

October 2016

PTSD Discharge Self Report

Form **D2**

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Notice to Veterans: The information requested is confidential and will be used only for the purposes of treatment planning and to assess the performance of the clinical programs. The information is **not** to be included in your medical record, nor is it to be released to anyone outside the VA unless you make a specific request in writing and sign a release.

1. Date of Admission for Treatment (mm/dd/yyyy) / /

2. Date of Discharge from Treatment (mm/dd/yyyy) / /

3. Site/Program:

[illegible]

4. Veteran's Name (Last name, First initial) [] [] [] [] [] [] [] [] [] [] [] [] [] [], []

5. Social Security Number - -

I. PSYCHOLOGICAL STATUS

Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and check the box that indicates how much you have been bothered by that problem **since being in this program, or the past 30 days if you have been in the program longer.**

6. Repeated, disturbing, and unwanted memories of the stressful experience.

☐ 0. Not at all ☐ 2. Moderately ☐ 4. Extremely
☐ 1. A little bit ☐ 3. Quite a bit

7. Repeated, disturbing dreams of the stressful experience.

☐ 0. Not at all ☐ 2. Moderately ☐ 4. Extremely
☐ 1. A little bit ☐ 3. Quite a bit

8. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were reliving it).

☐ 0. Not at all ☐ 2. Moderately ☐ 4. Extremely
☐ 1. A little bit ☐ 3. Quite a bit

9. Feeling very upset when something reminded you of the stressful experience.

☐ 0. Not at all ☐ 2. Moderately ☐ 4. Extremely
☐ 1. A little bit ☐ 3. Quite a bit

10. Having strong physical reactions (e.g. heart pounding, trouble breathing, sweating) when something reminded you of the stressful experience.

☐ 0. Not at all ☐ 2. Moderately ☐ 4. Extremely
☐ 1. A little bit ☐ 3. Quite a bit

11. Avoiding memories, thoughts, or feelings related to the stressful experience.

☐ 0. Not at all ☐ 2. Moderately ☐ 4. Extremely
☐ 1. A little bit ☐ 3. Quite a bit

12. Avoiding external reminders of the stressful experience (people, places, conversations, activities, objects, or situations).

☐ 0. Not at all ☐ 2. Moderately ☐ 4. Extremely
☐ 1. A little bit ☐ 3. Quite a bit

13. Trouble remembering important parts of the stressful experience.

☐ 0. Not at all ☐ 2. Moderately ☐ 4. Extremely
☐ 1. A little bit ☐ 3. Quite a bit

(1)

(2-11)

(12-21)

(22-51)

(52-64)

(65-81)

(82-92)

(93)

(94)

(95)

(96)

(97)

(98)

(99)

(100)

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14. Having strong negative beliefs about yourself, other people, or the world (having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, and the world is completely dangerous).

- ☐ 0. Not at all ☐ 2. Moderately ☐ 4. Extremely
☐ 1. A little bit ☐ 3. Quite a bit

(101)

15. Blaming yourself or someone else for the stressful experience or what happened after it.

- ☐ 0. Not at all ☐ 2. Moderately ☐ 4. Extremely
☐ 1. A little bit ☐ 3. Quite a bit

(102)

16. Having strong negative feelings such as fear, horror, anger, guilt, or shame.

- ☐ 0. Not at all ☐ 2. Moderately ☐ 4. Extremely
☐ 1. A little bit ☐ 3. Quite a bit

(103)

17. Loss of interest in activities that you used to enjoy.

- ☐ 0. Not at all ☐ 2. Moderately ☐ 4. Extremely
☐ 1. A little bit ☐ 3. Quite a bit

(104)

18. Feeling distant or cut off from other people.

- ☐ 0. Not at all ☐ 2. Moderately ☐ 4. Extremely
☐ 1. A little bit ☐ 3. Quite a bit

(105)

19. Trouble experiencing positive feelings (being unable to feel happiness or have loving feelings for people close to you).

