Name:_____ Date:_____

Northeast Florida State Hospital Trauma Screening Questionnaire

Many individuals we work with have had difficult experiences in their lives. Past experiences can have a lasting effect. To understand you as an individual, and to provide you with the best care, we need to be aware of what you may have been through in your life. I'll be asking you some questions about your childhood and adult life. To be sensitive about this, you don't have to go into any detail. Most of the questions are simply "Yes" or "No", and "At what age?" I'll also be asking you about symptoms you may be experiencing that could be related to what happened to you in the past.

Prior to your 18th birthday:

1	Were your parents ever separated or divorced?	Yes	No	☐
2	Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?	Yes	No	☐
3	Was a household member depressed or mentally ill, or did a household member attempt suicide?	Yes	No	☐
4	Did a household member go to prison?	Yes	No	☐
5	Did you often feel that your family was not loving and supportive?	Yes	No	☐
6	Did you often feel that you didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?	Yes	No	
	Did you often feel that your caregivers were too drunk or high to take care of you or take you to the doctor if you needed it?	Yes	No	☐
7	Did a parent or other adult in the household often swear at you or put you down?	Yes	No	
	Did a parent or other adult in the household often act in a way that made you feel afraid you might be physically hurt?	Yes	No	☐
8	Did a parent or other adult in the household often push, grab, slap or throw something at you or ever hit you so hard that you had marks or were injured? If Yes, at what age?_____	Yes	No	☐
9	As a child did anyone ever touch or fondle you or have you touch their body in a sexual way? If Yes, how old were you?_____	Yes	No	
	As a child did anyone ever attempt or actually have oral, anal, or vaginal intercourse with you? If Yes, how old were you?_____	Yes	No	☐

Adapted from the Adverse Childhood Experience (ACE) Questionnaire
Henry Benson, Ph.D., Katherine Donnelly, Psy.D., and Abigail Patterson, Psy.D., 2011

Name:_____ Date:_____

10	Did a loved one often get pushed, grabbed, slapped, or have something thrown at them, or sometimes get kicked, punched, or beaten with something hard?	Yes	No	
	Was a loved one ever hit repeatedly over a few minutes or threatened with a weapon?	Yes	No	☐
11	As an adult have you ever been physically abused?	Yes	No	☐
12	As an adult have you ever been sexually assaulted?	Yes	No	☐
13	As an adult have you often been emotionally abused (degraded, threatened, or put down)?	Yes	No	☐
14	Were you ever abused or neglected in an institutional setting (hospital, prison)?	Yes	No	☐
15	Did you ever witness abuse or neglect in an institutional setting (hospital, prison)?	Yes	No	☐
16	Have you ever had an extremely frightening experience in your life?	Yes	No	☐

For the following questions please indicate if you have experienced any of these in the past 30 days

17	Do you often have any strong or overwhelming memories regarding the past experiences that you previously mentioned?	Yes	No	☐
18	Do you often experience flashbacks or feel like the abuse is still happening?	Yes	No	☐
19	Do you often have blackouts?	Yes	No	☐
20	Do you often have difficulty managing feelings of anger, sadness, shame, and rage?	Yes	No	☐
21	Do you often avoid activities or situations because they remind you of a stressful experience from the past?	Yes	No	☐
22	Do you often feel distant or cut off from other people?	Yes	No	☐
23	Do you often feel “super alert” or watchful and on guard?	Yes	No	☐
24	Do you often feel guilty or ashamed about the things that have happened to you?	Yes	No	☐
25	Do you often have nightmares?	Yes	No	☐

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Name:_____ Date:_____

How have you learned to cope with the experiences/symptoms you have mentioned?

Have you ever had any treatment in the past for these experiences/symptoms? (What kind of treatment have you had? Was it helpful?)

Is there anything else you want to tell me about these experiences so that we can provide the best services for you?

Now that I have a better understanding of how you have been feeling and coping recently, I think you may benefit from some of the services that the hospital offers.

☐ DBT Motivation

☐ DBT Distress Tolerance

☐ DBT Emotion Regulation

☐ DBT Interpersonal Effectiveness

☐ Seeking Safety

☐ Anxiety

☐ Self Esteem

Was administered by self report ☐
Was administered by clinical interview ☐

Adverse Childhood Experiences Subtotal Items 1 - 10 ☐

Trauma Related Symptoms Subtotal Items 17 - 25 ☐

Total 1 - 25 ☐

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