Homecoming for Veterans - PTSD Checklist

Name _____ Date _____ Session # _____

Please put a number next to each question to indicate how much you have been bothered by that problem in the last week

1	2	3	4	5
not at all	a little bit	moderately	quite a bit	extremely

_____ Repeated, disturbing, and unwanted memories of the stressful experience?

_____ Repeated, disturbing dreams of the stressful experience?

_____ Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?

_____ Loss of interest in activities that you used to enjoy?

_____ 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, the world is completely dangerous)?

_____ Avoiding memories, thoughts, or feelings related to the stressful experience?

_____ Being "superalert" or watchful or on guard?

_____ Trouble remembering important parts of the stressful experience?

_____ Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?

_____ Suicidal thoughts?

_____ Body pain?

_____ Addictive behaviors?

_____ Having difficulty concentrating?

_____ Taking too many risks or doing things that could cause you harm?

_____ Feeling very upset when something reminded you of the stressful experience?

_____ Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?

_____ Feeling distant or cut off from other people?

_____ Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?

_____ Irritable behavior, angry outbursts, or acting aggressively?

_____ Feeling jumpy or easily startled?

_____ Having strong negative feelings such as fear, horror, anger, guilt, or shame?

_____ Blaming yourself or someone else for the stressful experience or what happened after it?

_____ Trouble falling or staying asleep?

_____ Fatigue?

_____ Headaches?

HOMECOMING FOR VETERANS INTAKE FORM

Name _____ Date _____

Gender ___male ___female Age _____ Date of Birth _____

Marital Status ___single ___married ___ separated ___ divorced ___ widowed other _____

Ethnicity ___ caucasian ___ african-american ___ hispanic/latino ___ native american ___ asian/pacific islander
other _____

Phone _____ Work Phone _____

I live with ___ spouse/significant other ___roommate ___ offspring (#) ___ alone

Military History

Rank / Rate _____ Branch ___USMC ___ USN ___ Army ___USAF

Duty Station _____ Unit _____

Time in Service _____ years _____ months _____ continuous service _____ broken service

EAS date (month/year) _____

Deployments	Dates (month/year)	Location
	to	
	to	
	to	
	to	
	to	
	to	