TABLE OF CONTENTS

Opening the Interview:

After obtaining verbal consent to participate from your subject and noting this consent where indicated in your scoring booklet, say:

I am going to ask you different questions about your life, health, and behavior.

Now before I begin with specific questions, do you think you could tell me a little about yourself?

Give the subject a few seconds to begin. Let the subject direct the flow of information here. If the subject asks you where s/he should begin, you can offer the following prompts:

Well, maybe you could begin by telling me where you live, who you live with, the kind of work you're doing or have done, what kinds of things you like to do in your free time.

Then let the subject speak. Do not probe for details at this time. However, before you begin the demographics section, make sure you have some information about the subject's worklife, if any, homelife, special interests and what the subject likes to do in his/her free time. Record all information on the facing page provided.

Listen carefully to your subject and as the subject speaks think about what the subject is saying. This is your chance to begin to know your subject. This is also a very important time for your subject, because the focus here is on "normal" daily activities, rather than pathology. If your subject feels that you have a sense of her/him as a person, it is more likely that your subject will give you accurate information about his/her difficulties. Although this section may be only 5-10 minutes in length, it is one of the most important sections of the interview.

When you feel you have a sense of your subject and the kind of life s/he leads, begin the first question in the demographics section. Whenever you come across a question the subject has already answered (such as marital status, job status, number of children) confirm with the subject your understanding of the information, and let your subject correct you, if necessary.

GENERAL OVERVIEW:

A. Background Questions

1. Where were you born? _____
(STATE OR COUNTRY)

STATE OR COUNTRY CODE

2a. What is your date of birth?

MONTH DAY YEAR

(Confirm with subject)
2b. So that makes you _____ years old.

YEARS

3. *Subject's gender is:*

1 Male

2 Female

B. Marital Status

1. What is your current legal marital status?

1 NA/No Information

2 Single, Never Married

3 Married, 1st Marriage

4 Separated

5 Divorced

6 Widowed

7 Remarried

(Ask if not currently married and living with spouse:)
2. Are you living with a partner as though married?
(…then skip to Question 7)

1 NA/No Information

2 No

3 Yes (less than 6 months)

4 Yes (at least 6 months)

(If ever married)

3a. How many times have you been married?

3b. What was the date of your current/most recent marriage?

MONTH YEAR

(If ever had terminated marriage)

4a. What was the date your marriage/most recent marriage ended?

MONTH YEAR

4b. Marriage ended with:

1 NA/No Information

2 Separation, no legal divorce

3 Legal divorce

4 Death of spouse

5 Annulment

(If married more than once)

5a. What was the date you married your previous spouse?

MONTH YEAR

5b. What was the date this marriage ended?

MONTH YEAR

5c. Marriage ended with:

1 NA/No Information

2 Separation, no legal divorce

3 Legal divorce

4 Death of spouse

5 Annulment

(If married more than twice)

6a. What was the date you married the spouse before the one we just talked about?

MONTH YEAR

6b. What was the date this marriage ended?

MONTH YEAR

6c. Marriage ended with:

1 NA/No Information
2 Separation, no legal divorce
3 Legal divorce
4 Death of spouse
5 Annulment

7. Are you satisfied with your current marital status?

1 NA/No Information
2 No
3 Indifferent
4 Yes

C. Children

1. How many children have you had? ____

 # Children

Complete the following information for each child born alive whether or not subject currently has any relationship with child. Also include any child for whom subject has had caretaking responsibilities. All questions apply to current situation. (If changing relationship with child, code situation most typical of past 3 years). If more than 7 children, note answers to questions to the right of question D.1 a.

List in chronological order:	1ST CHILD	2ND CHILD	3RD CHILD	4TH CHILD	5TH CHILD	6TH CHILD	7TH CHILD
A. Date of Birth (Month/Year) (Write in first name)_____	__/__	__/__	__/__	__/__	__/__	__/__	__/__
B. GENDER **1=male** **2=female**							
C. STATUS **1=biological child** **2=step/adopted** **3=foster child**							
D. LIVES W. SUBJECT **1=NA/No info** **2=always/almost always** **3=more often than not** **4=usually lives elsewhere** **5=seldom with subject** **6=never with subject** **7=deceased**							

D. Education

1 a. How far did you go in school?
Code type of last school attended using codes below, and total years/grades of school completed.

TYPE

Type Of School
1 = NA/No Information
2 = Grade School (K-6 Grades)
3 = Junior High School (7-9th Grades)
4 = Trade/Tech School, no High School Diploma
5 = High School (10-12th Grades)
6 = Trade/Technical School after High School
7 = Two Year College; Community College
8 = Four Year College or University
9 = Graduate or Professional School

1 b. Are you currently in school?

1 NA/NO INFORMATION
2 NO
3 YES

1 c. Within your current/last type of school attended, how many years/grades have you completed?

years/grades:

2. Did you get a diploma, degree, or certificate?
(Indicate highest:)

1	NA/No Information
2	No Degree or Certification or Diploma
3	Technical Certificate (no HS diploma)
4	G.E.D. (High school equivalency)
5	High School Diploma
6	Technical Certificate (post high school)
7	Two Year College Degree (AA, AS, AAS)
8	Four Year College Degree (BA, BS)
9	Graduate or Professional Degree (specify)_____
10	Other (specify)_____

E. Occupation

1a. What is your usual (or most recent) occupation? What kind of work do/did you do? What is your job called?

_____

_____

_____

(If not clear)
1b. What do you actually do in that job? What are some of your duties? Do you work for yourself or someone else? Do you supervise other employees?

_____

_____

_____

2a. Is this the best level job you've ever had?

1 NA/NO INFO

2 NO

3 YES

(If No, ask about best-level job in terms of income, security, prestige)
2b. What was that job? What kind of work did you do? Did you supervise others?

_____

_____

2c. When did you leave that job?

MONTH YEAR

(Ask if married and living with spouse/partner or economically dependent upon spouse/partner)
3a. What about your spouse/partner? What is his/her usual occupation? What kinds of work does s/he do?

_____

_____

3b. Does your spouse contribute the most financial support to your household?

1 NA/NO INFO
2 NO
3 YES

3c. Does someone other than yourself or your spouse contribute the most financial support to your household?

