

## SCS Outcome Measures

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Instructions: Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please read each one carefully, put an "X" in the box to indicate how much you have been bothered by that problem ***in the last month***.

No.	Problem/Complaint	Not at all (1)	A little bit (2)	Moderately (3)	Quite a bit (4)	Extremely (5)
1	Repeated , disturbing <i>memories, thoughts, or images</i> of a stressful experience from the past?					
2	Have physical reactions (e.g., heart pounding, trouble breathing, or sweating, when something reminded you of a stressful experience from the past?					
3	Being " <i>super alert</i> " or watchful, on guard?					
4	Feeling " <i>jumpy</i> " or easily startled?					
5	Having nightmares and/or night terrors?					
6	Having flashbacks?					
7	Feeling emotionally numb or being unable to have loving feelings for those close to you?					
8	Having a depressed mood?					
9	Frequent feelings of sadness or guilt?					
10	Loss of interest in things you used to enjoy?					
11	Trouble falling or staying asleep?					
12	Feeling irritable or having angry outbursts?					
13	Feelings of worthlessness and/or hopelessness?					
14	Obsessive negative thoughts?					
15	Thoughts of harming or killing yourself?					
16	Having difficulty concentrating or thinking?					
17	Feeling anxious or out of control?					
18	Panic attacks?					
19	Frequent worry?					
20	Racing thoughts?					
21	Repetitive behaviors or mental acts (i.e., counting, checking doors, washing hands)?					
22	Sudden change in energy and activity?					
23	Rapid mood changes?					