MIRACLE Counseling

The PTSD Checklist—Civilian Version—(PCL-C)

Lancashire Traumatic Stress Service PCL 5

Patient Name | DOB | Female ☐ Other ☐

Provider Name | Date | Male ☐

Instructions

On the next page are a list of problems that people sometimes have in response to extremely stressful experiences: **keeping your worst event in mind,** please read each problem carefully and then circle once of the numbers to indicate how much you have been bothered by that problem **in the past month.**

Description of the specific event you are holding in mind

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In the past month, how much were you bothered by:	*Not at all*	*A little bit*	*Moderately*	*Quite a bit*	*Extremely*
1. Repeated, disturbing, and unwanted memories of the stressful experience?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
2. Repeated, disturbing dreams of the stressful experience?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
3. Suddenly feeling or acting as if the stressful experience were actually happening again *(as if you were actually back there reliving it)*?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
4. Feeling very upset when something reminded you of the stressful experience?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
5. Having strong physical reactions when something reminded you of the stressful experience *(for example, heart pounding, trouble breathing, sweating)*?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
7. Avoiding external reminders of the stressful experience *(for example, people, places, conversations, activities, objects, or situations)*?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
8. Trouble remembering important parts of the stressful experience?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
9. 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)*?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
12. Loss of interest in activities that you used to enjoy?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
13. Feeling distant or cut off from other people?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
14. Trouble experiencing positive feelings *(for example, being unable to feel happiness or have loving feelings for people close to you)*?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
15. Irritable behavior, angry outbursts, or acting aggressively?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
16. Taking too many risks or doing things that could cause you harm?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
17. Being "superalert" or watchful or on guard?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
18. Feeling jumpy or easily startled?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
19. Having difficulty concentrating?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
20. Trouble falling or staying asleep?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

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SCORING SUMMARY SHEET

CRITERION	QUESTION NUMBER							TOTALS
B	1	2	3	4	5			
	☐	☐	☐	☐	☐			
C	6	7						
	☐	☐						
D	8	9	10	11	12	13	14	
	☐	☐	☐	☐	☐	☐	☐	
E	15	16	17	18	19	20		
	☐	☐	☐	☐	☐	☐		
							TOTAL SCORE	0

Criterion B – at least one YES/NO

Criterion C – at least one YES/NO

Criterion D – at least two YES/NO

Criterion E – at least two YES/NO

NOTES:

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