

# Post Traumatic Stress Disorder Checklist (PCL-5)-Partner Version

Total score:

**Instructions:** Below is a list of problems that your *partner* may be experiencing 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 perceive they have been bothered by that problem in the past WEEK.

<i>In the past WEEK, how much was your partner bothered by:</i>	<i>Not at all</i>	<i>A little bit</i>	<i>Moderately</i>	<i>Quite a bit</i>	<i>Extremely</i>
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 ( <i>as if you were actually back there reliving it</i> )?	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 ( <i>for example, heart pounding, trouble breathing, sweating</i> )?	0	1	2	3	4
<i>For Clinician: Total for cluster B (1-5)</i>					
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience ( <i>for example, people, places, conversations, activities, objects, or situations</i> )?	0	1	2	3	4
<i>For Clinician: Total for cluster C (6-7)</i>					
8. Trouble remembering important parts of the stressful experience ( <i>for some reason besides a head injury or alcohol or drug use</i> )?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world ( <i>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</i> )?	0	1	2	3	4

Post Traumatic Stress Disorder Checklist (PCL-5)

<i>In the past month, how much were you bothered by:</i>	<i>Not at all</i>	<i>A little bit</i>	<i>Moderately</i>	<i>Quite a bit</i>	<i>Extremely</i>
<b>10. Blaming yourself or someone else (<i>who didn't directly cause the event or actually harm you</i>) for the stressful experience or what happened after it?</b>	0	1	2	3	4
<b>11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?</b>	0	1	2	3	4
<b>12. Loss of interest in activities that you used to enjoy?</b>	0	1	2	3	4
<b>13. Feeling distant or cut off from other people?</b>	0	1	2	3	4
<b>14. Having trouble experiencing positive feelings (<i>for example, being unable to feel happiness or have loving feelings for people close to you</i>)?</b>	0	1	2	3	4
<i>For Clinician: Total for cluster D (items 8-14)</i>					
<b>15. Feeling irritable or angry or acting aggressively?</b>	0	1	2	3	4
<b>16. Taking too many risks or doing things that could cause you harm?</b>	0	1	2	3	4
<b>17. Being "superalert" or watchful or on guard?</b>	0	1	2	3	4
<b>18. Feeling jumpy or easily startled?</b>	0	1	2	3	4
<b>19. Having difficulty concentrating?</b>	0	1	2	3	4
<b>20. Trouble falling or staying asleep?</b>	0	1	2	3	4
<i>For Clinician: Total for cluster E (items 15-20)</i>					

On the scale below, please CIRCLE THE NUMBER that best indicates the degree of happiness, all things considered, of your relationship in the past week.

<b>Extremely Unhappy</b>	<b>Fairly Unhappy</b>	<b>A little Unhappy</b>	<b>Happy</b>	<b>Very Happy</b>	<b>Extremely Happy</b>	<b>Perfect</b>
0	1	2	3	4	5	6

*For Clinician only:*

Total items from B C D & E 1-20: \_\_\_\_\_