

Trauma Screening Questionnaire (TSQ) From (Foa 2002)

Please consider the following reactions which some- sometimes occur after a traumatic event. This question- times questionnaire is concerned with your personal reactions to the traumatic event which happened to you. Please indicate (Yes/No) whether or not you have experienced any of the following **at least twice in the past week**.

For each question mark the option that matches how you feel then and then move to the next question

1. Upsetting thoughts or memories about the event that have come into your mind against your will	YES	NO
2. Upsetting dreams about the event	YES	NO
3. Acting or feeling as though the event were happening again	YES	NO
4. Feeling upset by reminders of the event	YES	NO
5. Bodily reactions (such as fast heartbeat, stomach churning, sweatiness, dizziness) when reminded of the event	YES	NO
6. Difficulty falling or staying asleep	YES	NO
7. Irritability or outbursts of anger Irritability or	YES	NO
8. Difficulty concentrating	YES	NO
9. Heightened awareness of potential dangers to yourself and others	YES	NO
10. Being jumpy or being startled at something unexpected	YES	NO

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