

# George Laws Social Work Services LLC

Licensed Clinical Social Worker

EMDR Practitioner

Somatic Experiencing Practitioner

Date: \_\_\_\_\_ Name: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_  
 \_\_\_\_\_

For each of the following symptoms, please circle a number 0-5 for the difficulty you are having with each symptom, with 0 being no difficulty, 1 being little difficulty and 5 being severe difficulty. Please answer every question (on both sides of page).

- |  |  |             |
|--|--|-------------|
| 1. Briefly describe the traumatic event or events:<br>_____<br>_____<br>_____<br>_____ | 15. Extreme emotional shifts                         | 0 1 2 3 4 5 |
| _____ Date of event(s) _____   | 16. Rage   | 0 1 2 3 4 5 |
| 2. Feelings of helplessness and/or powerlessness                                       | 17. Overcautiousness                                 | 0 1 2 3 4 5 |
| 3. Lack of focus   | 18. Fear of being watched/ followed                  | 0 1 2 3 4 5 |
| 4. Gaps in memory  | 19. Heightened startle response                      | 0 1 2 3 4 5 |
| 5. Disorientation  | 20. Feeling overwhelmed                              | 0 1 2 3 4 5 |
| 6. Accident proneness  | 21. Feeling defeated, inadequate, can't do anything  | 0 1 2 3 4 5 |
| 7. Feeling out of control  | 22. Feeling confused or fragmented                   | 0 1 2 3 4 5 |
| 8. Feeling frozen or paralyzed   | 23. Too much energy (hyperactivity)                  | 0 1 2 3 4 5 |
| 9. Recurring dreams related to traumatic event   | 24. Impulses to run away                             | 0 1 2 3 4 5 |
| 10. Intrusive imagery related to traumatic event                                       | 25. Unable to feel weight of body                    | 0 1 2 3 4 5 |
| 11. Flashbacks   | 26. Feeling physically heavy--like dead weight       | 0 1 2 3 4 5 |
| 12. Disrupted sleeping patterns<br>Circle one: insomnia    oversleeping    both        | 27. Constricted range of motion                      | 0 1 2 3 4 5 |
| 13. Lethargy, exhaustion, chronic fatigue  | 28. Feeling disconnected, lost, "not here"           | 0 1 2 3 4 5 |
| 14. Night terrors or abrupt awakening with intense fear                                | 29. Trouble orienting in time                        | 0 1 2 3 4 5 |
|  | 30. Trouble orienting in space                       | 0 1 2 3 4 5 |
|  | 31. Avoidance of triggers or associations with event | 0 1 2 3 4 5 |
|  | 32. Panic attacks                                    | 0 1 2 3 4 5 |
|  | 33. Free-floating anxiety                            | 0 1 2 3 4 5 |
|  | 34. Nausea or vomiting                               | 0 1 2 3 4 5 |

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255 Canyon Blvd., Suite 200  
Boulder, CO 80302

|  |             |   |             |
|--|-------------|---|-------------|
| 35. Shame  | 0 1 2 3 4 5 | 64. Inability to cry  | 0 1 2 3 4 5 |
| 36. Self judgment/ blaming self  | 0 1 2 3 4 5 | 65. Fear of leaving home or familiar surroundings   | 0 1 2 3 4 5 |
| 37. Electric or overcharged feeling in body  | 0 1 2 3 4 5 | 66. Adamant "everything fine" stance  | 0 1 2 3 4 5 |
| 38. Obsessive review of incident   | 0 1 2 3 4 5 | 67. No sense of future  | 0 1 2 3 4 5 |
| 39. Disrupted eating patterns<br>Circle one: overeating    undereating    both   | 0 1 2 3 4 5 | 68. Loss of creativity  | 0 1 2 3 4 5 |
| 40. Recurring tension patterns in body   | 0 1 2 3 4 5 | 69. Depression  | 0 1 2 3 4 5 |
| 41. Chronic pain   | 0 1 2 3 4 5 | 70. Shakiness   | 0 1 2 3 4 5 |
| 42. Hypervigilance   | 0 1 2 3 4 5 | 71. Apathy, no energy for life  | 0 1 2 3 4 5 |
| 43. Inability to cope  | 0 1 2 3 4 5 | 72. Feeling dead or in "no man's land"  | 0 1 2 3 4 5 |
| 44. Isolation  | 0 1 2 3 4 5 | 73. Feeling blocked about finishing what you start  | 0 1 2 3 4 5 |
| 45. Constriction, suppression, shut down   | 0 1 2 3 4 5 | 74. Starting many projects and not completing them  | 0 1 2 3 4 5 |
| 46. Distrust   | 0 1 2 3 4 5 | 75. Hypersensitivity to sound or light  | 0 1 2 3 4 5 |
| 47. Little or no awareness of choices  | 0 1 2 3 4 5 | 76. Get feelings hurt easily  | 0 1 2 3 4 5 |
| 48. Disinterest in life  | 0 1 2 3 4 5 | 77. Irritability, overreacting to things  | 0 1 2 3 4 5 |
| 49. Generalized fear or anger (for example, believing all men or all women are threatening, or all drivers are unsafe) | 0 1 2 3 4 5 | 78. Checking everything you do  | 0 1 2 3 4 5 |
| 50. Excessive worrying   | 0 1 2 3 4 5 | 79. Circle those that apply: Shouting, throwing objects, hitting or kicking, desire to have tantrum or scream | 0 1 2 3 4 5 |
| 51. Disrupted relationships  | 0 1 2 3 4 5 | 80. Everything seems too much trouble   | 0 1 2 3 4 5 |
| 52. Alienation, believing no one can understand  | 0 1 2 3 4 5 | 81. Feeling weak in body, collapsed in joints   | 0 1 2 3 4 5 |
| 53. Bonding with others through trauma   | 0 1 2 3 4 5 | 82. Feeling doomed or as if something bad is going to happen  | 0 1 2 3 4 5 |
| 54. Sudden fearfulness for no apparent reason  | 0 1 2 3 4 5 | 83. Restlessness  | 0 1 2 3 4 5 |
| 55. Fearlessness of dangerous situations   | 0 1 2 3 4 5 | 84. Heart pounding  | 0 1 2 3 4 5 |
| 56. Temper or outbursts  | 0 1 2 3 4 5 | 85. Not remembering aspects of traumatic event  | 0 1 2 3 4 5 |
| 57. Desire to hurt self or others  | 0 1 2 3 4 5 | 86. Difficulty connecting or feeling close to others  | 0 1 2 3 4 5 |
| 58. Loss of sexual interest  | 0 1 2 3 4 5 | 87. Difficulty making decisions   | 0 1 2 3 4 5 |
| 59. Dizziness  | 0 1 2 3 4 5 | 88. Guilt   | 0 1 2 3 4 5 |
| 60. Idea that someone can control your thoughts  | 0 1 2 3 4 5 | 89. Numbing   | 0 1 2 3 4 5 |
| 61. Fear of being alone  | 0 1 2 3 4 5 | 90. Going blank   | 0 1 2 3 4 5 |
| 62. Fear of being with others  | 0 1 2 3 4 5 | 91. Feelings of worthlessness   | 0 1 2 3 4 5 |
| 63. Crying easily  | 0 1 2 3 4 5 | 92. Feeling your life was threatened during the traumatic event(s)  | 0 1 2 3 4 5 |
|  |             | 93. Feeling your life is in danger since the traumatic event(s)   | 0 1 2 3 4 5 |