1 NA/NO INFO
2 NO
3 YES

(Ask if someone other than subject or subject's spouse/partner is head of household)
4. You said that *(name)* **contributes the most financial support to your household. What is his/her usual occupation? What kind of work does s/he do?**

_____

_____

5. Code Current Head of Household here:	1	NA/No Information
	2	Self
	3	Spouse/partner
	4	Parent
	5	Other (specify) _____

(Ask about spouse and/or person contributing most to household if not subject or spouse)
6. How much schooling did your spouse/partner (head of household) complete?

	SPOUSE/PARTNER	**HEAD OF HOUSEHOLD**
NA/No Information	1	1
Under 7 years of Schooling	2	2
Junior High School (7-9th Grade)	3	3
Partial High School (10-11th Grade)	4	4
High School Graduate	5	5
Some College; Community College	6	6
Four Year College Graduate	7	7
Completed Graduate Professional Training	8	8
Other *(specify)* _____	9	9

If you don't already know subject's employment status, then probe. Otherwise, clarify what information you have already gathered and code accordingly.

7. Are you presently employed in a salaried position, part-time or full-time?	1	NA/No Information
	2	Employed full time (35+ hrs/wk)
	3	Employed part-time, regular job (less than 35 hrs/wk)
	4	Irregular, occasional part-time work (less than 35 hrs/wk)
	5	Not employed

F. Work Patterns

Rate according to information recorded on previous page. Indicate total time in last 5 years subject did not work at all at some paying job because of psychopathology - when s/he was expected to work (including any time in the current episode.) If subject is a student, homemaker, or has not worked full-time, determine if this was primarily due to psychopathology. If any doubt about work history, confirm with subject. Ask if student missed any class time due to psychopathology and rate accordingly.

Let's think about your work in the last five years, that is since *(date five years prior to interview date).*

If you add up all the time that you were unable to work or missed work because of your not feeling emotionally up to working- (like feeling too depressed or too nervous or even just taking a "mental health day") in the last 5 years, how much would it come to?

Don't include any days missed due to the flu or some medical problem.

1	NA/No Information
2	Did not work at all because retired, homemaker, physically ill, or some other reason not related to psychopathology
3	Virtually no time at all out of work (or absenteeism) because of reasons related to psychopathology
4	Only a few days to 1 month
5	Up to 6 months (10% of time)
6	Up to 1 year (20% of time)
7	Up to 2 years (40% of time)
8	Up to 3 years (60% of time)
9	Up to 4 years (80% of time)
10	Up to almost 5 years
11	Worked none, or practically none, of the time due to psychopathology

Interviewer leave this page blank

OCCUPATION
Code occupation for subject and spouse/partner or other head of household

Hollingshead Codes

1 = Higher Executive Proprietor of Large Concern, Major Professional

2 = Business Manager of Large Concern, Proprietor of Medium Sized Business, Lesser Professional

3 = Administrative Personnel, Owner of Small Independent Business, Minor Professional, Farm Owner with Large Farm

4 = Clerical or Sales Worker, Technician, Owner of Little Business, Farmer with Medium Farm ($10,000 - $20,000)

5 = Skilled Manual Employee, Farmer with Small Farm (Under $10,000)

6 = Machine Operator, Semi-Skilled Employee, Tenant Farmer

7 = Unskilled Employee, Farm Hand, Welfare Recipient, Chronicly Unemployed

8 = Person never worked in paid employment (including student who never worked)

9 = Homemaker (who never worked)

SUBJECT ☐

SPOUSE/PARTNER ☐

HEAD OF HOUSEHOLD ☐

What about total income for the year?
(Hand income card to subject)
Which of these groups on this card includes your total income (before taxes) during last year? Include all income received from any source. Just tell me the number for the amount that fits.

How about your household income? That is, all income received from any source by all the people in your household.

Subject	Household	Income
1	1	(1) NA/No info
2	2	(2) less than $9,999
3	3	(3) $10,000-$19,999
4	4	(4) $20,000-$29,999
5	5	(5) $30,000-$39,999
6	6	(6) $40,000-$49,999
7	7	(7) $50,000-$59,999
8	8	(8) $60,000-$69,999
9	9	(9) $70,000-$89,999
10	10	(10) $90,000 and above

G. Religion

1. How important to you is religion or spirituality?

1 NA/No Information
2 Highly important
3 Moderately important
4 Slightly important
5 Not important at all

2. How would you describe your current religious beliefs? What religion were you raised in?
(Ask if not apparent)
Is there a particular denomination or religious organization that you are/were part of?
(Ask if Protestant or Catholic)
Do you consider yourself a Charismatic or Fundamentalist Christian?

	CURRENT	RAISED
NA/No info	1	1
Protestant: (denomination: _____)	2	2
Charismatic or Fundamentalist Protestant: (denomination:_____)	3	3
Roman Catholic	4	4
Charismatic Catholic	5	5
Eastern Orthodox	6	6

	CURRENT	RAISED
Jewish: (Orthodox, Conservative, Reformed, Other)	**7**	**7**
Buddhist/Hindu/Islam	**8**	**8**
Personal religious or spiritual beliefs not affiliated with any institutionalized religion	**9**	**9**
Agnostic/Atheist	**10**	**10**
Other (specify)_____	**11**	**11**
DETAILED RELIGION CODES	☐☐	☐☐

3. How often, if at all, do you attend church, synagogue, or other religious or spiritual services? How often did you attend services during the time you were growing up *(prior to age 15)?*

	NOW	GROWING UP
NA/No info	**1**	**1**
Never	**2**	**2**
Less than once a year	**3**	**3**
About once or twice a year	**4**	**4**
About once a month	**5**	**5**
Once a week or more	**6**	**6**

H. Ethnic Background

1. What is your racial or ethnic background? Do you consider yourself *(read choices)***?**

1 NA/No Information

2 Black

3 Black Hispanic

4 White, not of Hispanic origin

5 White Hispanic

6 Asian

7 Native American

8 Other *(specify)*

_____

2. Which country did most of your ancestors come from?

Code

(SPECIFY COUNTRY OR COUNTRIES)

