DSPS

The following questions ask about experiences you may or may not have had. For each question, you will be asked if you have ever experienced this symptom and, if so, if you have experienced it in the past month. You will also be asked about the frequency and severity of the symptom in the past month. There are no right or wrong answers to these questions; just respond with what is true for you.

Symptom	a. Has this EVER happened?	b. Has this happened in the PAST MONTH?	In this past month: c. How often has this happened?						In the past month: d. How strong is that feeling?						e. Did this only occur when you were tired or on medications or drugs that made you tired?
			Never	Once or Twice	Once or Twice a Week	Three or Four times a week	Daily		N/A	Not very strong	Somewhat Strong	Moderately Strong	Very Strong	Extremely Strong	
1. Have there been times where you felt disconnected from your body, as if your body were not your own?	Yes No	Yes No	0	1	2	3	4		0	1	2	3	4	5	Yes No
2. Have you felt "checked out," that is, as if you were not really present and aware of what was going on around you?	Yes No	Yes No	0	1	2	3	4		0	1	2	3	4	5	Yes No
3. Have there been times when you felt like you were outside of your own body, as if you could look at yourself from the outside?	Yes No	Yes No	0	1	2	3	4		0	1	2	3	4	5	Yes No
4. Have you "lost time"—that is, been unable to account for large portions of your day or had trouble accounting for what you did for portions of your day?	Yes No	Yes No	0	1	2	3	4		0	1	2	3	4	5	Yes No
5. Have there been times when you looked in the mirror and did not recognize yourself physically?	Yes No	Yes No	0	1	2	3	4		0	1	2	3	4	5	Yes No

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			Never	Once or Twice	Once or Twice a Week	Three or Four times a week	Daily		N/A	Not very Strong	Somewhat Strong	Moderately Strong	Very Strong	Extremely Strong	
6. Have there been times when you were in a familiar place, yet it seemed strange and unfamiliar to you?	Yes No	Yes No	0	1	2	3	4		0	1	2	3	4	5	Yes No
7. Have there been times when your body did not feel real?	Yes No	Yes No	0	1	2	3	4		0	1	2	3	4	5	Yes No
8. Have there been times when the world around you (other people, objects, places) did not seem real?	Yes No	Yes No	0	1	2	3	4		0	1	2	3	4	5	Yes No
9. Have there been times when your body felt very strange and unfamiliar to you, as if it were not your own body?	Yes No	Yes No	0	1	2	3	4		0	1	2	3	4	5	Yes No
10. Have there been times when you felt lost, disoriented, or confused in a location that you know well?	Yes No	Yes No	0	1	2	3	4		0	1	2	3	4	5	Yes No
11. Have there been times (other than when you were tired, sleepy, or on medications or drugs that made you drowsy) when you felt as if you were in a daze or a fog?	Yes No	Yes No	0	1	2	3	4		0	1	2	3	4	5	Yes No

Symptom	a. Has this EVER happened?	b. Has this happened in the PAST MONTH?	In the past month: c. How often has this happened?						In the past month: d. How strong was this feeling?						e. Did this only occur when you were tired or on medications or drugs that made you tired?
			Never	Once or Twice	Once or Twice a week	Three or Four times a week	Daily		N/A	Not very strong	Somewhat Strong	Moderately Strong	Very Strong	Extremely Strong	
12. Have there been times when you felt like you were watching the world around you as an outsider, as if it were a movie, but the world did not seem real?	Yes No	Yes No	0	1	2	3	4		0	1	2	3	4	5	Yes No
13. Have you had trouble remembering how you got somewhere (i.e., finding yourself at work, at home, at a store, or elsewhere without remembering how you traveled there)?	Yes No	Yes No	0	1	2	3	4		0	1	2	3	4	5	Yes No
14. Have you had trouble remembering important details about your worst traumatic event (_____)?	Yes No	Yes No	0	1	2	3	4		0	1	2	3	4	5	Yes No
15. Have you thought that you should be able to remember more about this worst traumatic event (_____)?	Yes No	Yes No	0	1	2	3	4		0	1	2	3	4	5	Yes No