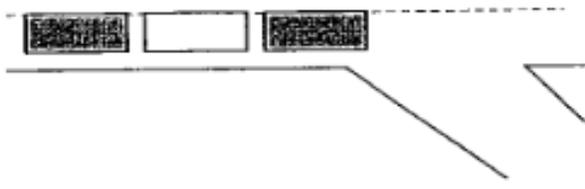
4. What do you recall happening to you personally throughout the accident?\_\_\_\_\_
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- 
5. Were you wearing a seatbelt?\_\_\_ If so, did it feel restrictive?\_\_\_ Protective?\_\_\_ Both?\_\_\_
6. Did an airbag release?\_\_\_ If so, how did that affect you?\_\_\_\_\_
7. Were you injured or did you feel trapped by the seatbelt or airbag?\_\_\_\_\_
8. Are you aware of any gaps in your memory related to the sequence of events?\_\_\_\_\_
9. Were you unconscious at any time?\_\_\_ If so, any idea how long?\_\_\_ Disoriented?\_\_\_
10. Did you see the other car approaching before impact?\_\_\_ How much time did you have?\_\_\_
11. During the event, did you have time to respond to the threat or to begin to avoid it?\_\_\_\_\_
12. What do you remember attempting to do?\_\_\_\_\_
13. Do you recall any of your thoughts, emotions, or sensations in your body during the event?\_\_\_\_\_
14. What were they?\_\_\_\_\_
15. How long did you wait for help to arrive?\_\_\_\_\_
16. How did other drivers respond?\_\_\_\_\_
17. How did people present at the scene respond?\_\_\_\_\_

**POST-ACCIDENT INFORMATION:**

1. What was the first thing that happened after the event?\_\_\_\_\_
- Was it helpful or not?\_\_\_\_\_
2. Who was the first person(s) you interacted with?\_\_\_\_\_
3. Did you feel supported?\_\_\_ Threatened?\_\_\_ Other?\_\_\_\_\_
4. Did you experience the police, ambulance and/or hospital staff, if involved, to be helpful?\_\_\_
- Competent?\_\_\_ Informative?\_\_\_ Any concerns?\_\_\_\_\_
5. When did you begin to feel safer again?\_\_\_\_\_
6. What helps you feel safe now?\_\_\_\_\_ Do you feel safe driving since the accident?\_\_\_
7. Do you experience "spacing out" or feeling disconnected while driving?\_\_\_ At other times?\_\_\_
8. What disturbs you the most while driving now?\_\_\_\_\_
- Do you have flashbacks, intrusive images, nightmares, fears or anxiety provoking triggers related to the accident?\_\_\_ Please describe them \_\_\_\_\_
- 
9. Do you fear that the accident might reoccur in the future?\_\_\_ Do you feel trusting of your responses while driving?\_\_\_ Do you feel trusting of other drivers?\_\_\_\_\_
10. If there had been enough time, was there anything you were aware of that could have helped to avoid the accident? i.e. honking horns, better visibility, slower speeds, advance warning, etc.?\_\_\_\_\_
- 
11. What are/were your injuries?\_\_\_\_\_
12. Any fatalities involved?\_\_\_ Did you feel your life was threatened?\_\_\_\_\_
13. Do you feel your continuity or integrity of self was disrupted?\_\_\_\_\_
14. Where did you go afterwards?\_\_\_\_\_ Did you rest?\_\_\_\_\_

Draw the event of each accident and use back of paper if needed.

Date sample 6 Ave. at Federal



Date \_\_\_\_\_

Date \_\_\_\_\_

Date \_\_\_\_\_

Date \_\_\_\_\_

Date \_\_\_\_\_

Auto Accident Time Line  
(indicate dates)

