Appendix C – PTSD Screening Protocol for Primary Care Settings

1. In general, would you say that your health is: ___Excellent ___Very Good ___Good ___Fair ___Poor

2. Have you received health care: [ ] Now, at the VA [ ] In the Past, at the VA [ ] Now, Outside the VA [ ] In the Past, Outside the VA
   - For depression, anxiety, nerves or PTSD? ___YES ___NO
   - For alcohol or drug use problems? ___YES ___NO

3. Have you ever witnessed or had a terrible experience that most people never go through, like a serious accident, a natural disaster, a violent crime, being sexually assaulted or raped, or being in a military warzone or in combat? YES ___NO
   - Did you ever have a military or civilian experience that caused you serious injury or made you believe you might die? YES ___NO

4. In the past month, have you:
   a. Repeatedly remembered these experiences when you did not want to? YES ___NO
   b. Had repeated dreams or nightmares about these experiences? YES ___NO
   c. Thought about these experiences when you didn’t want to, or been bothered by repeated, disturbing memories, feelings, or dreams? YES ___NO
   d. Tried hard not to think about these experiences, or avoided situations, conversations, people, or feelings that reminded you? YES ___NO
   e. Often felt extremely unsafe, on-guard, watchful when you didn’t need to be, or jumpy and easily startled? YES ___NO
   f. Felt emotionally numb (unable to feel most feelings) or detached from your relationships, activities or surroundings? YES ___NO

5. How much of the time during the past month:
   - Have you felt calm and peaceful? [ ] All the Time [ ] Most of the Time [ ] A Good Bit [ ] Some of the Time [ ] A Little [ ] Not at All
   - Have you felt downhearted and blue? [ ] All the Time [ ] Most of the Time [ ] A Good Bit [ ] Some of the Time [ ] A Little [ ] Not at All
   - Have you been a very nervous person? [ ] All the Time [ ] Most of the Time [ ] A Good Bit [ ] Some of the Time [ ] A Little [ ] Not at All
   - Have you been a happy person? [ ] All the Time [ ] Most of the Time [ ] A Good Bit [ ] Some of the Time [ ] A Little [ ] Not at All
   - Have you felt so down in the dumps that nothing could cheer you up? [ ] All the Time [ ] Most of the Time [ ] A Good Bit [ ] Some of the Time [ ] A Little [ ] Not at All

6. Did you ever drink alcohol? ___NO—Please stop here. Thank you. ___YES—Please continue and answer these questions:
   a. Have you felt you ought to cut down on drinking? [ ] Yes, in the past month [ ] Yes, at some time in my life [ ] No, never
   b. Have people annoyed you by criticizing your drinking? [ ] Yes, in the past month [ ] Yes, at some time in my life [ ] No, never
   c. Have you felt bad or guilty about your drinking? [ ] Yes, in the past month [ ] Yes, at some time in my life [ ] No, never
   d. Have you had a drink first thing in the morning to steady your nerves or get rid of a hangover (an “eye-opener”)? [ ] Yes, in the past month [ ] Yes, at some time in my life [ ] No, never