

PTSD Checklist

Complete the PTSD Checklist to track your symptoms. Be sure to complete this measure on the same index event each time. When the instructions and questions refer to a “stressful experience,” remember that that is your index event.

Write in here the trauma that you are working on: _____

Complete this PTSD Checklist with reference to that event.

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 week*.

In the past week, 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 (<i>as if you were actually back there reliving it</i>)?	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 (<i>for example, heart pounding, trouble breathing, sweating</i>)?	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 (<i>for example, people, places, conversations, activities, objects, or situations</i>)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience (not due to head injury or substances)?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (<i>for example, having thoughts such as I am bad, There is something seriously wrong with me, No one can be trusted, or The world is completely dangerous</i>)?	0	1	2	3	4
10. Blaming yourself or someone else (who didn't intend the outcome) 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 (<i>for example, being unable to feel happiness or have loving feelings for people close to you</i>)?	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 “super alert” 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

Add up the total and write it here: _____

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