Post-Traumatic Stress Disorder (PTSD) Assessment

PC-PTSD Scale

In your life, have you ever had any experience that was so frightening, horrible or upsetting that, IN THE PAST MONTH, you: (circle "YES" or "NO")

1.	Have had nightmares about it or thought about it when you did not want to?	**NO**	**YES**
2.	Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?	**NO**	**YES**
3.	Were constantly on guard, watchful, or easily startled?	**NO**	**YES**
4.	Felt numb or detached from others, activities, or your surroundings?	**NO**	**YES**

Prins, Ouimette, & Kimerling, 2003

How to Score Your Self-Assessment

If you answered "yes" to three or four questions, we encourage you to contact us or another behavioral health professional.