International Trauma Questionnaire for Complex PTSD Testing

Patient's Name: _____ **Date:** _____

Patient's Signature: _____ **Physician's Name:** _____

What is an experience that's troubling you? When did it occur? Any there any more details you would like to share?

Response to Traumatic or Stressful Life Events

Please read the following items carefully, then tick the appropriate number to indicate how much you have been bothered by the problem for the **past month.**

		Not all = 0	A little bit = 1	Moderately = 2	Quite a bit = 3	Extremely = 4
1	Do you have upsetting dreams that either replay a part of the experience or are related to the experience?	☐	☐	☐	☐	☐
2	Do you have powerful images/memories that enter your mind that make you feel that you are going through the experience now?	☐	☐	☐	☐	☐
3	Do you avoid internal reminders of the experience like thoughts, feelings, or physical sensations?	☐	☐	☐	☐	☐
4	Do you avoid external reminders of the experience like people, places, conversations, objects, or activities?	☐	☐	☐	☐	☐
5	Are you constantly on "super alert", watchful, or on guard?	☐	☐	☐	☐	☐
6	Do you feel jumpy or are easily startled?	☐	☐	☐	☐	☐
7	Have the problems you mentioned affected your relationships and/or social life?	☐	☐	☐	☐	☐
8	Have the problems affected your work or ability to work?	☐	☐	☐	☐	☐
9	Have the problems affected other important activities/parts of your life: school/college work, caring for your children?	☐	☐	☐	☐	☐

Cloitre, M., Shevlin M., Brewin, C.R., Bisson, J.I., Roberts, N.P., Maercker, A., Karatzias, T., Hyland, P. (2018). The International Trauma Questionnaire: Development of a self-report measure of ICD-11 PTSD and Complex PTSD. Acta Psychiatrica Scandinavica. DOI: 10.1111/acps.12956

Problems When Experiencing Stressful or Traumatic Events

Note: These questions are referring to how you typically feel, think about yourself, and related to others. Please answer the following according to how true the statement is about you.

		Not all = 0	A little bit = 1	Moderately = 2	Quite a bit = 3	Extremely = 4
1	It takes me a long time to calm down when I am upset.	☐	☐	☐	☐	☐
2	I feel emotionally shut down or numb.	☐	☐	☐	☐	☐
3	I feel like a failure.	☐	☐	☐	☐	☐
4	I feel worthless.	☐	☐	☐	☐	☐
5	I feel distant or cut off from people.	☐	☐	☐	☐	☐
6	I find it hard to remain emotionally close to people.	☐	☐	☐	☐	☐
7	Have your problems with emotions, and beliefs about yourself/relationships, created concern or distress about your relationships or social life in the past month?	☐	☐	☐	☐	☐
8	Have your problems with emotions, and beliefs about yourself/relationships affected your work or ability to work in the past month?	☐	☐	☐	☐	☐
9	Have your problems with emotions, and beliefs about yourself/relationships affected other important activities/parts of your life: school/college work, caring for your children?	☐	☐	☐	☐	☐

TOTAL SCORE: _____

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