HEALING MINDS

PC-PTSD-5 — Primary Care PTSD Screen

Patient Name: _____ Date: _____

1. Have you had nightmares about the event(s) or thought about the event(s) when you did not want to?

○ Yes ○ No

2. Tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)

○ Yes ○ No

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

○ Yes ○ No

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

○ Yes ○ No

5. Felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused

○ Yes ○ No

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