

PTSD Checklist - Homecoming For Veterans

New Client Evaluation/PTSD Pilot Program

Client's Name: _____

Facility: _____

Clinician: _____ **Date:** _____

Instruction to client: Below is a list of common problems and complaints that are related to stressful military experiences. Please read each one carefully, put an "X" in the box to indicate how much you have been bothered by that problem in *the last month*.

No.	Response:	Not at all (1)	A little bit (2)	Moderately (3)	Quite a bit (4)	Extremely (5)
1.	Repeated, disturbing <i>memories, thoughts, or images</i> of a stressful military experience?					
2.	Repeated, disturbing <i>dreams</i> of a stressful military experience?					
3.	Suddenly <i>acting or feeling</i> as if a stressful military experience were happening again (as if you were reliving it)?					
4.	Feeling <i>very upset</i> when <i>something reminded</i> you of a stressful military experience?					
5.	Having <i>physical reactions</i> (e.g., heart pounding, trouble breathing, or sweating) when <i>something reminded</i> you of a stressful military experience?					
6.	Avoid <i>thinking about</i> or <i>talking about</i> a stressful military experience or avoid <i>having feelings</i> related to it?					
7.	Avoid <i>activities</i> or <i>situations</i> because <i>they remind</i> you of a stressful military experience?					
8.	Trouble <i>remembering important parts</i> of a stressful military experience?					
9.	Loss of <i>interest in things that you used to enjoy</i> ?					
10.	Feeling <i>distant</i> or <i>cut off</i> from other people?					
11.	Feeling <i>emotionally numb</i> or being unable to have loving feelings for those close to you?					
12.	Feeling as if your <i>future</i> will somehow be <i>cut short</i> ?					
13.	Trouble <i>falling</i> or <i>staying asleep</i> ?					
14.	Feeling <i>irritable</i> or having <i>angry outbursts</i> ?					
15.	Having <i>difficulty concentrating</i> ?					
16.	Being " <i>super alert</i> " or watchful on guard?					
17.	Feeling <i>jumpy</i> or easily startled?					

INTAKE FORM

Identifying Information

Name: _____ Date: _____

Gender: male female SSN: (last 4) _____

Marital Status: single married separated divorced widowed other: _____ Age: _____

Ethnicity: Caucasian African-American Hispanic/Latino Native American
 Asian/Pacific Islander Other: _____

Contact Phone#: _____ Work Phone#: _____

Living with: wife/significant other roommate offspring(#: _____) alone

Rank/Rate: _____ Branch of Service: USMC USN Army USAF

Duty Station: _____ Unit: _____

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

EAS date (month/year): _____

Deployments:	Dates (mo/yr to mo/yr)	Location:
	1) _____ to _____	_____
	2) _____ to _____	_____
	3) _____ to _____	_____
	4) _____ to _____	_____
	5) _____ to _____	_____

Mental Health History

Chief/Current Complaint:

1. Who referred you? _____

2. What brings you in today? _____

Mental Health History (cont.)

Ever had any:

Prior mental health therapy/counseling? Yes No When? _____ Why? _____

Prior psychiatric medications? Yes No When? _____ Why? _____

Prior psychiatric hospitalizations? Yes No When? _____ Why? _____

Please list past psych meds: _____

Prior mental health/psychiatric diagnoses given: _____

Any current psychiatric medications or therapy/counseling: _____

Biological family history of mental health diagnosis or treatment? Yes No Don't Know

Who (relationship)?	Diagnosis	Treatment (check all that apply):		
_____	_____	<input type="checkbox"/> Medication	<input type="checkbox"/> Therapy	<input type="checkbox"/> Hospitalization
_____	_____	<input type="checkbox"/> Medication	<input type="checkbox"/> Therapy	<input type="checkbox"/> Hospitalization
_____	_____	<input type="checkbox"/> Medication	<input type="checkbox"/> Therapy	<input type="checkbox"/> Hospitalization
_____	_____	<input type="checkbox"/> Medication	<input type="checkbox"/> Therapy	<input type="checkbox"/> Hospitalization

In the past, have you ever:

Thought of suicide? Yes No When? _____

Attempted suicide? Yes No How? _____

Thought of killing someone else? (non-combat situation) Yes No Who? _____

Tried to kill someone else? (non-combat situation) Yes No Who? _____
How? _____ When? _____

Engaged in self-injury (cutting, burning yourself, etc.) Yes No When? _____

Are you now:

Thinking of hurting yourself? Yes No How? _____

Thinking of hurting someone else? Yes No How? _____

Thinking of cutting/burning yourself? Yes No

What stops you from acting on thoughts of hurting others of yourself?

Current Physical Problems/Medical Conditions (please list): _____

History of Head Injury? Yes No Medication Allergies? Yes No

History of Seizures? Yes No If yes, to what? _____

History of Blackouts? Yes No Problems with dizziness now? Yes No

Current Physical Problems/Medical Conditions (cont.)

Problems with headaches now? Yes No Problems with ringing in ears now? Yes No

Current physical pain rating: from 0 (none) to 10 (excrutiating) = of 10

Current medications: _____

Sleep problems? (circle) trouble getting to sleep waking up at night oversleeping
waking too early in the morning excessive snoring naps during the day
bothered by nightmares vivid dreams restless legs

Eating problems? (circle) overeating loss of appetite binging&purging

Weight change in past month? None Gain Loss of _____ lb.

Substance Use

Current number of times using alcohol per week: _____

Current number of drinks per occasion: _____

Past evaluation or treatment for alcohol abuse? Yes No When? _____

Type: evaluation only inpatient/residential outpatient alcohol awareness classes

Ever had alcohol-related ticket/arrest/DUI? Yes No When? _____

Current illicit drug use: Yes No What? _____ When? _____

Past illicit drug use: Yes No What? _____ When? _____

Family alcohol/drug history? Yes No Who? _____ When? _____

Social History

Early Development:

Born where? _____ Rasied where? _____

Number of brothers: _____ Number of sisters: _____ Number of half/step-siblings: _____

Home discipline/enforcement of rules: strict lenient inconsistent absent

Raised by: biological parents mother&stepfather father&stepmother grandparents
 foster care adoptive parents single parent institution

How would you describe your childhood? _____

Exposure to Trauma/Abuse/Neglect:

How old were you?

Emotional/psychological abuse: Yes No unsure _____

Physical abuse: Yes No unsure _____

Sexual abuse/molestation Yes No unsure _____

Neglect/abandonment: Yes No unsure _____

HPI: (check any that apply)

Problems with:

Mood Behavior Thinking/Attitude Relationships Stress

For how long? _____ days/weeks/months/years

Possibly started/triggered by: _____

(please circle which of the following apply):

Mood: sad angry happy numb afraid ashamed confused silly
irritated worried "on edge" moody don't care bored

Behavior: fighting breaking things irresponsible impulsive withdrawn unpredictable
odd habits/rituals work problems jumpy thrill-seeking

Thinking/Attitude: negative confused constant worrying too distracted
unmotivated guilty hopeless distrustful suspicious

Relationships: conflicts separation unfaithfulness parenting problems jealousy
domestic violence grief/loss isolation don't care arguing

Current Stressors: family finances deaths/losses
(check which apply) friends school lifestyle changes
 relatives significant other health problems
 work separation other: _____

What else should we know about you and what would be most helpful for you today?

Thank you for taking the time to complete this form. Please return this to your provider.