PTSD CheckList – Military Version (PCL-M)

Patient's Name:						
SSN	:Rank					
exper	nction to patient: Below is a list of problems and complaints iences. Please read each one carefully, put an "X" in the bo last month.	that veteran x to indicate	s sometimes how much y	have in respor ou have been b	nse to stressful oothered by tha	military t problem
				Frequency:		
No.	Problem or Complaint:	Not at all (1)	A little bit (2)	Moderately (3)	Quite a bit (4)	Extremely (5)
1.	Repeated, disturbing <i>memories, thoughts,</i> or <i>images</i> of a stressful military experience?				N N	
2.	Repeated, disturbing <i>dreams</i> of a stressful military experience?	ı				
3.	Suddenly acting or feeling as if a stressful military experience were happening again (as if you were reliving it)?				f _w	
4.	Feeling very upset when something reminded you of a stressful military experience?		N	*		
5.	Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful military experience?	2	F			
6.	Avoid thinking about or talking about a stressful military experience or avoid having feelings related to it?	8			,	
7.	Avoid activities or talking about a stressful military experience or avoid having feelings related to it?		,			
8.	Trouble remembering important parts of a stressful military experience?					12
9.	Loss of interest in things that you used to enjoy?					
10.	Feeling distant or cut off from other people?					8 8
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?	4		8		
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?					

PCL-M for DSM-IV (11/1/94)

Feeling jumpy or easily startled?

17.

Weathers, F.W., Huska, J.A., Keane, T.M. PCL-M for DSM-IV. Boston; National Center for PTSD – Behavioral Science Division, 1991.

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TBI CHECKLIST

Patient's Name:		Date:	Date:			
Last 4# SSN:	Service:	Rank:	*			
Instructions to patient response to brain inju		s and complaints that veterans so	ometimes have in			
If you <u>never</u> suffered	ł any traumatic brain inju	ry, Sign here:				
Please rate the follow	ing symptoms with regard	to how much they have disturbed	you since your injury.			

- 0 = None- Rarely if ever present; not a problem at all.
- 1 = Mild- Occasionally present, but it does not disrupt activities; I can usually continue what I'm doing; doesn't really concern me.
- 2 = Moderate- Often present, occasionally disrupts my activities; I can usually continue what I'm doing with some effort; I feel somewhat concerned.
- 3 = Severe- Frequently present and disrupts activities; I can only do things that are fairly simple or take little effort; I feel like I need help.
- 4 = Very Severe- Almost always present and I have been unable to perform at work, school or home due to this problem; I probably cannot function without help.

		Frequency:					
		0	1	2	3	4	
No.	Problem or Complaint	None	Mild	Moderate	Severe	Very Severe	
1.	Feeling Dizzy:						
2.	Loss of balance:						
3.	Poor coordination, clumsy:		-			e ×	
4.	Headaches:						
5.	Nausea:						
6.	Vision problems, blurring, trouble seeing:						
7.	Sensitivity to light:				×.		
8.	Hearing difficulty:			2			
9.	Sensitivity to noise:						
10.	Numbness to tingling on parts of body:					*	
11.	Change in taste and/or smell:					1921	
12.	Loss or increase of appetite:						
13.	Poor concentration or easily distracted:				н.		
14.	Forgetfulness, can't remember things:						
15.	Difficulty making decisions:						
16.	Slowed thinking, can't finish things:						
17.	Fatigue, loss of energy, easily tired:						
18.	Difficulty falling or staying asleep:			2			
19.	Feeling anxious or tense:					80	
20.	Feeling depressed or sad:						
21.	Irritability, easily annoyed:						
22.	Poor frustration tolerance, overwhelmed:						