Version date: 2005


URL: http://www.ptsd.va.gov/professional/assessment/te-measures/ths.asp
Trauma History Screen

The events below may or may not have happened to you. Circle “YES” if that kind of thing has happened to you or circle “NO” if that kind of thing has not happened to you. **If you circle “YES” for any events:** put a number in the blank next to it to show how many times something like that happened.

<table>
<thead>
<tr>
<th>Event</th>
<th>Circle “YES” if that kind of thing has happened to you</th>
<th>Circle “NO” if that kind of thing has not happened to you</th>
<th>Number of times something like this has happened</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. A really bad car, boat, train, or airplane accident</td>
<td>YES</td>
<td>NO</td>
<td>_____ times</td>
</tr>
<tr>
<td>B. A really bad accident at work or home</td>
<td>YES</td>
<td>NO</td>
<td>_____ times</td>
</tr>
<tr>
<td>C. A hurricane, flood, earthquake, tornado, or fire</td>
<td>YES</td>
<td>NO</td>
<td>_____ times</td>
</tr>
<tr>
<td>D. Hit or kicked hard enough to injure - as a child</td>
<td>YES</td>
<td>NO</td>
<td>_____ times</td>
</tr>
<tr>
<td>E. Hit or kicked hard enough to injure - as an adult</td>
<td>YES</td>
<td>NO</td>
<td>_____ times</td>
</tr>
<tr>
<td>F. Forced or made to have sexual contact - as a child</td>
<td>YES</td>
<td>NO</td>
<td>_____ times</td>
</tr>
<tr>
<td>G. Forced or made to have sexual contact - as an adult</td>
<td>YES</td>
<td>NO</td>
<td>_____ times</td>
</tr>
<tr>
<td>H. Attack with a gun, knife, or weapon</td>
<td>YES</td>
<td>NO</td>
<td>_____ times</td>
</tr>
<tr>
<td>I. During military service - seeing something horrible or being badly scared</td>
<td>YES</td>
<td>NO</td>
<td>_____ times</td>
</tr>
<tr>
<td>J. Sudden death of close family or friend</td>
<td>YES</td>
<td>NO</td>
<td>_____ times</td>
</tr>
<tr>
<td>K. Seeing someone die suddenly or get badly hurt or killed</td>
<td>YES</td>
<td>NO</td>
<td>_____ times</td>
</tr>
<tr>
<td>L. Some other sudden event that made you feel very scared, helpless, or horrified</td>
<td>YES</td>
<td>NO</td>
<td>_____ times</td>
</tr>
<tr>
<td>M. Sudden move or loss of home and possessions</td>
<td>YES</td>
<td>NO</td>
<td>_____ times</td>
</tr>
<tr>
<td>N. Suddenly abandoned by spouse, partner, parent, or family</td>
<td>YES</td>
<td>NO</td>
<td>_____ times</td>
</tr>
</tbody>
</table>

**Did any of these things really bother you emotionally?**

**NO**  **YES**

**If you answered “YES”, fill out one or more of the boxes on the next pages to tell about EVERY event that really bothered you.**
Letter from above for the type of event: ______ 
Your age when this happened: ______ 
Describe what happened:

When this happened, did anyone get hurt or killed?  NO  YES
When this happened, were you afraid that you or someone else might get hurt or killed?  NO  YES
When this happened, did you feel very afraid, helpless, or horrified?  NO  YES
When this happened, did you feel unreal, spaced out, disoriented, or strange?  NO  YES
After this happened, how long were you bothered by it?  not at all / 1 week / 2-3 weeks / a month or more
How much did it bother you emotionally?  not at all / a little / somewhat / much / very much

Letter from above for the type of event: ______ 
Your age when this happened: ______ 
Describe what happened:

When this happened, did anyone get hurt or killed?  NO  YES
When this happened, were you afraid that you or someone else might get hurt or killed?  NO  YES
When this happened, did you feel very afraid, helpless, or horrified?  NO  YES
When this happened, did you feel unreal, spaced out, disoriented, or strange?  NO  YES
After this happened, how long were you bothered by it?  not at all / 1 week / 2-3 weeks / a month or more
How much did it bother you emotionally?  not at all / a little / somewhat / much / very much
Letter from above for the type of event: ______
Your age when this happened: ______
Describe what happened:

When this happened, did anyone get hurt or killed?  NO  YES
When this happened, were you afraid that you or someone else might get hurt or killed?  NO  YES
When this happened, did you feel very afraid, helpless, or horrified?  NO  YES
When this happened, did you feel unreal, spaced out, disoriented, or strange?  NO  YES
After this happened, how long were you bothered by it?  not at all / 1 week / 2-3 weeks / a month or more
How much did it bother you emotionally?  not at all / a little / somewhat / much / very much
Letter from above for the type of event: ______ Your age when this happened: ______
Describe what happened:

When this happened, did anyone get hurt or killed?   NO   YES
When this happened, were you afraid that you or someone else might get hurt or killed?   NO   YES
When this happened, did you feel very afraid, helpless, or horrified?   NO   YES
When this happened, did you feel unreal, spaced out, disoriented, or strange?   NO   YES
After this happened, how long were you bothered by it?  not at all / 1 week / 2-3 weeks / a month or more
How much did it bother you emotionally?  not at all / a little / somewhat / much / very much

IF THERE WERE MORE EVENTS THAT REALLY BOTHERED YOU, PLEASE ASK FOR ANOTHER SHEET.