

## Severity Measure for Agoraphobia—Adult

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: Male  Female  Date: \_\_\_\_\_

**Instructions:** The following questions ask about thoughts, feelings, and behaviors you may have had in the following situations: crowds, public places, using transportation (e.g., buses, planes, trains), traveling alone, or away from home. **Please respond to each item by marking (✓ or x) one box per row.**

							Clinician Use
	During the PAST 7 DAYS, I have...	Never	Occasionally	Half of the time	Most of the time	All of the time	Item score
1.	felt moments of sudden terror, fear, or fright in these situations	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
2.	felt anxious, worried, or nervous about these situations	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
3.	had thoughts about panic attacks, uncomfortable physical sensations, getting lost, or being overcome with fear in these situations	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
4.	felt a racing heart, sweaty, trouble breathing, faint, or shaky in these situations	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
5.	felt tense muscles, felt on edge or restless, or had trouble relaxing in these situations	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
6.	avoided, or did not approach or enter, these situations	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
7.	moved away from these situations, left them early, or remained close to the exits	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
8.	spent a lot of time preparing for, or procrastinating about (putting off), these situations	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
9.	distracted myself to avoid thinking about these situations	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
10.	needed help to cope with these situations (e.g., alcohol or medication, superstitious objects, other people)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
<b>Total/Partial Raw Score:</b>							
<b>Prorated Total Raw Score: (if 1-2 items left unanswered)</b>							
<b>Average Total Score:</b>							

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## Severity Measure for Depression—Adult \*

\* Adapted from the Patient Health Questionnaire—9 (PHQ-9)

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: Male  Female  Date: \_\_\_\_\_

**Instructions:** Over the **last 7 days**, how often have you been bothered by any of the following problems? (Use “✓” to indicate your answer)

						Clinician Use
						Item score
		Not at all	Several days	More than half the days	Nearly every day	
1.	Little interest or pleasure in doing things	0	1	2	3	
2.	Feeling down, depressed, or hopeless	0	1	2	3	
3.	Trouble falling or staying asleep, or sleeping too much	0	1	2	3	
4.	Feeling tired or having little energy	0	1	2	3	
5.	Poor appetite or overeating	0	1	2	3	
6.	Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3	
7.	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3	
8.	Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3	
9.	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3	
<b>Total/Partial Raw Score:</b>						
<b>Prorated Total Raw Score: (if 1-2 items left unanswered)</b>						

Adapted from Patient Health Questionnaire—9 (PHQ-9) for research and evaluation purposes.

## Severity Measure for Generalized Anxiety Disorder—Adult

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: Male  Female  Date: \_\_\_\_\_

**Instructions:** The following questions ask about thoughts, feelings, and behaviors, often tied to concerns about family, health, finances, school, and work. **Please respond to each item by marking (✓ or x) one box per row.**

							Clinician Use
	During the PAST 7 DAYS, I have...	Never	Occasionally	Half of the time	Most of the time	All of the time	Item score
1.	felt moments of sudden terror, fear, or fright	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
2.	felt anxious, worried, or nervous	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
3.	had thoughts of bad things happening, such as family tragedy, ill health, loss of a job, or accidents	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
4.	felt a racing heart, sweaty, trouble breathing, faint, or shaky	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
5.	felt tense muscles, felt on edge or restless, or had trouble relaxing or trouble sleeping	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
6.	avoided, or did not approach or enter, situations about which I worry	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
7.	left situations early or participated only minimally due to worries	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
8.	spent lots of time making decisions, putting off making decisions, or preparing for situations, due to worries	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
9.	sought reassurance from others due to worries	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
10.	needed help to cope with anxiety (e.g., alcohol or medication, superstitious objects, or other people)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
<b>Total/Partial Raw Score:</b>							
<b>Prorated Total Raw Score: (if 1-2 items left unanswered)</b>							
<b>Average Total Score:</b>							

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## Severity Measure for Panic Disorder—Adult

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: Male  Female  Date: \_\_\_\_\_

**Instructions:** The following questions ask about thoughts, feelings, and behaviors about panic attacks. A panic attack is an episode of intense fear that sometimes comes out of the blue (for no apparent reason). The symptoms of a panic attack include: a racing heart, shortness of breath, dizziness, sweating, and fear of losing control or dying. **Please respond to each item by marking (✓ or x) one box per row.**

							Clinician Use
	During the PAST 7 DAYS, I have...	Never	Occasionally	Half of the time	Most of the time	All of the time	Item score
1.	felt moments of sudden terror, fear or fright, sometimes out of the blue (i.e., a panic attack)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
2.	felt anxious, worried, or nervous about having more panic attacks	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
3.	had thoughts of losing control, dying, going crazy, or other bad things happening because of panic attacks	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
4.	felt a racing heart, sweaty, trouble breathing, faint, or shaky	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
5.	felt tense muscles, felt on edge or restless, or had trouble relaxing or trouble sleeping	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
6.	avoided, or did not approach or enter, situations in which panic attacks might occur	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
7.	left situations early, or participated only minimally, because of panic attacks	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
8.	spent a lot of time preparing for, or procrastinating about (putting off), situations in which panic attacks might occur	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
9.	distracted myself to avoid thinking about panic attacks	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
10.	needed help to cope with panic attacks (e.g., alcohol or medication, superstitious objects, other people)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
<b>Total/Partial Raw Score:</b>							
<b>Prorated Total Raw Score: (if 1-2 items left unanswered)</b>							
<b>Average Total Score:</b>							

