

Region:

TNO:

PTSD CheckList – Civilian Version (PCL-C)

Instruction to patient: Below is a list of problems and complaints that veterans sometimes have in response to stressful life experiences. Please read each one carefully, put an “X” in the box to indicate how much you have been bothered by that problem *in the last month*.

No.	Response	Not at all (1)	A little bit (2)	Moderately (3)	Quite a bit (4)	Extremely (5)
1	Repeated, disturbing <i>memories, thoughts, or images</i> of a stressful experience from the past?					
2	Repeated, disturbing <i>dreams</i> of a stressful experience from the past?					
3	Suddenly <i>acting or feeling</i> as if a stressful experience <i>were happening</i> again (as if you were reliving it)?					
4	Feeling <i>very upset</i> when <i>something reminded</i> you of a stressful experience from the past?					
5	Having <i>physical reactions</i> (e.g., heart pounding, trouble breathing, or sweating) when <i>something reminded</i> you of a stressful experience from the past?					
6	Avoid <i>thinking about</i> or <i>talking about</i> a stressful experience from the past or avoid <i>having feelings</i> related to it?					
7	Avoid <i>activities or situations</i> because they <i>remind you</i> of a stressful experience from the past?					
8	Trouble <i>remembering important parts</i> of a stressful experience from the past?					
9	Loss of <i>interest in things that you used to enjoy</i> ?					
10	Feeling <i>distant</i> or <i>cut off</i> from other people?					
11	Feeling <i>emotionally numb</i> or being unable to have loving feelings for those close to you?					
12	Feeling as if your <i>future</i> will somehow be <i>cut short</i> ?					
13	Trouble <i>falling</i> or <i>staying asleep</i> ?					
14	Feeling <i>irritable</i> or having <i>angry outbursts</i> ?					
15	Having <i>difficulty concentrating</i> ?					
16	Being <i>“super alert”</i> or watchful on guard?					
17	Feeling <i>jumpy</i> or easily startled?					

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1. Over the *last three months* have you used any of the following hospital based or residential care services (for example, have you been admitted to hospital or had an outpatient clinic appointment)?

Type of service	Which service have you used in the last three months? Please tick (✓) yes or no		Total number of days spent in hospital/convalescent or nursing home in the last three months	Total number of <u>visits</u> in the last three months
	Yes	No		
Hospital inpatient stay	Yes	No		
Hospital outpatient clinic	Yes	No		
Hospital accident and emergency department	Yes	No		
Nursing/residential home	Yes	No		
Other (please specify)	Yes	No		

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2. Over the *last three months* have you used any of the following *community* based health and social services (this includes any services that are not within the hospital for example, visits to the GP)?

Type of service	Have you used the service in the last three months? Please tick (✓) yes or no		Total number of face to face contacts over the last three months
a. GP, surgery visit	Yes	No	
b. GP, home visit	Yes	No	
c. District nurse, health visitor or member of community health team	Yes	No	
d. Social worker	Yes	No	
e. Counsellor	Yes	No	
f. Home help or care worker	Yes	No	
g. Speech and language therapist	Yes	No	
h. Psychiatrist or psychologist	Yes	No	
i. Day centre	Yes	No	
j. Lunch or social club (organised by health or social care providers)	Yes	No	
k. Food, medicine or laundry delivery service (organised by health or social care providers)	Yes	No	
l. Family or patient support or self help groups	Yes	No	
m. Other (please specify, for example have you had any telephone consultations with your GP):	Yes	No	

***Thank you for
completing these
questions!***

Please return this booklet to the researcher.