[redacted]

Post Deployment Questionnaire

Name/Last four SSN:
Squadron:
Daytime ph#:

Deployment Location:

Briefing Date:

1. Have you experienced, witnessed, or confronted an event that involved actual or threatened death or serious injury? How long ago did this event happen?

1. Yes____ No____If Yes, how long ago?_____

2. If yes, did you feel intense fear, helplessness or horror in response to the event?

2. Yes____ No____

3. Have you experienced any of the following in response to the event?

3. Yes____ No____ If Yes, check all that apply

_____ Recurrent and/or distressing recollections of the event, including images, thoughts, or perceptions.

_____Recurrent, distressing dreams of the event.

_____Intense psychological distress when exposed to triggers or cues of the traumatic event.

_____Physical bodily reactions (e.g. heart racing, sweating, trouble breathing etc) when exposed to triggers

4. Have you avoided things that you associate with a traumatic experience or experienced any of the following?

4. Yes____ No____ If Yes, check all that apply

_____Tried to avoid thoughts, feelings or conversations associated with the traumatic event or deployed experience.

_____Tried to avoid activities, places or people that arouse negative recollections.

_____Have an inability to recall an important aspect of the trauma or negative experience.

_____Experienced diminished interest or participation in enjoyable or meaningful activities.

5. Have you, recently experienced any of the following

5. Yes____ No____ If Yes, Check all that apply

_____Difficulty falling or staying asleep
_____Irritability or outburst of anger
_____Difficulty concentrating
_____Hypervigilance (always keep a “watch” out for things)
_____exaggerated startle response
_____Muscle tension
_____Easily fatigued
_____Depressed mood
_____Diminished interest or pleasure in activities
_____Weight gain/ loss or decrease/ increase in appetite
_____Feeling worthless or guilt
_____Increased use of alcohol or other substance
_____tearful/ crying spells
_____problems relating to significant other and/or children
_____Other:

Name:
Squadron:
Last four SSN:

6. When did the symptoms you checked in #3, 4 and 5, start?	6. Date_____
7. Do you have difficulty seeing or having a future (e.g. don't expect to have a career, marriage, children or a normal life span)	7. Yes____ No____
8. Have any of the symptoms you checked, caused significant distress or problems in social, occupational, or other important areas of your life?	8. Yes____ No____
9. Have you had thoughts of hurting or killing yourself or others?	9. Yes____ No____
10. Are you interested in attending up to 3 - one on one sessions at Life Skills related to your deployment issues or concerns?	10. Yes____ No____

Note: These visits will not be documented as a typical Life Skills Visit. Receiving services is strictly voluntary. Don't wait until the situation is at its maximum effect before seeking help. **Prevention is key!**