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**POST-TRAUMATIC STRESS DISORDER SELF-TEST**

If you suspect that you might suffer from post-traumatic stress disorder, complete the following self-test by clicking the "yes or "no" boxes next to each question, print out the test and show the results to your health care professional.

**HOW CAN I TELL IF IT'S PTSD?**

**Yes or No?**

**Yes**  **No**  Have you experienced or witnessed a life-threatening event that caused intense fear, helplessness or horror?

Do you re-experience the event in at least one of the following ways?

**Yes**  **No**  Repeated, distressing memories and/or dreams?

**Yes**  **No**  Acting or feeling as if the event were happening again (flashbacks or a sense of reliving it)?

**Yes**  **No**  Intense physical and/or emotional distress when you are exposed to things that remind you of the event?

Do you avoid reminders of the event and feel numb, compared to the way you felt before, in three or more of the following ways:

**Yes**  **No**  Avoiding thoughts, feelings, or conversations about it?

**Yes**  **No**  Avoiding activities, places, or people who remind you of it?

**Yes**  **No**  Blanking on important parts of it?

**Yes**  **No**  Losing interest in significant activities of you life?


**Yes**  **No**  Feeling detached from other people?

**Yes**  **No**  Feeling your range of emotions is restricted?

**Yes**  **No**  Sensing that your future has shrunk (for example, you don't expect to have a career, marriage, children, or a normal life span)?

Are you troubled by two or more of the following:

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- Yes**  **No**  Problems sleeping?
- Yes**  **No**  Irritability or outbursts of anger?
- Yes**  **No**  Problems concentrating?
- Yes**  **No**  Feeling "on guard"?
- Yes**  **No**  An exaggerated startle response?

Having more than one illness at the same time can make it difficult to diagnosis and treat the different conditions. Illnesses that sometimes complicate an anxiety disorder include depression and substance

abuse. With this in mind, please take a minute to answer the following questions:

- Yes**  **No**  Have you experienced changes in sleeping or eating habits?

More days than not, do you feel:

- Yes**  **No**  Sad or depressed?
- Yes**  **No**  Disinterested in life?
- Yes**  **No**  Worthless or guilty?

During the last year, has the use of alcohol or drugs:

- Yes**  **No**  Resulted in your failure to fulfill responsibilities with work, school, or family?
- Yes**  **No**  Placed you in a dangerous situation, such as driving a car under the influence?
- Yes**  **No**  Gotten you arrested?
- Yes**  **No**  Continued despite causing problems for you and/or your loved ones?

**Reference:**

Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. Washington, DC, American Psychiatric Association, 1994.

If you or someone you know would like more information on PTSD, please [click here](#) to go to the ADAA resource page on this topic.

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