

STANLEY L. GOODMAN, M.D.
Forensic, Child, Adolescent, and Adult Psychiatry

INDIVIDUAL & FAMILY PSYCHOPHARMACOLOGIC TREATMENT OF:

- MOOD AND ANXIETY DISORDERS • OBSESSIVE-COMPULSIVE DISORDER
- PERVASIVE DEVELOPMENTAL DISORDERS/AUTISM • MENTAL RETARDATION
- ATTENTION DEFICIT DISORDER • TOURETTE'S DISORDER • TRAUMATIC PSYCHIATRY
- TRAUMATIC BRAIN INJURY • POST-TRAUMATIC STRESS DISORDER • CHRONIC PAIN MANAGEMENT
- WORKERS' COMPENSATION

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MAIN OFFICE

18401 Burbank Blvd. – Suite 209 – Tarzana, CA 91356

Phone: (818) 708-8804 Fax: (818) 708-8841 E-mail: drsgoodman@earthlink.net

Website: www.dr-stanley-goodman.com

SATELLITE OFFICES

- Pacific Palisades • Oxnard • Santa Clarita

SCREENING QUESTIONNAIRE FOR
POST-TRAUMATIC STRESS DISORDER

BY STANLEY L. GOODMAN, M.D.

POST-TRAUMATIC STRESS DISORDER

Answer if your case involves an accident, injury, or other stressful and/or traumatic event

1. Do you have repeated and uncomfortable thoughts about the event(s)? Yes No
If so, describe one or two of your actual repeated and uncomfortable thoughts:

2. Does any one particular thought or idea trigger memories of the event? Yes No
If so, state what particular thought or idea will do this:

3. How long after the event(s) did these thoughts begin to occur? (Month/Year) _____
At first, how many times did these thoughts occur? _____ times/day; _____ times/month
Now, how many times do these thoughts occur? _____ times/day; _____ times/month

4. Have you had recurring dreams about the event(s)? Yes No
If so, describe one of your actual recurring dreams:

5. Did these dreams ever wake you up? Yes No
How long after the event(s) did these dreams begin to occur? (Month/Year) _____
At first, how many times did these dreams occur? _____ times/day; _____ times/month
Now, how many times do these dreams occur? _____ times/day; _____ times/month

6. Have you had recurring nightmares about the event(s)? Yes No
If so, describe one of your most frightening recurring nightmares:

7. Did these nightmares ever wake you up? Yes No
How long after the event(s) did these nightmares begin to occur? (Month/Year) _____
At first, how many times did these nightmares occur? _____ times/day; _____ times/month
Now, how many times do these nightmares occur? _____ times/day; _____ times/month

8. Have you had the feeling the event(s) was happening all over again? Yes No
(For instance if, afterwards, you were at or near the event site. Or, if it was a car accident, you were driving the same car again.)

9. Do you avoid activities similar to those in which you were involved at the time of the event, because they remind you of the event? Yes No

Which activities? _____

10. If the event was an automobile accident, do you --
 No longer drive? Drive less? Drive, but now are very nervous about it?
11. Since the event, do you feel less interested in activities you once enjoyed? Yes No
If so, which? Work Hobbies Family activities Socializing with friends
Others: _____
12. Since the event, have you lost the ability to feel emotions of any kind? Yes No
If so, which? Tenderness Closeness with people Sexual feelings
Others: _____
13. Does this loss of feeling/emotions cause you relationship problems? Yes No
If so, with whom? Wife/Husband Significant other Children
 Parents Co-Workers Supervisor(s)
Others: _____
14. *Since the event --*
Do you suddenly become irritable? Yes No
Do you have sudden outbursts of temper? Yes No
Have you felt like hitting someone? Yes No
Have you actually hit anyone? Yes No
If so, how many months after the event did these feelings begin? _____
If you have actually hit someone, what was their relationship to you? _____
Briefly state the circumstances: _____
15. *Since the event --*
Do you have feelings of being especially alert? Yes No
Do you startle easily when there is a noise? Yes No
Do you have difficulty concentrating? Yes No
If so, is this because thoughts of the event come to mind? Yes No
Do you have difficulty falling asleep? Yes No
Do you have difficulty staying asleep? Yes No
16. *Since the event --*
Have you had the desire to take sudden trips? Yes No
Have you had the desire to leave work/family for periods of time? Yes No
Have you actually left home or work for a time? Yes No
Have you actually left work for a time? Yes No
State why you think you have these feelings: _____