Comprehensive Health Care PA

Phone (713) 984-4546 Fax (800) 930-4957

Patient Name		Today's Date	

PTSD SCALE Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, check the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment	Not At All	A Little Bit	Moderately	Quite a Bit	Extremely
Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
Suddenly feeling of acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
Feeling upset when something reminded you of the stressful experience?	0	1	2	3	4
Having strong physical reactions when something reminded you of the stressful experience (for example heart pounding, trouble breathing, sweating)?	0	1	2	3	4
Avoiding memories, thoughts, of feeling related to stressful experience?	0	1	2	3	4
Avoiding external reminders of the stressful experience (for example people, places. Conversations, activities, objects or situations)?	0	1	2	3	4
Trouble remembering important parts of the stressful experience?	0	1	2	3	4
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)?	0	1	2	3	4
Blaming yourself of others for stressful experience or what happened after it?	0	1	2	3	4
Having strong negative feelings such as fear, horror, anger, guilt or shame?	0	1	2	3	4
Loss of interest in activities that you used to enjoy?	0	1	2	3	4
Feeling distant or cut off from other people?	0	1	2	3	4
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
Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
Being super-alert or watchful or on guard?	0	1	2	3	4
Feeling jumpy or easily startled?	0	1	2	3	4
Having difficulty concentrating?	0	1	2	3	4
Trouble falling or staying asleep?	0	1	2	3	4

Total Score Please sum all the selected numbers	
Signature	