

HOMECOMING FOR VETERANS - PTSD CHECKLIST

Name _____ Date _____ Session # _____

Please put a number next to each question to indicate how much you have been bothered by that problem in the last week

1

not at all

2

a little bit

3

moderately

4

quite a bit

5

extremely

- | | |
|---|---|
| _____ Repeated, disturbing, and unwanted memories of the stressful experience? | _____ Taking too many risks or doing things that could cause you harm? |
| _____ Repeated, disturbing dreams of the stressful experience? | _____ Feeling very upset when something reminded you of the stressful experience? |
| _____ Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)? | _____ Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)? |
| _____ Loss of interest in activities that you used to enjoy? | _____ Feeling distant or cut off from other people? |
| _____ 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)? | _____ Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)? |
| _____ Avoiding memories, thoughts, or feelings related to the stressful experience? | _____ Irritable behavior, angry outbursts, or acting aggressively? |
| _____ Being "superalert" or watchful or on guard? | _____ Feeling jumpy or easily startled? |
| _____ Trouble remembering important parts of the stressful experience? | _____ Having strong negative feelings such as fear, horror, anger, guilt, or shame? |
| _____ Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)? | _____ Blaming yourself or someone else for the stressful experience or what happened after it? |
| _____ Suicidal thoughts? | _____ Trouble falling or staying asleep? |
| _____ Body pain? | _____ Fatigue? |
| _____ Addictive behaviors? | _____ Headaches? |
| _____ Having difficulty concentrating? | |

