

PTSD ORIENTATION CLASS

Please skip any questions you prefer not to answer.

Name: _____ Last 4: _____ Age: _____

Branch/es of Service: _____ Years served: _____

Service era/s (select all that apply):

- | | |
|---|---|
| <input type="checkbox"/> Korean Conflict (1950-1955) | <input type="checkbox"/> Post-Vietnam (1975-1990) |
| <input type="checkbox"/> Between Korea and Vietnam Eras (1955 – 1961) | <input type="checkbox"/> Persian Gulf War (1990-2001) |
| <input type="checkbox"/> Vietnam (1961 – 1975) | <input type="checkbox"/> OIF/OEF/OND (2001-present) |

With which race/ethnicity do you identify (select all that apply):

- | | |
|---|--|
| <input type="checkbox"/> African American or Black | <input type="checkbox"/> Multiracial |
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Pacific Islander |
| <input type="checkbox"/> Asian American or Asian | <input type="checkbox"/> White or Caucasian |
| <input type="checkbox"/> Hispanic or Latinx | <input type="checkbox"/> An identity not listed: _____ |

What are your pronouns (e.g., ze, they, he, she, etc.)? _____**With which gender do you identify (select all that apply):**

- | | |
|--------------------------------------|--|
| <input type="checkbox"/> Woman | <input type="checkbox"/> Non-binary |
| <input type="checkbox"/> Man | <input type="checkbox"/> Genderqueer or gender nonconforming |
| <input type="checkbox"/> Transgender | <input type="checkbox"/> An identity not listed: _____ |

With which sexual orientation do you identify (select all that apply):

- | | |
|-----------------------------------|--|
| <input type="checkbox"/> Asexual | <input type="checkbox"/> Heterosexual/straight |
| <input type="checkbox"/> Bisexual | <input type="checkbox"/> Lesbian |
| <input type="checkbox"/> Gay | <input type="checkbox"/> An identity not listed: _____ |

Do you identify as someone with a religious or spiritual affiliation? Please specify. _____**Relationship status (select all that apply):**

- | | |
|--------------------------------------|------------------------------------|
| <input type="checkbox"/> Unpartnered | <input type="checkbox"/> Partnered |
| <input type="checkbox"/> Married | <input type="checkbox"/> Separated |
| <input type="checkbox"/> Divorced | <input type="checkbox"/> Widowed |

Status not listed: _____

Living situation:

- | | |
|--|---|
| <input type="checkbox"/> My own residence (house, apartment, etc.) | <input type="checkbox"/> I am currently experiencing homelessness |
| <input type="checkbox"/> Unstable housing (staying with friends or family or in imminent danger of eviction) | <input type="checkbox"/> Living in a facility (treatment program, nursing home, hospital, etc.) |

Highest level of education:

- | | |
|--|---|
| <input type="checkbox"/> Some high school, no diploma | <input type="checkbox"/> Associate degree |
| <input type="checkbox"/> High school graduate, diploma or the equivalent | <input type="checkbox"/> Bachelor's degree |
| <input type="checkbox"/> Some college | <input type="checkbox"/> Master's degree |
| <input type="checkbox"/> Trade/technical/vocational training | <input type="checkbox"/> Doctorate/medical degree |

Employment status (select all that apply):

- Employed Looking for work
 Currently not working Retired
 Attending school Unemployed due to disability

Have you had previous therapy before? Group _____ Individual _____

Are you able to attend weekly appointments for a three month stretch? _____

Are you able to commit daily time to therapy reading and practice? _____

How willing are you to talk about your trauma/s with a therapist from 0-10? _____

Would you like to involve loved ones in your care? Who? _____

What would you most like to change in your life with the help of therapy? _____

Describe your current pattern of alcohol, marijuana, opiates, benzodiazepine, or other substances:

List any medical or mental health conditions other than PTSD: _____

Are there any barriers to your full participation (in session and with home practice)?

- Childcare School and/or work commitments
 Transportation difficulties Chronic pain
 Sedation from medications Difficulties with reading/writing
 Technological difficulties. Please specify: _____

Others: _____

Times/days you are NOT available for appointments: _____

Please indicate how often the following statements apply to you by writing the appropriate number from the scale below on the line beside each item.

Over the past month, what percentage of the time does this happen?

1-----2-----3-----4-----5
almost never sometimes about half the time most of the time almost always
(0-10%) (11-35%) (36-65%) (66-90%) (91-100%)

1. When I am upset I lose control of my behavior. _____
2. When I am upset, I know that I can find a way to eventually feel better. _____
3. I experience feeling extremely disconnected from my thoughts, feelings, memories, and/or surroundings. _____