PTSD Checklist (PCL) - 5

Name:_____ Date:_____

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. 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 _____

PTSD Screening Form

Name_____ DOB_____ Date_____

Social History_____

_____

_____

Medical History_____

_____

_____

_____

Current Medications_____

_____

_____

_____

Have you ever experienced or witnessed an event in which you were seriously injured or your life was in danger, or you thought you were going to be seriously injured?

_____

_____

What is the worst thing that has ever happened to you?

_____

_____

When did this occur? _____

Have you ever sought treatment for this? What have you tried?

_____

_____

_____

_____

DSM-5 2013

Name _____ DOB _____

(Memories)

After that experience, do you ever experienced upsetting memories that you are unable to stop thinking about regarding the experience when you did not want to think about it? Y / N

(Dreams)
Do you have recurrent, distressing dreams related to the experience? Y / N

(Flashbacks)
After that experience, do you ever feel like it is happening to you again? Y / N

(Exposure distress)
When you are around people, places or things that remind you of that experience, do you feel intense or prolonged stress? Y / N

(Physiological reactions)
When you think about or are around people, places, or things, and things that remind you of that experience, do you have distressing physical responses? Y / N

(Internal reminders)
Do you work hard to avoid thoughts, feelings, or physical sensations that bring up memories of this experience? Y / N

(External reminders)
Do you work hard to avoid people, places and things that bring up memories of this experience? Y / N

Name _____ DOB _____

(Impaired memory)
Do you have trouble remembering important parts of the experience? Y / N

(Negative self-image)
Do you frequently think negative thoughts about yourself, other people or the world? Y / N

(Blame)

Do you frequently blame yourself or others for your experience, even when you know that you or they are not responsible? Y / N

(Negative emotional state)

Do you stay down, angry, ashamed or fearful most of the time? Y / N

(Decreased participation)

Are you much less interested in activities in which you used to participation? Y / N

(Detachment)

Do you feel detached or estranged from the people in your life because of this experience Y / N

(Inability to experience positive emotions)

Do you find that you cannot feel happy, loved, or satisfied? Y / N

Do you feel numb, or like you cannot love? Y / N

Name _____ DOB _____

(Irritable or aggressive)

Do you often act very grumpy or become aggressive? Y / N

(Reckless)

Do you often act reckless or have self-destructive behaviors? Y / N

(Hypervigilance)

Do you feel that you always on edge or keyed up? Y / N

(Impaired concentration)

Do you often have trouble concentrating on a task or a problem? Y / N

(Sleep disturbance)

Do you often have difficulty falling asleep, or do you often wake up without feeling rested? Y / N