I. Childhood

1. When you were growing up, did any <u>educational or health professional</u> ever say that you suffered from:

	NO	YES	AGE
LEARNING DISABILITY	1	2	
APHASIA (SPEECH OR RECEPTIVE LANGUAGE DELAY)	1	2	
MINIMAL BRAIN DYSFUNCTION	1	2	
HYPERACTIVITY	1	2	
ATTENTION DEFICIT DISORDER	1	2	
DEVELOPMENTAL DISORDER	1	2	
MENTAL RETARDATION	1	2	
BEING A SLOW LEARNER	1	2	
OTHER NEUROLOGIC OR NEUROPSYCHIATRIC CONDITION	1	2	

Describe and specify who diagnosed:

2. Were you ever placed in a special class or special school? *(Not gifted programs)*

1 NA/NO INFO

2 NO

3 YES

Specify Disorder and Treatment	TOTAL TIME RECEIVED (MONTHS)	AGE BEGAN TREATMENT (YEARS)

J. Interpersonal Functioning

BEST LEVEL OF SOCIAL RELATIONS DURING THE LAST FIVE YEARS
Consider contact that has a pleasurable quality and is not merely for the purpose of completing some task or fulfilling some duty. May include family members not living in the same household.

During the past five years, that is since *(date five years ago)***, how much did you socialize with friends or other people? What about visiting or having people over to your place?**

What about church activities, bowling, playing cards, etc.? Whom do you see?

How close are you to them?

Would you consider them close friends, somebody you could really trust?

1 NA/No Information

2 Superior, e.g., had many special friends that s/he saw regularly and was very close with

3 Very good, e.g., had several special friends that s/he saw regularly and was close to

4 Good, e.g., had 1 or 2 special friends that s/he saw from time to time and was fairly close to emotionally

5 Fair, e.g., had 1 special friend that s/he saw from time to time and was fairly close to OR social contacts were limited to people that s/he was not very close to emotionally

6 Poor, e.g., had no special friends that s/he saw from time to time and was fairly close to OR social contacts were limited to people that s/he was not very close to emotionally

7 Very poor, e.g., had no special friends and social contacts were limited to one or two people that s/he was not very close to emotionally

8 Grossly inadequate, e.g., had practically no social contact

Notes:

A. Medical Problem Checklist

(For phone interview, read list of medical problems. For in person interview, hand medical problems card to subject and ask if he/she has ever had each of the conditions listed. For each "yes", ask age of onset and offset. Provide details of illness in space below)

1. Please look at the list of illnesses on this card and tell me if you have ever had any of these conditions in your lifetime.

_____

_____

_____

_____

2. Have you taken any medication for physical problems?

1 NA/NO INFO

2 NO

3 YES

_____

_____

_____

Medication	Condition or Medical Problems *(Use codes from next page)*
a. _____	☐☐
b. _____	☐☐
c. _____	☐☐
d. _____	☐☐

Medication Taken?

Health Problems	DK	NO	YES PAST	YES CURRENT	AGE AT ONSET	D K	NO	YES
CANCER								
01 Cancer (specify)_____	1	2	3	4	_____	1	2	3
CARDIOVASCULAR								
02 Angina/Myocardial Infarction (heart attack)	1	2	3	4	_____	1	2	3
03 Hypertension (high blood pressure)	1	2	3	4	_____	1	2	3
04 Mitral Valve Prolapse (leaky valve)	1	2	3	4	_____	1	2	3
05 Other Cardiovascular_____	1	2	3	4	_____	1	2	3
DERMATOLOGIC/SKIN DISEASE								
06 Skin disorder (acne, psoriasis, eczema)	1	2	3	4	_____	1	2	3
07 Scleroderma (thickening of tissue)	1	2	3	4	_____	1	2	3
08 Other Dermatologic/Skin Disease_____	1	2	3	4	_____	1	2	3
ENDOCRINE/GLANDULAR								
09 Hyperthyroid (high)	1	2	3	4	_____	1	2	3
10 Hypothyroid (low)	1	2	3	4	_____	1	2	3
11 Other Endrocrine/Glandular_____	1	2	3	4	_____	1	2	3
GASTROINTESTINAL/DIGESTIVE SYSTEM								
12 Colitis ("irritable bowel")	1	2	3	4	_____	1	2	3
13 Enteritis (chronic inflamed intestines)	1	2	3	4	_____	1	2	3
14 Gallbladder problems	1	2	3	4	_____	1	2	3
15 Hepatitis/Jaundice (liver inflammation)	1	2	3	4	_____	1	2	3
16 Liver disease (other than hepatitis)	1	2	3	4	_____	1	2	3
17 Ulcer	1	2	3	4	_____	1	2	3

Medication Taken?

Health Problems	DK	NO	YES PAST	YES CURRENT	AGE AT ONSET	D K	NO	YES
18 Other Gastrointestinal_____	1	2	3	4	_____	1	2	3
GENITO-URINARY								
19 Kidney disease	1	2	3	4	_____	1	2	3
20 STD (Syphilis, Gonorrhea, Herpes)	1	2	3	4	_____	1	2	3
21 Other Genito-Urinary	1	2	3	4	_____	1	2	3
Bladder Problems If yes, specify (e.g., surgery, recurrent UTI's, enuresis > age 4) _____	1	2	3	4	_____	1	2	3
HEMATOLOGIC/BLOOD DISORDER								
22 Anemia (specify)	1	2	3	4	_____	1	2	3
23 Other Hematologic/Blood Disorder_____	1	2	3	4	_____	1	2	3
INFECTIOUS								
24 Tuberculosis	1	2	3	4	_____	1	2	3
25 Rheumatic fever	1	2	3	4	_____	1	2	3
26 Seropositive for HIV	1	2	3	4	_____	1	2	3
27 AIDS, ARC (diagnosed)	1	2	3	4	_____	1	2	3
28 Other Infectious_____	1	2	3	4	_____	1	2	3
METABOLIC								
29 Diabetes (high blood sugar)	1	2	3	4	_____	1	2	3
30 Hypercholesterolemia (high cholesterol)	1	2	3	4	_____	1	2	3
31 Hypoglycemia (low blood sugar)	1	2	3	4	_____	1	2	3
32 Other Metabolic_____	1	2	3	4	_____	1	2	3
MUSCULO-SKELETAL								

Medication Taken?

