Participant ID: _____	Date: _____
Evaluator: _____	Appointment: _____

Trauma-Related Nightmare Survey (TRNS)

Instructions: The following questions relate to your experience of nightmares in the past month. Nightmares are dreams with **negative emotions** that **wake you up** [if you do not wake up, that is a bad dream, not a nightmare]. Please read each question and answer to the best of your ability. If you need more room, feel free to use the back of the page.

1. Approximately how many hours do you sleep per night? _____ hours

2. Approximately how long does it usually take for you to fall asleep?
   - ☐ Less than 15 minutes
   - ☐ 15 minutes to 1 hour
   - ☐ 1 hour to 2 hours
   - ☐ More than 2 hours *if more than 2 hours, how many?* _____

3. In general, how fearful are you to go to sleep?
   ☐ Not at all ☐ Slightly ☐ Moderately ☐ Very much ☐ Extremely

4. In general, how depressed do you feel when you wake up?
   ☐ Not at all ☐ Slightly ☐ Moderately ☐ Very much ☐ Extremely

5. In general, how rested do you feel when you wake up?
   ☐ Not at all ☐ Slightly ☐ Moderately ☐ Very much ☐ Extremely

6. How long have you experienced nightmares? _____ months OR _____ years

7. Did your nightmares begin after a traumatic event, such as sexual assault, combat, fire or any other stressful event?
   ☐ Yes ☐ No

8. Approximately, how many nightmares have you experienced?
   - _____ in the past week
   - _____ in the past month
   - _____ in the past year

9. On how many nights in the past week have you experienced a nightmare? _____

10. On how many nights in the past week have you experienced **more than one** nightmare per night? _____

11. In general, how disturbing have the nightmares been?
    ☐ Not at all ☐ Slightly ☐ Moderately ☐ Very much ☐ Extremely

12. How many different nightmares do you generally experience? _____

Participant ID: _____	Date: _____
Evaluator: _____	Appointment: _____

Trauma-Related Nightmare Survey (TRNS)

13. If you have experienced a trauma (serious car accident, natural disaster, sexual assault, etc.), please indicate how similar your nightmare is to the trauma you experienced. If you have more than one nightmare, please answer for the most frequent nightmare. My most frequent nightmare is:

☐ Exactly or almost exactly like the trauma

☐ Similar to trauma, but not exact
Please explain: _____
_____
_____

☐ Unrelated to traumatic event(s)
Please explain: _____
_____
_____

14a. How long does it typically take you to return to sleep after a nightmare?

☐ less than 15 minutes
☐ 15 minutes to 1 hour
☐ 1 hour to 2 hours
☐ more than 2 hours
☐ typically do not return to sleep

14b. What do you do to help you get back to sleep? (e.g. nothing, read, watch TV, consume alcohol or drugs, etc…)

_____
_____

14c. After waking from the nightmare, do you experience any of the following symptoms? *(check all that apply)*

☐ Palpitations, pounding heart, or accelerated heart rate
☐ Feeling dizzy, unsteady, lightheaded, or faint
☐ Sensations of shortness of breath or smothering
☐ Chest pain or discomfort
☐ Numbness or tingling sensations
☐ Derealization (feelings of unreality)
☐ Depersonalization (being detached from oneself)
☐ Sweating
☐ Trembling or shaking
☐ Feeling of choking
☐ Nausea or abdominal distress
☐ Fear of losing control
☐ Chills or hot flashes
☐ Fear of dying

14d. What time do you generally wake up from a nightmare?
[if you experience more than one nightmare per night, please indicate the time you wake from the first nightmare]

☐ 0-2 hours after sleep onset
☐ 3-5 hours after sleep onset
☐ 6-8 hours after sleep onset
☐ 9+ hours after sleep onset

Participant ID: _____	Date: _____
Evaluator: _____	Appointment: _____

Trauma-Related Nightmare Survey (TRNS)

15. In general, I have the same nightmare[s] over and over.
    ☐ Not at all ☐ Slightly ☐ Moderately ☐ Very much ☐ Extremely