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## Severity Measure for Separation Anxiety Disorder—Adult

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: Male  Female  Date: \_\_\_\_\_

**Instructions:** The following questions ask about thoughts, feelings, and behaviors that you may have had about being separated from home or from people who are important to you. Please rate how often the following statements are true for you. **Please respond to each item by marking (✓ or x) one box per row.**

							Clinician Use
	During the PAST 7 DAYS, I have...	Never	Occasionally	Half of the time	Most of the time	All of the time	Item score
1.	felt moments of sudden terror, fear, or fright when separated	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
2.	felt anxious, worried, or nervous about being separated	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
3.	have had thoughts of bad things happening to people important to me or bad things happening to me when separated from them (e.g., getting lost, accidents)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
4.	felt a racing heart, sweaty, trouble breathing, faint, or shaky when separated	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
5.	felt tense muscles, felt on edge or restless, or had trouble relaxing or trouble sleeping when separated	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
6.	avoided going places where I would be separated	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
7.	when separated, left places early to go home	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
8.	spent a lot of time preparing for how to deal with separation	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
9.	distracted myself to avoid thinking about being separated	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
10.	needed help to cope with separation (e.g., alcohol or medications, superstitious objects)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
<b>Total/Partial Raw Score:</b>							
<b>Prorated Total Raw Score: (if 1-2 items left unanswered)</b>							
<b>Average Total Score:</b>							

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## Severity Measure for Social Anxiety Disorder (Social Phobia)—Adult

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: Male  Female  Date: \_\_\_\_\_

**Instructions:** The following questions ask about thoughts, feelings, and behaviors that you may have had about *social situations*. Usual social situations include: public speaking, speaking in meetings, attending social events or parties, introducing yourself to others, having conversations, giving and receiving compliments, making requests of others, and eating and writing in public. **Please respond to each item by marking (✓ or x) one box per row.**

							Clinician Use
	During the PAST 7 DAYS, I have...	Never	Occasionally	Half of the time	Most of the time	All of the time	Item score
1.	felt moments of sudden terror, fear, or fright in social situations	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
2.	felt anxious, worried, or nervous about social situations	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
3.	had thoughts of being rejected, humiliated, embarrassed, ridiculed, or offending others	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
4.	felt a racing heart, sweaty, trouble breathing, faint, or shaky in social situations	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
5.	felt tense muscles, felt on edge or restless, or had trouble relaxing in social situations	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
6.	avoided, or did not approach or enter, social situations	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
7.	left social situations early or participated only minimally (e.g., said little, avoided eye contact)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
8.	spent a lot of time preparing what to say or how to act in social situations	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
9.	distracted myself to avoid thinking about social situations	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
10.	needed help to cope with social situations (e.g., alcohol or medications, superstitious objects)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
<b>Total/Partial Raw Score:</b>							
<b>Prorated Total Raw Score: (if 1-2 items left unanswered)</b>							
<b>Average Total Score:</b>							

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## Severity Measure for Specific Phobia—Adult

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: Male  Female  Date: \_\_\_\_\_

The following questions ask about thoughts, feelings, and behaviors that you may have had in a variety of situations. Please check (✓) the item below that makes you most anxious. <u>Choose only one item and make your ratings based on the situations included in that item.</u>											
<input type="checkbox"/> Driving, flying, tunnels, bridges, or enclosed spaces	<input type="checkbox"/> Animals or insects	<input type="checkbox"/> Heights, storms, or water	<input type="checkbox"/> Blood, needles, or injections	<input type="checkbox"/> Choking or vomiting							
Please respond to each item by marking (✓ or x) one box per row.						Clinician Use					
During the PAST 7 DAYS, I have...						Never	Occasionally	Half of the time	Most of the time	All of the time	Item score
1.	felt moments of sudden terror, fear, or fright in these situations	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4					
2.	felt anxious, worried, or nervous about these situations	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4					
3.	had thoughts of being injured, overcome with fear, or other bad things happening in these situations	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4					
4.	felt a racing heart, sweaty, trouble breathing, faint, or shaky in these situations	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4					
5.	felt tense muscles, felt on edge or restless, or had trouble relaxing in these situations	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4					
6.	avoided, or did not approach or enter, these situations	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4					
7.	moved away from these situations or left them early	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4					
8.	spent a lot of time preparing for, or procrastinating about (i.e., putting off), these situations	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4					
9.	distracted myself to avoid thinking about these situations	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4					
10.	needed help to cope with these situations (e.g., alcohol or medications, superstitious objects, other people)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4					
<b>Total/Partial Raw Score:</b>											
<b>Prorated Total Raw Score: (if 1-2 items left unanswered)</b>											
<b>Average Total Score:</b>											

