 of the following items with scores ≥ 2 - items 55 (D1), 56 (D5), [60 (D2a) -or- 61 (D2b)] 62 (D6), [66 (D3a) -or- 67 (D3b)] 72 (D4), 75 (D7)
- Alterations in Arousal & Reactivity Criterion E Met:** (≥ 2 of the following items with scores ≥ 2 - items 57 (E3), 63 (E4), 68 (E1), 69 (E5), 73 (E2), 74 (E6)
- Evidence of functional Impairment:** ≥ 1 of the following items: 78, 79, 80, 81, 82, 83
- Evidence of Dissociative Symptoms:** item 76 (DS1) or 77 (DS2) with score of ≥ 2
- Full PTSD Likely** (Symptom Criteria B, C, D, and E met) OR **Partial PTSD Likely** (≥ 1 Symptom Criteria met)

NOTES: