



NAME: _____

DATE: _____

Primary Care PTSD Screen (PC-PTSD)

Instructions

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:

1. Have had nightmares about it or thought about it when you did not want to?

YES / NO

2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?

YES / NO

3. Were constantly on guard, watchful, or easily startled?

YES / NO

4. Felt numb or detached from others, activities, or your surroundings?

YES / NO

References

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