PTSD CheckList – Stressor Specific Version (PCL-S)

The event you experienced was: _____ on: _____
Instruction to patient: Please read each one carefully, put a number in the box to indicate how much you have been bothered by that problem *in the last month*.

Not at all (1) A little bit (2) Moderately (3) Quite a bit (4) Extremely (5)

1. Repeated, disturbing memories, thoughts, or images of a stressful experience from the past? _____

2. Repeated, disturbing dreams of a stressful experience from the past? _____

3. Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)? _____

4. Feeling very upset when something reminded you of a stressful experience from the past? _____

5. Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful experience from the past?_____

6. Avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it? _____

7. Avoid activities or situations because they remind you of a stressful experience from the past? _____

8. Trouble remembering important parts of a stressful experience from the past? _____

9. Loss of interest in things 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 on guard? _____