Frontier Health and Wellness

PTSD Checklist (PCL)

Client Name: ______________________________ **Date:** ______________

Please complete the items below. If more than one traumatic event has happened, then please choose the one that is **most troublesome to you now.**

The event you experienced was ______________________________ on ______________ .
(EVENT) (DATE)

Instructions: Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please read each one carefully, then check the corresponding **circle** to indicate how much you have been **bothered** by the problem **in the past month.**

BOTHERED BY	NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY
1. Repeated disturbing memories, thoughts, or images of the stressful experience?					
2. Repeated, disturbing dreams of the stressful experience?					
3. Suddenly acting or feeling as if the stressful experience were happening again (as if you were reliving it)?					
4. Feeling very upset when something reminded you of the stressful experience?					
5. Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of the stressful experience?					
6. Avoiding thinking about or talking about the stressful experience or avoiding having feelings related to it?					
7. Avoiding activities or situations because they remind you of the stressful experience?					
8. Trouble remembering important parts of the stressful experience?					
9. Loss of interest in activities that you used to enjoy?					
10. Feeling distant or cut off from other people?					
11. Feeling emotionally numb or being unable to have loving feelings for those close to you?					
12. Feeling as if your future will somehow be cut short?					
13. Trouble falling or staying asleep?					
14. Feeling irritable or having angry outbursts?					
15. Having difficulty concentrating?					
16. Being “super alert” or watchful or on guard?					
17. Feeling jumpy or easily startled?					

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