16. In general, my nightmares are related to themes of…
    a. Powerlessness
       ☐ Not at all ☐ Slightly ☐ Moderately ☐ Very much ☐ Extremely
    b. Trust
       ☐ Not at all ☐ Slightly ☐ Moderately ☐ Very much ☐ Extremely
    c. Intimacy
       ☐ Not at all ☐ Slightly ☐ Moderately ☐ Very much ☐ Extremely
    d. Safety
       ☐ Not at all ☐ Slightly ☐ Moderately ☐ Very much ☐ Extremely
    e. Esteem
       ☐ Not at all ☐ Slightly ☐ Moderately ☐ Very much ☐ Extremely

Christopher C. Cranston PhD, Katherine E. Miller MA, Joanne L. Davis PhD & Jamie L. Rhudy PhD (2016): Preliminary validation of a brief measure of the frequency and severity of nightmares: The Trauma-Related Nightmare Survey, Journal of Trauma &Dissociation, DOI: 10.1080/15299732.2016.1191578.

Client ID: _____ Date: _____
Evaluator: _____ Appointment: _____

Insomnia Severity Index

The Insomnia Severity Index has seven questions. The seven answers are added up to get a total score. When you have your total score, look at the 'Guidelines for Scoring/Interpretation' below to see where your sleep difficulty fits.

For each question, please CIRCLE the number that best describes your answer.

Please rate the CURRENT (i.e. LAST 2 WEEKS) SEVERITY of your insomnia problem(s).

Insomnia Problem	None	Mild	Moderate	Severe	Very Severe
1. Difficulty falling asleep	0	1	2	3	4
2. Difficulty staying asleep	0	1	2	3	4
3. Problems waking up too early	0	1	2	3	4

4. How SATISFIED/DISSATISFIED are you with your CURRENT sleep pattern?

Very Satisfied	Satisfied	Moderately Satisfied	Dissatisfied	Very Dissatisfied
0	1	2	3	4

5. How NOTICEABLE to others do you think your sleep problem is in terms of impairing the quality of your life?

Not at all Noticeable	A Little	Somewhat	Much	Very Much Noticeable
0	1	2	3	4

6. How WORRIED/DISTRESSED are you about your current sleep problem?

Not at all Worried	A Little	Somewhat	Much	Very Much Worried
0	1	2	3	4

7. To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g. daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, mood, etc.) CURRENTLY?

Not at all Interfering	A Little	Somewhat	Much	Very Much Interfering
0	1	2	3	4

Guidelines for Scoring/Interpretation:

Add the scores for all seven items (questions 1 + 2 + 3 + 4 + 5 +6 + 7) = _____ your total score

Total score categories:
0–7 = No clinically significant insomnia
8–14 = Subthreshold insomnia
15–21 = Clinical insomnia (moderate severity)
22–28 = Clinical insomnia (severe)

Participant ID: _____	Date: _____
Evaluator: _____	Appointment: _____

DSI-SS

INSTRUCTIONS: Please read all of the statements in a given group. Pick out and circle the one statement in each group that describes you best for the past ***two weeks***. If several statements in a group seem to apply to you, pick the one with the higher number. *Be sure to read all of the statements in each group before making your choice.*

1. ⓪ I do not have thoughts of killing myself.
   ① Sometimes I have thoughts of killing myself.
   ② Most of the time I have thoughts of killing myself.
   ③ I always have thoughts of killing myself.

2. ⓪ I am not having thoughts about suicide.
   ① I am having thoughts about suicide but have not formulated any plans.
   ② I am having thoughts about suicide and am considering possible ways of doing it.
   ③ I am having thoughts about suicide and have formulated a definite plan.

3. ⓪ I am not having thoughts about suicide.
   ① I am having thoughts about suicide but have these thoughts completely under my control.
   ② I am having thoughts about suicide but have these thoughts somewhat under my control.
   ③ I am having thoughts about suicide but have little or no control over these thoughts.

4. ⓪ I am not having impulses to kill myself.
   ① In some situations I have impulses to kill myself.
   ② In most situations I have impulses to kill myself.
   ③ In all situations I have impulses to kill myself.

