

PTSD Screening Questionnaire

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, *in the past month, you . . .*

1. Have had nightmares about it or thought about it when you did not want to?
2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?
3. Were constantly on guard, watchful, or easily startled?
4. Felt numb or detached from others, activities, or your surroundings?

Screen is positive if patient answers "yes" to any two of the four questions.