St. Clair County Community Mental Health

Questionnaire Regarding History of Dissociation

Individual:____ Date______________ Case #________________

1. Have you ever felt as if you are watching yourself talk and do things and you could not stop it?
   ☐ YES or ☐ NO

2. Have you ever felt that your thoughts, emotions or actions were not your own?
   ☐ YES or ☐ NO

3. Have you ever felt your body is not your own and it is not under your control?
   ☐ YES or ☐ NO

4. Have you ever experienced gaps in your memory about your personal life events?
   ☐ YES or ☐ NO

5. Have you ever experienced gaps in your memory about what happened on a particular day?
   ☐ YES or ☐ NO

6. Have you ever found that you did things and you had no memory of doing it?
   ☐ YES or ☐ NO

7. Have you ever traveled to a place and did not know how you got there?
   ☐ YES or ☐ NO

8. Have you ever found yourself dressed in clothes that you did not remember putting on?
   ☐ YES or ☐ NO

9. Have you ever found that you did certain things but don’t have any memory of doing it?
   ☐ YES or ☐ NO

10. Did any of these experiences impair your ability to function in your daily life?
    ☐ YES or ☐ NO
    If yes, explain: ____
    ____