- ☐ 0. Not at all ☐ 2. Moderately ☐ 4. Extremely
☐ 1. A little bit ☐ 3. Quite a bit

(106)

20. Irritable behavior, angry outbursts, or acting aggressively.

- ☐ 0. Not at all ☐ 2. Moderately ☐ 4. Extremely
☐ 1. A little bit ☐ 3. Quite a bit

(107)

21. Taking too many risks or doing things that could cause you harm.

- ☐ 0. Not at all ☐ 2. Moderately ☐ 4. Extremely
☐ 1. A little bit ☐ 3. Quite a bit

(108)

22. Being "super alert" or watchful or on guard.

- ☐ 0. Not at all ☐ 2. Moderately ☐ 4. Extremely
☐ 1. A little bit ☐ 3. Quite a bit

(109)

23. Feeling jumpy or easily startled.

- ☐ 0. Not at all ☐ 2. Moderately ☐ 4. Extremely
☐ 1. A little bit ☐ 3. Quite a bit

(110)

24. Having difficulty concentrating.

- ☐ 0. Not at all ☐ 2. Moderately ☐ 4. Extremely
☐ 1. A little bit ☐ 3. Quite a bit

(111)

25. Trouble falling or staying asleep.

- ☐ 0. Not at all ☐ 2. Moderately ☐ 4. Extremely
☐ 1. A little bit ☐ 3. Quite a bit

(112)

The next few questions are about how you have been feeling during the past 30 days. For each question, please give the one answer that comes closest to how often you have felt....

26. Little interest or pleasure in doing things?

- ☐ 0. Not at all ☐ 2. More than half the days
☐ 1. Several days ☐ 3. Nearly every day

(113)

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- | | | | |
|---|--|---|-------|
| 27. Feeling down, depressed or hopeless? | <input type="checkbox"/> 0. Not at all | <input type="checkbox"/> 2. More than half the days | (114) |
| | <input type="checkbox"/> 1. Several days | <input type="checkbox"/> 3. Nearly every day | |
| 28. Trouble falling asleep, staying asleep, or sleeping too much? | <input type="checkbox"/> 0. Not at all | <input type="checkbox"/> 2. More than half the days | (115) |
| | <input type="checkbox"/> 1. Several days | <input type="checkbox"/> 3. Nearly every day | |
| 29. Feeling tired or having little energy? | <input type="checkbox"/> 0. Not at all | <input type="checkbox"/> 2. More than half the days | (116) |
| | <input type="checkbox"/> 1. Several days | <input type="checkbox"/> 3. Nearly every day | |
| 30. Poor appetite or overeating? | <input type="checkbox"/> 0. Not at all | <input type="checkbox"/> 2. More than half the days | (117) |
| | <input type="checkbox"/> 1. Several days | <input type="checkbox"/> 3. Nearly every day | |
| 31. Feeling bad about yourself or that you're a failure or have let yourself or your family down? | <input type="checkbox"/> 0. Not at all | <input type="checkbox"/> 2. More than half the days | (118) |
| | <input type="checkbox"/> 1. Several days | <input type="checkbox"/> 3. Nearly every day | |
| 32. Trouble concentrating on things, such as reading a newspaper or watching television? | <input type="checkbox"/> 0. Not at all | <input type="checkbox"/> 2. More than half the days | (119) |
| | <input type="checkbox"/> 1. Several days | <input type="checkbox"/> 3. Nearly every day | |
| 33. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual? | <input type="checkbox"/> 0. Not at all | <input type="checkbox"/> 2. More than half the days | (120) |
| | <input type="checkbox"/> 1. Several days | <input type="checkbox"/> 3. Nearly every day | |
| 34. Thoughts that you would be better off dead or of hurting yourself in some way? | <input type="checkbox"/> 0. Not at all | <input type="checkbox"/> 2. More than half the days | (121) |
| | <input type="checkbox"/> 1. Several days | <input type="checkbox"/> 3. Nearly every day | |
| 35. Feeling nervous, anxious, or on edge? | <input type="checkbox"/> 0. Not at all | <input type="checkbox"/> 2. More than half the days | (122) |
| | <input type="checkbox"/> 1. Several days | <input type="checkbox"/> 3. Nearly every day | |
| 36. Not being able to stop or control worrying? | <input type="checkbox"/> 0. Not at all | <input type="checkbox"/> 2. More than half the days | (123) |
| | <input type="checkbox"/> 1. Several days | <input type="checkbox"/> 3. Nearly every day | |
| 37. Worrying too much about different things? | <input type="checkbox"/> 0. Not at all | <input type="checkbox"/> 2. More than half the days | (124) |
| | <input type="checkbox"/> 1. Several days | <input type="checkbox"/> 3. Nearly every day | |
| 38. Trouble relaxing? | <input type="checkbox"/> 0. Not at all | <input type="checkbox"/> 2. More than half the days | (125) |
| | <input type="checkbox"/> 1. Several days | <input type="checkbox"/> 3. Nearly every day | |
| 39. Being so restless that it is hard to sit still? | <input type="checkbox"/> 0. Not at all | <input type="checkbox"/> 2. More than half the days | (126) |
| | <input type="checkbox"/> 1. Several days | <input type="checkbox"/> 3. Nearly every day | |
| 40. Becoming easily annoyed or irritable? | <input type="checkbox"/> 0. Not at all | <input type="checkbox"/> 2. More than half the days | (127) |
| | <input type="checkbox"/> 1. Several days | <input type="checkbox"/> 3. Nearly every day | |
| 41. Feeling afraid as if something awful might happen? | <input type="checkbox"/> 0. Not at all | <input type="checkbox"/> 2. More than half the days | (128) |
| | <input type="checkbox"/> 1. Several days | <input type="checkbox"/> 3. Nearly every day | |