Staff Initials/Date:

Client ID: _____ Date: _____
Evaluator: _____ Appointment: _____

PCL-5 with LEC-5 – Criterion A

PART 1: Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right to indicate that: (a) it *happened to you* personally; (b) you *witnessed it* happen to someone else; (c) you *learned about it* happening to a close family member or close friend; (d) you were exposed to it as *part of your job* (for example, paramedic, police, military, or other first responder); (e) you're *not sure* if it fits; or (f) it *doesn't apply* to you.

Be sure to consider your *entire life* (growing up as well as adulthood) as you go through the list of events.

Event	Happened to me	Witnessed it	Learned about it	Part of my job	Not Sure	Doesn't apply
1. Natural disaster (for example, flood, hurricane, tornado, earthquake)	☐	☐	☐	☐	☐	☐
2. Fire or explosion	☐	☐	☐	☐	☐	☐
3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash)	☐	☐	☐	☐	☐	☐
4. Serious accident at work, home, or during recreational activity	☐	☐	☐	☐	☐	☐
5. Exposure to toxic substance (for example, dangerous chemicals, radiation)	☐	☐	☐	☐	☐	☐
6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)	☐	☐	☐	☐	☐	☐
7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)	☐	☐	☐	☐	☐	☐
8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)	☐	☐	☐	☐	☐	☐
9. Other unwanted or uncomfortable sexual experience	☐	☐	☐	☐	☐	☐
10. Combat or exposure to a war-zone (in the military or as a civilian)	☐	☐	☐	☐	☐	☐
11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)	☐	☐	☐	☐	☐	☐
12. Life-threatening illness or injury	☐	☐	☐	☐	☐	☐
13. Severe human suffering	☐	☐	☐	☐	☐	☐
14. Sudden, violent death (for example, homicide, suicide)	N/A	☐	☐	☐	☐	☐
15. Sudden accidental death	N/A	☐	☐	☐	☐	☐
16. Serious injury, harm, or death you caused to someone else	☐	☐	☐	☐	☐	☐
17. Any other very stressful event or experience	☐	☐	☐	☐	☐	☐

PLEASE COMPLETE PART 2 ON THE FOLLOWING PAGE

Client ID: _____ Date: _____
Evaluator: _____ Appointment: _____

PCL-5 with LEC-5 – Criterion A

PART 2:

A. If you checked anything for #17 in PART 1, briefly identify the event you were thinking of:

_____

B. If you have experienced more than one of the events in PART 1, think about the event you consider the *worst event*, which for this questionnaire means the event that currently bothers you the most. If you have experienced only one of the events in PART 1, use that one as the worst event. Please answer the following questions about the worst event *(check all options that apply)*:

1. **Briefly describe the worst event *(for example, what happened, who was involved, etc.)*.**

   _____

   _____

2. **When did this happen?** Year: _____ Month: _____ *(please estimate if you are not sure)*

3. **How did you experience it?**
   - ◯ It happened to me directly
   - ◯ I witnessed it
   - ◯ I learned about it happening to a close family member or close friend
   - ◯ I was repeatedly exposed to details about it as part of my job (for example, paramedic, police, military, or other first responder)
   - ◯ Other, please describe: _____

4. **Was someone's life in danger?**
   - ◯ Yes, my life
   - ◯ Yes, someone else's life
   - ◯ No

5. **Was someone seriously injured or killed?**
   - ◯ Yes, I was seriously injured
   - ◯ Yes, someone else was seriously injured or killed
   - ◯ No

6. **Did it involve sexual violence?** ◯ Yes ◯ No

7. **If the event involved the death of a close family member or close friend, was it due to some kind of accident or violence, or was it due to natural causes?**
   - ◯ Accident or violence
   - ◯ Natural causes
   - ◯ Not applicable (The event did not involve the death of a close family member or close friend)

8. **How many times altogether have you experienced a similar event as stressful or nearly as stressful as the worst event?**
   - ◯ Just once
   - ◯ More than once (please specify or estimate the total # of times you have had this experience _____)

