

PTSD CHECKLIST (PCL)



Patient's Name _____ Date ____/____/____

If an event listed on the Life Events Checklist **happened to you** or you **witnessed it**, please complete the items below. If more than one event happened, please choose the one that is **most troublesome to you now**.

The event you experienced was _____ on ____/____/____.
(event) (date)

DIRECTIONS Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please read each one carefully, then select the number in the columns next to the item to indicate how much you have been **BOTHERED** by the problem **IN THE PAST MONTH**.

1 = not at all 2 = a little bit 3 = moderately 4 = quite a bit 5 = extremely

Bothered by ...

- | | | | | | |
|--|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| 1. Repeated disturbing memories, thoughts, or images of the stressful experience? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| 2. Repeated, disturbing dreams of the stressful experience? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| 3. Suddenly acting or feeling as if the stressful experience were happening again (as if you were reliving it)? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| 4. Feeling very upset when something reminded you of the stressful experience? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| 5. Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of the stressful experience? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| 6. Avoiding thinking about or talking about the stressful experience or avoiding having feelings related to it? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| 7. Avoiding activities or situations because they remind you of the stressful experience? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| 8. Trouble remembering important parts of the stressful experience? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| 9. Loss of interest in activities that you used to enjoy? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| 10. Feeling distant or cut off from other people? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| 11. Feeling emotionally numb or being unable to have loving feelings for those close to you? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| 12. Feeling as if your future will somehow be cut short? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| 13. Trouble falling or staying asleep? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| 14. Feeling irritable or having angry outbursts? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| 15. Having difficulty concentrating? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| 16. Being "super alert" or watchful or on guard? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| 17. Feeling jumpy or easily startled? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |