Name: _____Date_____

PTSD Checklist
National Center for PTSD

Circle the number in the box marking how much these things have bothered you in the past month.

In the past month, how much have you been bothered by__?	Not at all	A Little Bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing memories, thoughts, or images of these events?	1	2	3	4	5
2. Repeated, disturbing dreams of these events?	1	2	3	4	5
3. Suddenly acting or feeling as if these events were happening again (as if you were reliving it)?	1	2	3	4	5
4. Feeling very upset (worried or distressed) when something reminded you of these events?	1	2	3	4	5
5. Having physical reactions (like your heart pounding, trouble breathing, sweating) when something reminded you of these events?	1	2	3	4	5
6. Avoiding thinking about or talking about these events or avoiding having feelings related to them?	1	2	3	4	5
7. Avoiding activities or situations because they remind you of being these events?	1	2	3	4	5
8. Trouble remembering what happened during these events (don't count things you couldn't remember because you were unconscious)?	1	2	3	4	5
9. Loss of interest in activities that you used to enjoy?	1	2	3	4	5
10. Feeling distant or cut off from other people?	1	2	3	4	5
11. Feeling emotionally numb or being unable to have loving feelings for those close to you?	1	2	3	4	5
12. Feeling as if your future somehow will be cut short?	1	2	3	4	5
13. Trouble falling or staying asleep?	1	2	3	4	5
14. Feeling irritable or having angry outbursts?	1	2	3	4	5
15. Having difficulty concentrating?	1	2	3	4	5
16. Being "super alert" or watchful or on guard?	1	2	3	4	5
17. Feeling jumpy or easily startled?	1	2	3	4	5

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