Health Problems	DK	NO	YES PAST	YES CURRENT	AGE AT ONSET	D K	NO	YES
33 Myasthenia gravis (muscle weakening)	1	2	3	4	_____	1	2	3
34 Multiple sclerosis	1	2	3	4	_____	1	2	3
35 Other Musculo-Skeletal_____	1	2	3	4	_____	1	2	3
NEUROLOGICAL/ NEUROMUSCULAR								
36 Convulsions, seizures, epilepsy	1	2	3	4	_____	1	2	3
37 Encephalitis (inflammation of brain)	1	2	3	4	_____	1	2	3
38 Head injury	1	2	3	4	_____	1	2	3
39 Meningitis	1	2	3	4	_____	1	2	3
40 Migraine headaches	1	2	3	4	_____	1	2	3
41 Repeated headaches (not migraine)	1	2	3	4	_____	1	2	3
42 Polio, palsy or paralysis	1	2	3	4	_____	1	2	3
43 Stroke	1	2	3	4	_____	1	2	3
44 Vision problems (e.g., glaucoma)	1	2	3	4	_____	1	2	3
45 Other neuromuscular_____	1	2	3	4	_____	1	2	3
RESPIRATORY	1	2	3	4	_____	1	2	3
46 Asthma	1	2	3	4	_____	1	2	3
47 Bronchitis	1	2	3	4	_____	1	2	3
48 Emphysema	1	2	3	4	_____	1	2	3
49 Other respiratory _____	1	2	3	4	_____	1	2	3
SYSTEMIC	1	2	3	4	_____	1	2	3
50 Allergies (specify)	1	2	3	4	_____	1	2	3
51 Arthritis/Rheumatism	1	2	3	4	_____	1	2	3
52 Autoimmune disorder (e.g., lupus erythematosus)	1	2	3	4	_____	1	2	3
53 Other Systemic_____	1	2	3	4	_____	1	2	3

Health Problems	DK	NO	YES PAST	YES CURRENT	AGE AT ONSET	Medication Taken? D K	NO	YES
OTHER	1	2	3	4	_____	1	2	3
54 Lead Poisoning	1	2	3	4	_____	1	2	3
55 Unconsciousness	1	2	3	4	_____	1	2	3
56 Other_____	1	2	3	4	_____	1	2	3
57 Other_____	1	2	3	4	_____	1	2	3

Ask for subject's current: **Height** _____ _____
Feet **Inches**

Weight _____
Lbs.

B. Hospitalization

1. Have you ever had any operations that required hospitalization?

1 NA/NO INFO

2 NO

3 YES

If yes, give reason and dates (month/year).

OPERATIONS MONTH YEAR

1._____ | | | | |

2._____ | | | | |

3._____ | | | | |

Total number of times hospitalized for operations | | |

2. Have you ever been hospitalized for non-psychiatric medical reasons?
(Exclude pregnancies, operations)

1 NA/NO INFO
2 NO
3 YES

If yes, give reason and dates (month/year).

HOSPITALIZATION

MONTH YEAR

1._____ | | | | |

2._____ | | | | |

3._____ | | | | |

Total number of times hospitalized for medical problems | | |

3. Have you ever been to the emergency room or treated by a physician because of an accident or injury?

1 NA/NO INFO
2 NO
3 YES

If yes, give reason and date of accident or injury.

MONTH YEAR

ACCIDENT/INJURY

1._____ | | | | |

2._____ | | | | |

3._____ | | | | |

(ASK WOMEN ONLY)

4. Have you ever been pregnant?

1 NA/NO INFO
2 NO
3 YES

(If yes to last question)

5. How many times have you been pregnant?

Have you ever had any pregnancies that ended in miscarriage or stillbirth? Have you ever had an abortion? Have you ever placed a child for adoption? When was that?

Record birth outcomes for all pregnancies. Ask the following questions if respondent reports no children, or fewer children than pregnancies. Code month and year of pregnancy outcome (birth, abortion, etc.) NOT month/year subject became pregnant

Pregnancy Outcome Codes:

1 = NA/No Information
2 = Live birth, child with mother
3 = Child given for adoption
4 = Miscarriage
5 = Stillbirth
6 = Abortion
7 = Other *(specify)*_____

	Pregnancy Outcome	Month/Year
1st Pregnancy		
2nd Pregnancy		
3rd Pregnancy		
4th Pregnancy		
5th Pregnancy		
6th Pregnancy		
7th Pregnancy		
8th Pregnancy		
9th Pregnancy		

1. INTRODUCTORY PROBE

Similar to the general overview of your subject's life in Section A, this section is very important because it can provide you with a general guide to your subject's psychopathology. In the course of this overview, you must get treatment information indicated below. Begin this section by saying something such as:

> **Now I would like to begin to get an idea of difficulties you may have had in your life. I'd like to know if there have ever been times in your life when you weren't your "normal" self, or when your feelings got out of your control, or when you began acting in ways that you didn't understand?**

If the subject asks, "like what?" say:

> **Well, any times when you were very, very sad, or times when you were so active you couldn't slow down, or times when fear or anxiety interrupted your life, or times when you couldn't control your thoughts or feelings or had problems with drinking or drugs.**

If necessary repeat or rephrase the probe.

If the subject answers "no," then say:

> **Well, I'd like to ask you a few more specific questions about that...**

and proceed to the questions regarding treatment.

If the subject answers "yes," say:

> **Tell me when those times were, and tell me, in a general way, what was troubling you at those times.**

Sometimes subjects can give you a very thorough and accurate overview of their periods of difficulty. Don't hurry the subject if s/he spontaneously gives you specific information about the onset and offset and the type of problem. However, DO NOT collect great detail regarding specific symptoms, but enough to make a tentative differential diagnosis. You will cover that later in the interview. As you get information on periods of difficulty, always ask about treatment for the difficulty being described and record below as indicated.

If a subject cannot give you specific information on the general type of difficulty s/he was having, onset and offset, and instead, tends to ramble about general life problems, proceed to the treatment questions and let those structure the information you collect.

