

Name: _____

Date: _____

PCL-5

Instructions for Criteria A: This questionnaire asks about problems you may have had in response to a very stressful experience. **This could be any event that involved *actual or threatened death, serious injury, or sexual violence*. It could be something that happened to you directly, something you witnessed, or something you learned happened to a close family member or close friend. Some examples are a *serious accident; fire; disaster such as a hurricane, tornado, or earthquake; physical or sexual attack or abuse; war; or homicide or suicide*.** If nothing like this has happened to you, just identify the most stressful event you have experienced.

Please start by briefly describing your *worst event*, that is, the event that bothers you the most currently. The worst event might be something that happened more than once, and you might have a hard time deciding which time was the worst. If so, you may want to consider all of the similar events together as the worst event.

Next, please read each of the problems below and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month. Make sure to base your answers on problems that started or got worse after the event.

Briefly describe the event:

How long ago did it happen?

NOTE: To proceed, the individual should have been exposed to actual or threatened death, serious injury, or sexual violence in one or more of the following ways: directly experiencing the traumatic event, witnessing in person the event as it occurred to others, learning that the traumatic event occurred to a close family member or friend, or experienced repeated or extreme exposure to aversive details of the event.

Only administer the following scale if Criteria A has been met.

<i>In the past month, how much were you bothered by:</i>	<i>Not at all</i>	<i>A little bit</i>	<i>Moderately</i>	<i>Quite a bit</i>	<i>Extremely</i>
1. Repeated, disturbing, and unwanted memories of the stressful experience?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
2. Repeated, disturbing dreams of the stressful experience?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 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>)?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
4. Feeling very upset when something reminded you of the stressful experience?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

<i>In the past month, how much were you bothered by:</i>	<i>Not at all</i>	<i>A little bit</i>	<i>Moderately</i>	<i>Quite a bit</i>	<i>Extremely</i>
5. Having strong physical reactions when something reminded you of the stressful experience (<i>for example, heart pounding, trouble breathing, sweating</i>)?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
7. Avoiding external reminders of the stressful experience (<i>for example, people, places, conversations, activities, objects, or situations</i>)?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
8. Trouble remembering important parts of the stressful experience (<i>for some reason besides a head injury or alcohol or drug use</i>)?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 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, the world is completely dangerous</i>)?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
10. Blaming yourself or someone else (<i>who didn't directly cause the event or actually harm you</i>) for the stressful experience or what happened after it?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

12. Loss of interest in activities that you used to enjoy?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
13. Feeling distant or cut off from other people?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
14. Having trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
15. Feeling irritable or angry or acting aggressively?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
16. Taking too many risks or doing things that could cause you harm?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
17. Being “superalert” or watchful or on guard?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
18. Feeling jumpy or easily startled?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
19. Having difficulty concentrating?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
20. Trouble falling or staying asleep?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4