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II. ALCOHOL AND DRUG USE

Next is a standard set of questions about several areas of your life such as your alcohol and drug use during the past 30 days. **If you needed a qualifying period of no substance abuse or were hospitalized during this period then answer for the 30 days prior. Please answer as accurately as possible.**

42. In the past 30 days, how many days did you drink ANY alcohol? Include Nyquil, vanilla extract, etc. (129)
- | | | |
|---------------------------------|----------------------------------|-----------------------------------|
| <input type="checkbox"/> 1. 0 | <input type="checkbox"/> 3. 4-8 | <input type="checkbox"/> 5. 16-30 |
| <input type="checkbox"/> 2. 1-3 | <input type="checkbox"/> 4. 9-15 | |

43. In the past 30 days, how many days did you have at least 5 drinks (if you are a man) or at least 4 drinks (if you are a woman) within a two or three hour period? (130)
- | | | |
|---------------------------------|----------------------------------|-----------------------------------|
| <input type="checkbox"/> 1. 0 | <input type="checkbox"/> 3. 4-8 | <input type="checkbox"/> 5. 16-30 |
| <input type="checkbox"/> 2. 1-3 | <input type="checkbox"/> 4. 9-15 | |

44. In the past 30 days, how many days did you use illegal/street drugs? (131)
- | | | |
|---------------------------------|----------------------------------|-----------------------------------|
| <input type="checkbox"/> 1. 0 | <input type="checkbox"/> 3. 4-8 | <input type="checkbox"/> 5. 16-30 |
| <input type="checkbox"/> 2. 1-3 | <input type="checkbox"/> 4. 9-15 | |

45. In the past 30 days, how many days did you use prescription medications (obtained legally or illegally) specifically for the experience or feelings they caused? (132)
- | | | |
|---------------------------------|----------------------------------|-----------------------------------|
| <input type="checkbox"/> 1. 0 | <input type="checkbox"/> 3. 4-8 | <input type="checkbox"/> 5. 16-30 |
| <input type="checkbox"/> 2. 1-3 | <input type="checkbox"/> 4. 9-15 | |

46. In the past 30 days, how much were you bothered by cravings or urges to drink alcohol or use drugs? (133)
- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> 1. Not at all | <input type="checkbox"/> 3. Moderately | <input type="checkbox"/> 5. Extremely |
| <input type="checkbox"/> 2. Slightly | <input type="checkbox"/> 4. Considerably | |

47. How confident are you in your ability to be completely abstinent (clean) from alcohol and drugs for the next 30 days? (134)
- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> 1. Not at all | <input type="checkbox"/> 3. Moderately | <input type="checkbox"/> 5. Extremely |
| <input type="checkbox"/> 2. Slightly | <input type="checkbox"/> 4. Considerably | |