Record all information about difficulties on the facing page provided. Score treatment questions as indicated.

OVERVIEW OF PSYCHIATRIC DISTURBANCE

2. TREATMENT

Now I would like to know whether you have ever seen a mental health professional, such as a psychiatrist, psychologist, social worker, counselor or even your medical doctor for emotional problems, your nerves or the way you were feeling or acting? Who did you see? What was the reason?
How often did you go to that person? Were there other times?

A. Outpatient Treatment

(Include contact with any professionally trained person for help with emotional or behavioral problems. Include pills from M.D. for "nerves.")

1. DURATION OF OUTPATIENT TREATMENT

1 NA/No Information

2 No Contact

3 Consultation or brief period of treatment

4 Continuous treatment for at least 6 months or few brief periods (four periods or less)

5 Continuous treatment lasting several years or numerous brief periods (more than four)

2. AGE AT FIRST OUTPATIENT CARE
(leave blank if never)

How old were you when you first went for help?

AGE

B. Inpatient Treatment

1. NUMBER OF PSYCHIATRIC HOSPITALIZATIONS
Were you ever a patient in a psychiatric hospital or ward?

1 NA/No Information

2 NO

3 YES

How many times?

2. AGE AT FIRST HOSPITALIZATION
(leave blank if never)

How old were you when you were first hospitalized?

AGE

3. TOTAL TIME OF PSYCHIATRIC HOSPITALIZATION

(Best estimate if exact time unknown)

1 NA/No Information

2 Never Hospitalized

3 Less than 5 days

4 Less than 3 months

5 Less than 6 months

6 Less than 1 year

7 Less than 2 years

8 Less than 5 years

9 Five or more years

NOTES

3. MEDICATIONS

Have you ever taken any medication because of the way you were feeling or behaving? Medications such as sleeping pills, tranquilizers, pills to give you more energy or make you think more clearly?

IF YES: **What were the names of the medications you were taking?** *Circle all those that apply. Then say:* **Sometimes people forget medications they've taken in the past. I'm going to read you a list of medications and I want you to tell me if you've ever been prescribed any of these or if you've ever taken any of these.** *Read highlighted names unless subject states that s/he is unable to remember a drug previously taken. In this case, read all names in relevant categories.*

MEDICATIONS	NO	YES, IN PAST	YES, WITHIN PAST 3 MONTHS	DATE FIRST PRESCRIBED (MONTH/YEAR)
SEDATIVES: (**Phenobarbital, Nembutal, Seconal**, Amytal, **Tuinal, Miltown**, Equanil, Demol, Soma, Deprol, Pathibamate, **Atarax**, Vistaril)	1	2	3	____/____
MINOR TRANQUILIZERS: (**Ativan**, **Librium**, **Valium**, Serax, **Xanax**, Paxipam, **Tranxene**, Dalmane, **Klonopin**)	1	2	3	____/____
SLEEPING PILLS: (Benadryl, Chloralhydrate, Doriden, **Halcion**, **Nembutal**, Noludar, **Placidyl**, Restoril)	1	2	3	____/____
OVER-THE-COUNTER SEDATIVES: (Nytol, **Compoz, Cope**, Mr. Sleep, Devarex, Miles, **N ervine**, Tranquilaid, **Benadryl**)	1	2	3	____/____
STIMULANTS: (Amphetamine, **Dexedrine, Ritalin**, Ambar, **Benzedrine**, Diphetamine, **Methadrine, Preludin**, Speed, Desburtal, **Dexabarb**, Dextro-Amphetamine, **Cylert, Pemoline**, Desolyn, Sanorex, Tenuate, Tempariel, Lonamine, Pondamin)	1	2	3	____/____
OVER-THE-COUNTER STIMULANTS: (Alert-Pep, **Brisk**, Cafecon, **Enerjets**, **No-Doz**, Revs, Tirend, **Vivarin**, Wakeup)	1	2	3	____/____
MAJOR TRANQUILIZERS: (**Thorazine**, Compazine, **Stelazine, Mellaril, Prolixin**, Sparine, **Trilafon, Haldol, Moban**, Loxitane, Permitil, **Serentil**, Navane, Vesprin, Quide, Tindal, **Proketazine**, Repoise, Taracdon, Serpasil, Risperidone, Clozaril, Zyprexa)	1	2	3	____/____
ANTIDEPRESSANTS: (**Tofranil, Elavil**, Aventyl, **Nardil**, Marplan, **Parnate**, Pertofane, Norpramine, **Pamelor**, Endep, **Sinequan**, Asendin, **Ludiomil**, Surmontil, Desyrel, Vivactil, **Adapin, Prozac, Anafranil**, Fluvoxamine, **Imipramine,** Effexor, Paxil,Welbutrin, Zoloft)	1	2	3	____/____
COMBINATION: (ANTIDEPRESSANT AND ANTIPSYCHOTIC): (**Triavil**, Etrafon, **Limbitrol**)	1	2	3	____/____
MOOD STABILIZERS: (**Tegretol, Depakote, Depakene**)	1	2	3	____/____
ANTICONVULSANTS: (**Dilantin, Tegretol, Depakote, Depakene**, Mysoline, Zarontin, Celontin, Mebaral, Tridion)	1	2	3	____/____
LITHIUM: (**Lithane**, **Lithonate**, Eskalith)	1	2	3	____/____
OTHER PSYCHOTROPIC DRUGS: (Ondansetron, **Zofran**, **Buspar**, Buspirone) (Specify):_____	1	2	3	____/____
PSYCHOACTIVE MEDICATION FOR MEDICAL PROBLEM (e.g., CNS Stimulants)	1	2	3	____/____

Periods of dysphoric mood are categorized as Major Depression if they are relatively discrete and are associated with other symptoms of the disorder. These categories are distinguished from Generalized Anxiety Disorder, in which there is a clear predominance of anxious mood.

