National Center for PTSD
POSTTRAUMATIC STRESS DISORDER

PTSD Checklist for *DSM-5* (PCL-5)

Version date: 11 April 2018

Reference: Weathers, F. W., Litz, B. T., Keane, T. M., Palmieri, P. A., Marx, B. P., & Schnurr, P. P. (2013). *The PTSD Checklist for DSM-5 (PCL-5) – Standard* [Measurement instrument]. Available from https://www.ptsd.va.gov/

URL: https://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp

Note: This is a fillable form. You may complete it electronically.

PCL-5

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

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

Adverse Childhood Experience (ACE) Questionnaire

Name: _____ Date: _____

This Questionnaire will be asking you some questions about events that happened during your childhood; specifically the first 18 years of your life. The information you provide by answering these questions will allow us to better understand problems that may have occurred early in your life and allow us to explore how those problems may be impacting the challenges you are experiencing today. This can be very helpful in the success of your treatment.

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household <u>often</u>:

   Swear at you, insult you, put you down, or humiliate you?

   Or

   Act in a way that made you afraid that you might be physically hurt?

   ☐ Yes ☐ No If Yes, enter 1 _____

2. Did a parent or other adult in the household <u>often</u>:

   Push, grab, slap, or throw something at you?

   Or

   Ever hit you so hard that you had marks or were injured?

   ☐ Yes ☐ No If Yes, enter 1 _____

3. Did an adult or person at least 5 years older than you <u>ever</u>:

   Touch or fondle you or have you touch their body in a sexual way?

   Or

   Attempt or actually have oral, anal, or vaginal intercourse with you?

   ☐ Yes ☐ No If Yes, enter 1 _____

4. Did you <u>often</u> feel that:

   No one in your family loved you or thought you were important or special?

   Or

Adverse Childhood Experience (ACE) Questionnaire

Your family didn't look out for each other, feel close to each other, or support each other?

☐ Yes ☐ No If Yes, enter 1 _____

5. Did you often feel that:

   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?

   Or

   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

   ☐ Yes ☐ No If Yes, enter 1 _____

6. Were your parents ever separated or divorced?

   ☐ Yes ☐ No If Yes, enter 1 _____

7. Were any of your parents or other adult caregivers:

   Often pushed, grabbed, slapped, or had something thrown at them?

   Or

   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?

   Or

   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

   ☐ Yes ☐ No If Yes, enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?

   ☐ Yes ☐ No If Yes, enter 1 _____

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?

   ☐ Yes ☐ No If Yes, enter 1 _____

10. Did a household member go to prison?

    ☐ Yes ☐ No If Yes, enter 1 _____

ACE SCORE (Total "Yes" Answers): _____

Adverse Childhood Experience (ACE) Questionnaire

PROVIDER INSTRUCTIONS ***(Revised April 11, 2019)***

Beginning June 1, 2019, the ACE Questionnaire shall be given to all adults ages 18 and older* who are seeking behavioral health services from the ODMHSAS and the OHCA (SoonerCare/Medicaid); with minimal exception**. The ACE score shall be reported on all CDC/PA 23 (admissions) and CDC/PA 42 (6-month updates/extensions). The questionnaire only has to be given once per person, per provider- but the score must be reported/carried forward on all subsequent CDCs like some of the other CDC responses (ex: gender and race are typically reported/carried forward on each CDC and rarely change). Valid ACE Scores should be entered on the CDC in one of the following formats: 00 to 10 or 0 to 10 (00 to 10, double digits, is preferred). For currently admitted/open adult clients, the ACE Questionnaire shall be given at the next 6-month treatment update and reported on the CDC/PA 42 (6-month update/extension).

*Note: This questionnaire should only be given to adults ages 18 and older; it should not be given to children or youth under the age of 18.

**Exceptions: Due to the nature of some levels of care and program types, there are circumstances in which the ACE Questionnaire shall not be required. They are as follows:

- *Community Living (CL) Level of Care* (ex: Homeless, Housing, Residential Care)
- *Service Focus-* 11 (Homeless, Housing, Residential Care); 23 (Day School); 24 Medication Clinic Only; and 26 Mobile Crisis.

GIVING THE ACE QUESTIONNAIRE

The ACE Questionnaire is to be given at the time of clinical assessment (at initial clinical assessment for new clients, and for currently admitted/open clients- at clinical assessment update completed as a part of the service plan update process at 6-month treatment update). This is to ensure ready access to a therapist should one be needed to address any issue that might arise from revisiting childhood trauma.

It is a self-administered instrument and shall be completed by the individual seeking services without intervention from staff (ex: staff may not reframe the question or give explanation regarding the intent of the question). The only assistance that staff may provide is with regard to literacy or vision challenges, and in that instance the introduction statement and questions must be read aloud to the individual exactly as written on the questionnaire. To ensure a trauma informed process, it is important that the introduction statement on the questionnaire is either read by the client or read to the client.

Due to the sensitive nature of the questions, the individual completing the ACE Questionnaire should be given a confidential space in which to complete it. They may choose to have someone with them in the room for support (ex: Peer Support Specialist, family, friend).

Scoring

For each of the ten (10) questions on the questionnaire, the individual will give a Yes or No answer. When scoring, each "Yes" answer will be given one (1) point. These points will be tallied to determine the individuals ACE Score.

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ DATE: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? (use "✓" to indicate your answer)	Not at all	Several Days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself/ or that you are a failure or have let yourself or family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite- being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns:		+	+

(Healthcare professionals: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____
11. In the past year have you felt depressed or sad most days, even if you felt okay sometimes?	**Yes** _____ **No**_____
12. Has there ever been a time in the past month when you have had serious thoughts about ending your life?	**Yes** _____ **No**_____
13. Have you EVER, in your whole life, tried to kill yourself or made a suicide attempt?	**Yes** _____ **No**_____

PHQ-9 modified for Adolescents (PHQ-A)

Name: _____ **Clinician:** _____ **Date:** _____

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an **"X"** in the box beneath the answer that best describes how you have been feeling.

	(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?

☐Yes ☐No

If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?

☐Not difficult at all ☐Somewhat difficult ☐Very difficult ☐Extremely difficult

Has there been a time in the **past month** when you have had serious thoughts about ending your life?

☐Yes ☐No

Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?

☐Yes ☐No

***If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.*

Office use only: **Severity score:** _____

Modified with permission from the PHQ (Spitzer, Williams & Kroenke, 1999) by J. Johnson (Johnson, 2002)