III. MEDICAL HISTORY

48. In general, how would you say your health is? (135)
- | | |
|---------------------------------------|----------------------------------|
| <input type="checkbox"/> 1. Excellent | <input type="checkbox"/> 4. Fair |
| <input type="checkbox"/> 2. Very Good | <input type="checkbox"/> 5. Poor |
| <input type="checkbox"/> 3. Good | |

The following two questions are about activities you might do during a typical day. Since being in this program does health now limit you in these activities? If so, how much?

49. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf. (136)
- | | | |
|--|---|--|
| <input type="checkbox"/> 1. Yes, limited a lot | <input type="checkbox"/> 2. Yes, limited a little | <input type="checkbox"/> 3. No, not limited at all |
|--|---|--|

50. Climbing several flights of stairs. (137)
- | | | |
|--|---|--|
| <input type="checkbox"/> 1. Yes, limited a lot | <input type="checkbox"/> 2. Yes, limited a little | <input type="checkbox"/> 3. No, not limited at all |
|--|---|--|

Since being in this program, how much of the time have you had any of the following problems with your work or other regular daily activities as the result of your physical health?

51. Accomplished less than you would like. (138)
- | | |
|--|--|
| <input type="checkbox"/> 1. All of the time | <input type="checkbox"/> 4. A little of the time |
| <input type="checkbox"/> 2. Most of the time | <input type="checkbox"/> 5. None of the time |
| <input type="checkbox"/> 3. Some of the time | |

52. Were limited in the kind of work or other activities. (139)
- | | |
|--|--|
| <input type="checkbox"/> 1. All of the time | <input type="checkbox"/> 4. A little of the time |
| <input type="checkbox"/> 2. Most of the time | <input type="checkbox"/> 5. None of the time |
| <input type="checkbox"/> 3. Some of the time | |

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Since being in this program, how much of the time have you had any of the following problems with your work or other regular daily activities as the result of any emotional problems such as feeling depressed or anxious?

53. Accomplished less than you would like.

- | | |
|--|--|
| <input type="checkbox"/> 1. All of the time | <input type="checkbox"/> 4. A little of the time |
| <input type="checkbox"/> 2. Most of the time | <input type="checkbox"/> 5. None of the time |
| <input type="checkbox"/> 3. Some of the time | |

(140)

54. Didn't do work or other activities as carefully as usual.

- | | |
|--|--|
| <input type="checkbox"/> 1. All of the time | <input type="checkbox"/> 4. A little of the time |
| <input type="checkbox"/> 2. Most of the time | <input type="checkbox"/> 5. None of the time |
| <input type="checkbox"/> 3. Some of the time | |

(141)

55. Are you currently experiencing pain that has persisted for three months or longer? ☐ 0. No ☐ 1. Yes

(142)

56. Since being in this program, how much did pain interfere with your normal everyday activities?

- | | |
|--|---|
| <input type="checkbox"/> 1. Not at all | <input type="checkbox"/> 4. Quite a bit |
| <input type="checkbox"/> 2. A little bit | <input type="checkbox"/> 5. Extremely |
| <input type="checkbox"/> 3. Moderately | |

(143)

57. What was your average severity of pain during the past week on a 0 (no pain) to 10 (worst pain imaginable) scale?

Pain Severity Rating

(144-145)

58. How satisfied are you with your progress toward achieving your recovery goals?

- | | | |
|--|---|--|
| <input type="checkbox"/> 1. Not at all satisfied | <input type="checkbox"/> 3. Somewhat satisfied | <input type="checkbox"/> 5. Completely satisfied |
| <input type="checkbox"/> 2. A little bit satisfied | <input type="checkbox"/> 4. Pretty much satisfied | |

(146)

Thank you for completing this form. If you have any concerns about the questions on the form or your answers please contact your clinician.

If at any time you are experiencing an emotional crisis and want to talk with a mental health professional, call the Veterans Crisis Line at 1-800-273-8255 and after you connect press 1 to reach a Veteran-specific line.