Note: In DSM-III-R, an episode is defined as a grief reaction if the onset follows the death of someone close even if depressive symptoms are of sufficient duration and number to meet criteria for a major depressive episode. The DSM-III-R does not specify a maximum duration criterion for grief reaction. In DSM-IV, the depressive symptoms of bereavement should not persist more than 2 months to qualify as a grief reaction. For both DSM-III-R and DSM-IV, feelings of worthlessness, psychomotor retardation, suicidal ideation, marked functional impairment or psychosis following the death of a loved one suggest the presence of Major Depression.
A period of Major Depression may be the only disturbance or may be superimposed upon another psychiatric disorder.

A. Screening Questions

I would now like to ask you some specific questions about your mood, both how you feel now and how you have felt in the past.

1. DEPRESSIVE MOOD

Has there ever been a period of time that lasted at least 1 week, when you were bothered most of the time, day and night, by feeling depressed, sad, blue, hopeless, down in the dumps or when you were tearful or had crying spells?

1 NA/NO INFORMATION
2 NO
3 YES

2. PERVASIVE ANHEDONIA

Has there ever been a period of time that lasted at least 1 week, when you just weren't interested in or couldn't enjoy the things that you usually enjoy? Were you able to enjoy anything?

1 NA/NO INFORMATION
2 NO
3 YES

3. IRRITABLE MOOD

(Ask only if episode occurred before age 18)
What about a period of at least 1 week when you felt predominantly irritable, easily annoyed?

1 NA/NO INFORMATION
2 NO
3 YES

SKIP TO DYSTHYMIC DISORDER, PAGE 40

If yes to any of the above:

4. DURATION (AT LEAST ONE WEEK)

How long did the longest of these periods last?

1 NA/No Information
2 Less than 1 week
3 1 week but less than 2 weeks
4 2 weeks but less than 4 weeks
5 4 weeks or more

SKIP TO DYSTHYMIC DISORDER, PAGE 40

B. Chronology

*At this point, the interviewer should establish chronology regarding the number of episodes, duration of 1 week or more and severity of each, determining which is the **worst to be coded** below, and record this information in space provided.*

C. Mood

	Worst Past Episode			Current Episode		
	NA/NO INFO	NO	YES	NA/NO INFO	NO	YES
1. DUE TO GRIEF REACTION **Had someone you were very close to just died?**	1	2	3	1	2	3
For DSM-IV **Did your grief last more than 2 months after the death occurred?**	1	2	3	1	2	3

D. Symptoms: Major Depression

*Code "4" if symptom present **most part of the day, nearly every day (NED)**.*

	Worst Past Episode				Current Episode			
	NA/NO INFO	NO	YES	NED	NA/NO INFO	NO	YES	NED
1. DEPRESSED MOOD **a. Were you feeling very sad, depressed, empty? Were you tearful?**	1	2	3	4	1	2	3	4
(Ask only if episode occurred before age 18): **b. Were you easily annoyed and irritable?**	1	2	3	4	1	2	3	4
2. ANHEDONIA *(At least several activities 50% less pleasurable or interesting. Does not need to be pervasive.)*								
LOSS OF PLEASURE (CONSUMMATORY) **a. Were you able to enjoy your usual activities? (e.g. enjoy a hobby or a good meal)**	1	2	3	4	1	2	3	4
LOSS OF INTEREST (APPETITIVE PLEASURE) **b. Did you feel you didn't care about the things that you usually care about, or that you couldn't get excited about doing them?**	1	2	3	4	1	2	3	4
c. How about a loss of interest in sex?	1	2	3	4	1	2	3	4
BOREDOM(50%) **d. Did you feel bored? How much of the time?**	1	2	3	4	1	2	3	4

	Worst Past Episode				Current Episode			
	NA/NO INFO	NO	YES	NED	NA/NO INFO	NO	YES	NED
1. EATING DISTURBANCES								
APPETITE LOSS **a. Did you lose your appetite?**	1	2	3	4	1	2	3	4
WEIGHT LOSS **b. Did you lose weight (even if you were not on a diet)?**	1	2	3		1	2	3	
c. How much weight did you lose during the (worst) episode? *Record % body weight loss during the episode.*		☐☐				☐☐		
d. During the worst month of this episode, how much weight did you lose? *Record % body weight loss during the worst month.*		☐☐				☐☐		
IF SUBJECT LOST AT LEAST 5% OF BODY WEIGHT DURING ONE MONTH OF THE EPISODE, CODE 4	1	2	3	4	1	2	3	4
APPETITE GAIN **e. Were you hungrier than usual? Did you eat more?**	1	2	3	4	1	2	3	4
WEIGHT GAIN **f. Did you gain weight?**	1	2	3		1	2	3	
g. How much weight did you gain during the (worst) episode? *Record % body weight gained during the episode.*		☐☐				☐☐		
h. During the worst month of this episode, how much weight did you gain? *Record % body weight gained during the worst month.*		☐☐				☐☐		
IF SUBJECT GAINED AT LEAST 5% OF BODY WEIGHT DURING ONE MONTH OF EPISODE, CODE 4	1	2	3	4	1	2	3	4
2. SLEEP DISTURBANCES INITIAL INSOMNIA **a. Did you have trouble falling asleep? How long did it take?**	1	2	3	4	1	2	3	4
MIDDLE INSOMNIA **b. Did you wake up during the night and couldn't go back to sleep?**	1	2	3	4	1	2	3	4

	Worst Past Episode				Current Episode			
	NA/NO INFO	NO	YES	NED	NA/NO INFO	NO	YES	NED
TERMINAL INSOMNIA **c. Did you wake up before you had to?** *(Positive rating should be at least 1 hour.)*	1	2	3	4	1	2	3	4
HYPERSOMNIA **d. Did you sleep more than you usually do?**	1	2	3	4	1	2	3	4
3. MOTOR DISTURBANCES AGITATION **a. Did you have trouble sitting still or were you walking back and forth so that others noticed it?**	1	2	3	4	1	2	3	4
RETARDATION **b. Did you talk or move more slowly than usual so that others noticed it?**	1	2	3	4	1	2	3	4
5. FATIGUE (*More tired or decreased energy at times out of proportion to what he/she had done.)* **a. Were you tired or did you have less energy than usual?**	1	2	3	4	1	2	3	4
b. Did you spend more time lying down or in bed than usual ?	1	2	3	4	1	2	3	4
c. Did you feel heavy, leaden or weighted down?	1	2	3	4	1	2	3	4
6. EXCESSIVE GUILT WORTHLESSNESS **a. Did you feel that you weren't a good person or did you feel worthless?**	1	2	3	4	1	2	3	4
GUILT **b. Did you feel guilty (bad) about things that happened a long time ago? Did you blame yourself for things?**	1	2	3	4	1	2	3	4
DELUSIONS OF POVERTY, GUILT OR PUNISHMENT **c. Did you think that the way you were feeling was a punishment for things you had done?**	1	2	3	4	1	2	3	4

