Adverse Childhood Experiences (ACE) **Name: _____**

Prior to your 18th birthday:

1. Did a parent or other adult in the household often or very often… Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?

   No enter 0: _____ If Yes, enter 1: _____

2. Did a parent or other adult in the household often or very often… Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?

   No enter 0: _____ If Yes, enter 1: _____

3. Did an adult or person at least 5 years older than you ever… Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?

   No enter 0: _____ If Yes, enter 1: _____

4. Did you often or very often feel that … No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?

   No enter 0: _____ If Yes, enter 1: _____

5. Did you often or very often feel that … You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

   No enter 0: _____ If Yes, enter 1: _____

6. Were your parents ever separated or divorced?

   No enter 0: _____ If Yes, enter 1: _____

7. Was your mother or stepmother: Often or very often pushed, grabbed, slapped, or had something thrown at her? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

   No enter 0: _____ If Yes, enter 1: _____

8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?

   No enter 0: _____ If Yes, enter 1: _____

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?

   No enter 0: _____ If Yes, enter 1: _____

10. Did a household member go to prison?

    No enter 0: _____ If Yes, enter 1: _____

Now add up your "Yes" answers: _____. This is your ACE Score

Trauma Symptom Checklist (TSC) **Name:** _____

How often have you experienced each of the following in the last two months?
0 = Never 3 = Often

1. Headaches	0 1 2 3
2. Insomnia (trouble getting to sleep)	0 1 2 3
3. Weight loss (without dieting)	0 1 2 3
4. Stomach problems	0 1 2 3
5. Sexual problems	0 1 2 3
6. Feeling isolated from others	0 1 2 3
7. "Flashbacks" (sudden/vivid/distracting memories)	0 1 2 3
8. Restless sleep	0 1 2 3
9. Low sex drive	0 1 2 3
10. Anxiety attacks	0 1 2 3
11. Sexual overactivity	0 1 2 3
12. Loneliness	0 1 2 3
13. Nightmares	0 1 2 3
14. "Spacing out" (going away in your mind)	0 1 2 3
15. Sadness	0 1 2 3
16. Dizziness	0 1 2 3
17. Not feeling satisfied with your sex life	0 1 2 3
18. Trouble controlling your temper	0 1 2 3
19. Waking up early in the morning and can't get back to sleep	0 1 2 3
20. Uncontrollable crying	0 1 2 3
21. Fear of men	0 1 2 3
22. Not feeling rested in the morning	0 1 2 3
23. Having sex that you didn't enjoy	0 1 2 3
24. Trouble getting along with others	0 1 2 3
25. Memory problems	0 1 2 3
26. Desire to physically hurt yourself	0 1 2 3
27. Fear of women	0 1 2 3
28. Waking up in the middle of the night	0 1 2 3
29. Bad thoughts or feelings during sex	0 1 2 3
30. Passing out	0 1 2 3
31. Feeling that things are "unreal"	0 1 2 3
32. Unnecessary or over-frequent washing	0 1 2 3
33. Feelings of inferiority	0 1 2 3
34. Feeling tense all the time	0 1 2 3
35. Being confused about your sexual feelings	0 1 2 3
36. Desire to physically hurt others	0 1 2 3
37. Feelings of guilt	0 1 2 3
38. Feelings that you are not always in your body	0 1 2 3
39. Having trouble breathing	0 1 2 3
40. Sexual feelings when you shouldn't have them	0 1 2 3