PLEASE COMPLETE PART 3 ON THE FOLLOWING PAGE

ID: _____	Date: _____
Clinician: _____	Session: _____

PCL-5 with LEC-5 – Criterion A

Part 3: Below is a list of problems that people sometimes have in response to a very stressful experience. Keeping your worst event in mind, please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	***Not at all***	***A little bit***	***Moderately***	***Quite a bit***	***Extremely***
1. Repeated, disturbing, and unwanted memories of the stressful experience?	(0)	(1)	(2)	(3)	(4)
2. Repeated, disturbing dreams of the stressful experience?	(0)	(1)	(2)	(3)	(4)
3. Suddenly feeling or acting as if the stressful experience were actually happening again (*as if you were actually back there reliving it*)?	(0)	(1)	(2)	(3)	(4)
4. Feeling very upset when something reminded you of the stressful experience?	(0)	(1)	(2)	(3)	(4)
5. Having strong physical reactions when something reminded you of the stressful experience (*for example, heart pounding, trouble breathing, sweating*)?	(0)	(1)	(2)	(3)	(4)
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	(0)	(1)	(2)	(3)	(4)
7. Avoiding external reminders of the stressful experience (*for example, people, places, conversations, activities, objects, or situations*)?	(0)	(1)	(2)	(3)	(4)
8. Trouble remembering important parts of the stressful experience?	(0)	(1)	(2)	(3)	(4)
9. Having strong negative beliefs about yourself, other people, or the world (*for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous*)?	(0)	(1)	(2)	(3)	(4)
10. Blaming yourself or someone else for the stressful experience or what happened after it?	(0)	(1)	(2)	(3)	(4)
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	(0)	(1)	(2)	(3)	(4)
12. Loss of interest in activities that you used to enjoy?	(0)	(1)	(2)	(3)	(4)
13. Feeling distant or cut off from other people?	(0)	(1)	(2)	(3)	(4)
14. Trouble experiencing positive feelings (*for example, being unable to feel happiness or have loving feelings for people close to you*)?	(0)	(1)	(2)	(3)	(4)
15. Irritable behavior, angry outbursts, or acting aggressively?	(0)	(1)	(2)	(3)	(4)
16. Taking too many risks or doing things that could cause you harm?	(0)	(1)	(2)	(3)	(4)
17. Being "superalert" or watchful or on guard?	(0)	(1)	(2)	(3)	(4)
18. Feeling jumpy or easily startled?	(0)	(1)	(2)	(3)	(4)
19. Having difficulty concentrating?	(0)	(1)	(2)	(3)	(4)
20. Trouble falling or staying asleep?	(0)	(1)	(2)	(3)	(4)

Total: 0

ID: _____	Date: _____
Clinician: _____	Session: _____

Part 4: Complete the questions..

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Over the *last 2 weeks*, how often have you been bothered by any of the following problems? Circle one of the numbers to indicate your response.	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

Scoring for use by study personnel only:

Total: 0

10. If you indicated any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all ○ Somewhat difficult ○ Very difficult ○ Extremely difficult ○

STOP Questionnaire for Obstructive Sleep Apnea (OSA)

Height: _____ inches Weight: _____ lbs

Age: _____ Male / Female Body Mass Index (BMI): _____

Collar size of shirt: S M L XL or _____ inches Neck Circumference: _____ cm / inches

The STOP Test consists of Four Questions:

1. Snoring

Do you snore loudly (louder than talking or loud enough to be

heard through closed door)? Yes No

2. Tired

Do you often feel tired, fatigued or sleepy during the day? Yes No

3. Observed

Has as anyone observed you stop breathing during your sleep? Yes No

4. Blood Pressure

Do you have or are you being treated for high blood pressure? Yes No

Total ____ Yes ____ No

High risk of OSA: answering yes to two or more questions

Low risk of OSA: answering yes to less than two questions

Chung, F., Yegneswaran, B., Liao, P., Chung, S., Vairavanathan, S., Islam, S., Khajehdehi, A., Shapiro C. (2008). STOP questionnaire. A tool to screen patients for obstructive sleep apnea. Anesthesiology, 108 (5), 812-21.