Birth Trauma Questionnaire

-Patient Details

Name:		Address:	
Your date of birth:			
Date of baby's birth:		Phone:	

Guidance for completion

This questionnaire aims to identify if you persistently/regularly experience any of the following.

Please tick **YES** or **NO** for *all* of the questions below

#	Question	Yes	No
SECTION A			
1	Do you keep having intrusive, distressing memories of your birth, including upsetting images, thoughts or perceptions?	☐	☐
2	Do you have nightmares about your birth?	☐	☐
3	Do you keep reliving the traumatic events of your birth, or keep having flashbacks?	☐	☐
4	Do you feel anxious or panicky when something reminds you of your birth?	☐	☐
5	Have you begun to experience any physical symptoms or problems when something reminds you of your birth? For example, asthma, stomach upsets/irritable bowel, etc.?	☐	☐
SECTION B			
6	Do you try to avoid thinking, or talking, about your birth because you find it too distressing?	☐	☐
7	Do you avoid activities, places or people that remind you of your birth?	☐	☐
8	Do you find it hard to remember important aspects of your birth?	☐	☐
9	Have you lost interest in activities you used to enjoy?	☐	☐
10	Do you feel disconnected and distant from those who would normally be close to you, such as family or friends?	☐	☐
11	Do you feel unable to have, or express, loving feelings towards those close to you, including your child, family or friends?	☐	☐

#	Question	Yes	No
12	Do you feel like you have no hopes or positive thoughts about the future?	☐	☐
SECTION C			
13	Do you have difficulty falling, or staying, asleep?	☐	☐
14	Do you feel irritable, or have outbursts of anger?	☐	☐
15	Do you have difficulty concentrating?	☐	☐
16	Are you hyper-vigilant (constantly watching out for danger)?	☐	☐
17	Do you constantly feel jumpy?	☐	☐