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## Severity of Acute Stress Symptoms—Adult\*

\* National Stressful Events Survey Acute Stress Disorder Short Scale (NSESSS)

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: Male  Female  Date: \_\_\_\_\_

Please list the traumatic event that you experienced: \_\_\_\_\_

Date of the traumatic event: \_\_\_\_\_

**Instructions:** People sometimes have problems after extremely stressful events or experiences. How much have you been bothered during the PAST SEVEN (7) DAYS by each of the following problems that occurred or became worse after an extremely stressful event/experience? **Please respond to each item by marking (✓ or x) one box per row.**

							Clinician Use
		Not at all	A little bit	Moderately	Quite a bit	Extremely	Item score
1.	Having “flashbacks,” that is, you suddenly acted or felt as if a stressful experience from the past was happening all over again (for example, you reexperienced parts of a stressful experience by seeing, hearing, smelling, or physically feeling parts of the experience)?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
2.	Feeling very emotionally upset when something reminded you of a stressful experience?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
3.	Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
4.	Trying to avoid thoughts, feelings, or physical sensations that reminded you of a stressful experience?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
5.	Being “super alert,” on guard, or constantly on the lookout for danger?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
6.	Feeling jumpy or easily startled when you hear an unexpected noise?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
7.	Being extremely irritable or angry to the point where you yelled at other people, got into fights, or destroyed things?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
<b>Total/Partial Raw Score:</b>							
<b>Prorated Total Raw Score: (if 1 item left unanswered)</b>							
<b>Average Total Score:</b>							

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## Severity of Dissociative Symptoms—Adult\*

### \*Brief Dissociative Experiences Scale (DES-B)—Modified

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: Male  Female  Date: \_\_\_\_\_

**Instructions:** For each statement below, please check (✓) the box that best answers each question to show how much each thing has happened to you in the past SEVEN (7) DAYS.

							Clinician Use
		Not at all	Once or twice	Almost every day	About once a day	More than once a day	Item score
1.	I find myself staring into space and thinking of nothing.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
2.	People, objects, or the world around me seem strange or unreal.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
3.	I find that I did things that I do not remember doing.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
4.	When I am alone, I talk out loud to myself.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
5.	I feel as though I were looking at the world through a fog so that people and things seem far away or unclear.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
6.	I am able to ignore pain.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
7.	I act so differently from one situation to another that it is almost as if I were two different people.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
8.	I can do things very easily that would usually be hard for me.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
<b>Total/Partial Raw Score:</b>							
<b>Prorated Total Raw Score: (if 1-2 items left unanswered)</b>							
<b>Average Total Score:</b>							

DES-B (Dalenberg C, Carlson E, 2010) modified for DSM-5 by C. Dalenberg and E. Carlson.  
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## Severity of Posttraumatic Stress Symptoms—Adult\*

### \*National Stressful Events Survey PTSD Short Scale (NSESSS)

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: Male  Female  Date: \_\_\_\_\_

Please list the traumatic event that you experienced: \_\_\_\_\_

Date of the traumatic event: \_\_\_\_\_

**Instructions:** People sometimes have problems after extremely stressful events or experiences. How much have you been bothered during the PAST SEVEN (7) DAYS by each of the following problems that occurred or became worse after an extremely stressful event/experience? **Please respond to each item by marking (✓ or x) one box per row.**

							Clinician Use
		Not at all	A little bit	Moderately	Quite a bit	Extremely	Item score
1.	Having “flashbacks,” that is, you suddenly acted or felt as if a stressful experience from the past was happening all over again (for example, you reexperienced parts of a stressful experience by seeing, hearing, smelling, or physically feeling parts of the experience)?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
2.	Feeling very emotionally upset when something reminded you of a stressful experience?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
3.	Trying to avoid thoughts, feelings, or physical sensations that reminded you of a stressful experience?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
4.	Thinking that a stressful event happened because you or someone else (who didn’t directly harm you) did something wrong or didn’t do everything possible to prevent it, or because of something about you?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
5.	Having a very negative emotional state (for example, you were experiencing lots of fear, anger, guilt, shame, or horror) after a stressful experience?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
6.	Losing interest in activities you used to enjoy before having a stressful experience?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
7.	Being “super alert,” on guard, or constantly on the lookout for danger?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
8.	Feeling jumpy or easily startled when you hear an unexpected noise?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
9.	Being extremely irritable or angry to the point where you yelled at other people, got into fights, or destroyed things?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
<b>Total/Partial Raw Score:</b>							
<b>Prorated Total Raw Score: (if 1-2 items left unanswered)</b>							
<b>Average Total Score:</b>							