PTSD CHECKLIST

Neurofeedback Advantage

Name ____________________ Date ____________ Session # ________

Please put a number next to each question to indicate how much you have been bothered by that problem in the last week

1	2	3	4	5
not at all	a little bit	moderately	quite a bit	extremely

Repeated, disturbing memories, thoughts, or images of stressful life experience?

Suddenly acting or feeling as if a stressful life experience were happening again (as if you were reliving it)?

Having physical reactions (e.g. heart pounding, trouble breathing, or sweating) when something reminded you of a stressful life experience?

Avoid activities or situations because they remind you of a stressful life experience?

Loss of interest in things that you used to enjoy?

Feeling emotionally numb or being unable to have loving feelings for those close to you?

Trouble falling or staying asleep?

Having difficulty concentrating?

Feeling jumpy or easily startled?

Headaches?

Fatigue?

Suicidal thoughts?

Repeated, disturbing dreams of a stressful life experience?

Feeling very upset when something reminded you of a stressful life experience?

Avoid thinking about or talking about a stressful life experience or avoid having feelings related to it?

Trouble remembering important parts of a stressful life experience?

Feeling distant or cut off from other people?

Feeling as if your future will somehow be cut short?

Feeling irritable or having angry outbursts?

Being "super alert" or watchful?

Poor short-term memory?

Body pain?

Addictive behaviors?

DEPLOYMENT HEALTH CLINIC - 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#:** ______________

Residence: ___barracks ___on-base housing ___off-base housing (location/city:______________)

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

History of Seizures? ___Yes ___No

History of Blackouts? ___Yes ___No

Medication Allergies? ___Yes ___No

If yes, to what?_____________________________

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? (check all that apply)

trouble getting to sleep   waking up at night   oversleeping   naps during the day

waking too early in the morning   excessive snoring   bothered by nightmares vivid dreams

restless legs

Eating problems?   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.)

Winessing 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 check 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
odd habits/rituals work problems jumpy thrill-seeking unpredictable

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?

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