Name _____ Date ___/___/_____

Please complete the questions below to help your obstetric provider understand how you have been feeling.

Circle the number in the boxes below to answer the questions. Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please read each one carefully and indicate how much you have been bothered by that problem **in the past month**.

	Not at all	A little bit	Moderately	Quite a bit	Extremely
Repeated disturbing memories, thoughts, or images of a stressful experience from the past?	1	2	3	4	5
Repeated disturbing dreams of a stressful experience from the past?	1	2	3	4	5
Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?	1	2	3	4	5
Feeling very upset when something reminded you of a stressful experience from the past	1	2	3	4	5
Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful experience from the past?	1	2	3	4	5
Avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it?	1	2	3	4	5
Avoid activities or situations because they remind you of a stressful experience from the past?	1	2	3	4	5
Trouble remembering important parts of a stressful experience from the past?	1	2	3	4	5
Loss of interest in things you used to enjoy?	1	2	3	4	5
Feeling distant or cut off from other people?	1	2	3	4	5
Feeling emotionally numb or being unable to have loving feelings for those close to you?	1	2	3	4	5
Feeling as if your future will somehow be cut short?	1	2	3	4	5
Trouble falling or staying asleep?	1	2	3	4	5
Feeling irritable or having angry outbursts?	1	2	3	4	5
Having difficulty concentrating?	1	2	3	4	5
Being super alert or watchful on guard?	1	2	3	4	5
Feeling jumpy or easily startled?	1	2	3	4	5

Done! Thank you for completing this questionnaire!

PCL-C