	Worst Past Episode				Current Episode			
	NA/NO INFO	NO	YES	NED	NA/NO INFO	NO	YES	NED
d. Did you believe that you were extremely poor, even though your financial situation did not justify it?	1	2	3	4	1	2	3	4
7. CONCENTRATION DIFFICULTY **Did you have difficulty paying attention or keeping your mind on your work? Did you have to make a much bigger effort than before just to keep up? Did you feel like your thoughts were slowed down? Did you have difficulty making decisions?**	1	2	3	4	1	2	3	4
8. SUICIDE THOUGHTS OF DEATH **a. Did you think about death a lot?**	1	2	3	4	1	2	3	4
SUICIDAL IDEATION **b. Did you think about killing yourself?**	1	2	3	4	1	2	3	4
c. Did you have a plan?	1	2	3	4	1	2	3	4
ATTEMPT **d. Did you try to harm yourself or attempt suicide?**	1	2	3	4	1	2	3	4

E. Other Characteristics of Depression

DIURNAL VARIATION **At what time of day did (do) you feel the worst? Morning? Afternoon? Evening?**	1 NA/No Information 2 AM Worse 3 PM Worse 4 Same	1 NA/No Information 2 AM Worse 3 PM Worse 4 Same
MOOD REACTIVITY **When you were down, if something good happened, did you feel better? How much better? For how long?** *(Code '3' if mood improved as much as 50% even if only temporarily or occasionally.)*	1 2 3	1 2 3
MINOR DEPRESSION 1. CRYING **Did you feel like crying? Did you cry?**	1 2 3 4	1 2 3 4

	Worst Past Episode				Current Episode			
	NA/NO INFO	NO	YES	NED	NA/NO INFO	NO	YES	NED
2. PESSIMISM **Did you think about things with a pessimistic attitude?**	1	2	3	4	1	2	3	4
3. BROODING **Were you preoccupied with unpleasant things that had happened?**	1	2	3	4	1	2	3	4
4. INADEQUATE **Were you bothered by feeling inadequate?**	1	2	3	4	1	2	3	4
5. RESENTFUL, IRRITABLE, ANGRY **Did you feel easily annoyed with others even when there was no reason to? Did you feel resentful, irritable or angry?**	1	2	3	4	1	2	3	4
6. REASSURANCE, CLINGING **Did you need someone to tell you that things were O.K. or that you were O.K.? Did you need to be with someone close to you all the time?**	1	2	3	4	1	2	3	4
7. FEELING SORRY FOR SELF **Did you feel sorry for yourself?**	1	2	3	4	1	2	3	4
8. PHYSICAL COMPLAINTS **Did you have a lot of aches and pains, stomach aches, headaches that weren't caused by physical problems?**	1	2	3	4	1	2	3	4
Specify any physical complaint _____ _____	1	2	3	4	1	2	3	4

SUMMARY	NA/NO INFO	FALSE	TRUE
1. <u>All</u> episodes associated with puberty (menarche in women and development of secondary sex characteristics in men)	1	2	3
2. <u>All</u> episodes associated with pregnancy or childbirth (within 2 months)	1	2	3
3. <u>All</u> episodes associated with menopause (within 3 years)	1	2	3

	NA/NO INFO	FALSE	TRUE
4. All episodes apparently followed some form of somatic treatment or drug abuse which might have provoked the Depressive Syndrome (e.g., Serpasil, birth control pills, Cortisone, barbiturates, or diet pills) *If yes, describe:* _____	1	2	3
5. All of the episodes apparently followed some serious physical illness which led to major changes in living conditions or had a physical illness which often is associated with psychological symptoms (e.g., thyrotoxicosis). *If yes, describe physical illness*: _____	1	2	3
6. All episodes occurred within 2 months of death of someone close (and/or were not characterized by: psychomotor retardation, worthlessness, suicidal ideation, functional impairment, or psychosis). *If any grief reaction, describe duration, severity, etc...* _____	1	2	3

G. Impairment (for DSM-IV)	NA/NO INFO	NO	YES
1. SOUGHT HELP			
Did you seek help from anyone, like a doctor or other professional?	1	2	3
or minister?	1	2	3
or even a friend?	1	2	3
or did someone suggest that you seek help?	1	2	3

	NA/NO INFO	NO	YES
2. TOOK MEDICATION	1	2	3
a. Did you take medicine? *If yes,* **What did you take?**			
	1	2	3
b. Did you take more medicine than usual or use nonprescription drugs? *If yes,* **What did you take?**			
	1	2	3

3. HOSPITALIZATION
Were you hospitalized for how you were feeling?

For how many days? ☐☐☐ Days

4. OVERALL ROLE IMPAIRMENT

Did the depression or the symptoms related to it prevent you from doing things, cause you to be less efficient in what you were doing, or interfere with your normal, daily routine in any way? *If yes, please describe*:	1	2	3

5. OCCUPATIONAL/ACADEMIC IMPAIRMENT

Did you stay home from work (or school) because of the way you were feeling? For how long? Was it harder to do your job when you felt depressed? *If yes, please describe*:	1	2	3

6. SOCIAL IMPAIRMENT

Did the depression and/or symptoms affect your social life? Were there any difficulties or problems with friends because of how you were feeling? *If yes, please describe*:	1	2	3

	NA/NO INFO	NO	YES
7. HOME/ FAMILY IMPAIRMENT **Did the depression and/or symptoms affect your tasks at home, responsibilities, or interactions with family members?** *If yes, please describe*:	1	2	3
8. SIGNIFICANT DISTRESS **Did you find that you were very distressed about how you were feeling or acting?** *If yes, please describe*:	1	2	3

F. Criteria Check

	NA/NO INFO	FALSE	TRUE
DSM-III-R/IV RULE OUTS			
a. An organic disorder did not initiate and maintain the disturbance	1	2	3
b. Disturbance is not a normal reaction to the death of a loved one	1	2	3
c. At no time during the disturbance have there been delusions or hallucinations for as long as two weeks in the absence of prominent mood symptoms (i.e., before the mood symptoms developed or after they have remitted).	1	2	3
d. Mood disturbance is not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder NOS.	1	2	3

NOTE: A Major Depressive episode that occurs in response to a psychological stressor is distinguished from Adjustment Disorder with depressed mood by the fact that the full criteria for a Major Depressive episode are not met in Adjustment Disorder. Also, depressed mood with clinically significant impairment followed by depressive symptoms that do not meet criteria for duration or severity should be diagnosed as Major Depression, Probable.

