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 *memories*, *thoughts*, or *images* of a stressful military experience?					
2.	Repeated, disturbing *dreams* of a stressful military experience?					
3.	Suddenly *acting* or *feeling* as if a stressful military experience were happening again (as if you were reliving it)?					
4.	Feeling *very upset* when *something reminded* you of a stressful military experience?					
5.	Having *physical reactions* (e.g., heart pounding, trouble breathing, or sweating) when *something reminded* you of a stressful military experience?					
6.	Avoid *thinking about* or *talking about* a stressful military experience or avoid *having feelings* related to it?					
7.	Avoid *activities* or *situations* because *they remind you* of a stressful military experience?					
8.	Trouble *remembering important parts* of a stressful military experience?					
9.	Loss of *interest in things that you used to enjoy?*					
10.	Feeling *distant* or *cut off* from other people?					
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?*					
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?					
17.	Feeling *jumpy* or easily startled?					

INTAKE FORM

Identifying Information

Name: _____ **Date:** _____

Gender: ___male ___female **SSN:** (last 4) _____

Marital Status: ___single ___married ___separated **Age:** _____
___divorced ___widowed ___other:

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):
_____	_____	___Medication ___Therapy ___Hospitalization
_____	_____	___Medication ___Therapy ___Hospitalization
_____	_____	___Medication ___Therapy ___Hospitalization
_____	_____	___Medication ___Therapy ___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	_____

Social History (cont.)

Witnessing Domestic Violence ___Yes ___No ___unsure _____

Deaths in the Family ___Yes ___No ___unsure _____

Out-of-home placement / homelessness ___Yes ___No ___unsure _____

School History:

Ever need special education services? ___Yes ___No What for?_____

Ever tested for a learning disability? ___Yes ___No Results: _____

Ever tested for ADHD? ___Yes ___No Results: _____

Ever expelled from school? ___Yes ___No Why?_____

Out-of-school suspensions in middle and high school: _____

Reasons for suspensions: (check all that apply) ___fighting ___destroying property ___defiance

___alcohol/drugs ___skipping school ___disrupting class

Educational level: ___ did not finish high school ___ high school diploma ___ GED

___ some college credits ___ AA degree ___ bachelor's degree

___ other: _____

Legal History:

Ever arrested/cited as a juvenile? ___Yes ___No What for?_____

Ever adjudicated delinquent? ___Yes ___No What for?_____

Ever arrested/cited as an adult? ___Yes ___No What for?_____

Ever convicted as an adult? ___Yes ___No What for?_____

Consequence: ___ Jail/Prison ___Fine ___Community Service ___ Restitution ___ Probation/Parole

Military Disciplinary Consequences: ***Reason:***

NJP: ___ Yes ___ No _____

Page 11 ___ Yes ___ No _____

Counseling Sheets ___ Yes ___ No _____

Captain's Masts ___ Yes ___ No _____

Court Martial ___ Yes ___ No _____

Restriction ___ Yes ___ No _____

Loss of Pay ___ Yes ___ No _____

Reduction in Rank ___ Yes ___ No _____

MPO ___ Yes ___ No _____

Confinement in Brig ___ Yes ___ No _____

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: (check which apply)

___ family	___ finances	___ deaths/losses
___ 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.