LIFECHART

We have already discussed different periods in your life when you had the problems we just talked about. Let's clarify the timing of those periods starting with the <u>worst</u> episode. *Code Major Depressive Disorder: MDD, DDNOS.*

Code	Onset			Offset			Duration	Status of Episode	Treatment Received
	Month	Year	Age	Month	Year	Age		1 - NA/No Info 2 - Prodromal or Partial Symptoms 3 - Full Syndrome Present	1 - NA/No Info 2 - No treatment 3 - Medication 4 -Psychotherapy 5 -Hospitalization 6 - Other
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	9 ___	__ __ __ __
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	___	__ __ __ __
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	___	__ __ __ __
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	___	__ __ __ __
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	___	__ __ __ __
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	___	__ __ __ __
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	___	__ __ __ __
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	___	__ __ __ __
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	___	__ __ __ __
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	___	__ __ __ __

Probe for a period of sadness that does not meet criteria for Major Depression and that cannot be attributed to a physical cause, e.g., prolonged administration of an anti-hypertensive medication. If subject has met criteria for a Major Depression, preface these questions as follows:

"Apart from the time(s) that you have just told me about,..."

A. Screening Questions

1. DEPRESSED OR ANHEDONIC MOOD

In the past year were you sad or down a lot of times, even if you felt O.K. sometimes? How often? For how long?

Was there ever a year or more when you were sad or down a lot of different times? How often? For how long?

[1] NA/NO INFORMATION
[2] NO
3 YES

SKIP TO MANIC DISORDER, PAGE 44

Specify:

2. ADDITIONAL SCREEN
(DSM-III-R and DSM-IV criteria: both must be true)

	NA/NO INFO	NO	YES
a. Have your feelings of being sad or down lasted for a period of two years or more? *If episode occurred before age 18, it should have lasted at least 1 year.*	1	[2]	3
b. If so, during that time did you feel down most of the day, more days than not?	1	[2]	3

If no to either additional screen, SKIP TO MANIC DISORDER, PAGE 44

B. Chronology

At this point, the interviewer should establish chronology for him/herself regarding the number of episodes, duration and severity of each and record this information in space provided. If more than one episode, establish which was the worst.

C. Symptom Review

During this period did you experience (more days than not)...

	WORST EPISODE		
	NA/NO INFO	**NO**	**YES**
1. INSOMNIA OR HYPERSOMNIA	1	2	3
2. POOR APPETITE OR OVEREATING	1	2	3
3. LOW ENERGY LEVEL OR CHRONIC TIREDNESS	1	2	3
4. FEELINGS OF INADEQUACY, LOW SELF- ESTEEM, OR SELF-DEPRECATION	1	2	3
5. DECREASED ATTENTION, CONCENTRATION, OR DIFFICULTY MAKING DECISIONS	1	2	3
6. FEELINGS OF HOPELESSNESS	1	2	3
7. Was there ever a time when you did not have the above symptoms for 2 months?	1	2	3

D. Impairment *(for DSM-IV)*

1. SOUGHT HELP

Did you seek help from anyone, like a doctor or other professional?	1	2	3
or minister?	1	2	3
or even a friend?	1	2	3
or did someone suggest that you seek help?	1	2	3

2. TOOK MEDICATION

a. Did you take medicine? *If yes,* **What did you take ?**	1	2	3
b. Did you take more medicine than usual or did you use non-prescription drugs? *If yes,* **What did you take?**	1	2	3

3. HOSPITALIZATION

Were you hospitalized for how you were feeling?	1	2	3

For how many days? ___ ___ ___ **Days**

	WORST EPISODE		
	NA/NO INFO	**NO**	**YES**
4. OVERALL ROLE IMPAIRMENT			
Did your sad mood or the symptoms we discussed interfere with or affect your normal, daily routine in any way?	1	2	3
If yes, please describe:			
5. OCCUPATIONAL/ACADEMIC IMPAIRMENT			
Did you stay home from work (or school) because of the way you were feeling? Was it harder to do your job when you felt depressed?	1	2	3
If yes, please describe:			
6. SOCIAL IMPAIRMENT			
Was your social life affected by how you were feeling? Were there any difficulties or problems with friends because of how you were feeling?	1	2	3
If yes, please describe:			
7. HOME/FAMILY IMPAIRMENT			
Was there a change in the way you interacted with your family or how you performed your household chores?	1	2	3
If yes, please describe:			
8. SIGNIFICANT DISTRESS			
How bothered have you been by your sadness or the symptoms we discussed? Have they caused you much distress?	1	2	3
If yes, please describe:			

E. Criteria Check

1. DSM-III-R/IV RULE OUTS	**NA/NO INFO**	**FALSE**	**TRUE**
a. During two year period (or one year if episode occurred prior to age 18), subject was not without symptoms for more than two months.	1	2	3
b. No evidence of unequivocal Major Depressive Episode during first two years of disturbance.	1	2	3

LIFECHART

We have already discussed different periods in your life when you had the problems we just talked about. Let's clarify the timing of those periods starting with the worst episode. *Code Dysthymia: DYS.*

Code	Onset			Offset			Duration	Status of Episode	Treatment Received
	Month	Year	Age	Month	Year	Age		**1 - NA/No Info 2 - Prodromal or Partial Symptoms 3 - Full Syndrome Present**	**1 - NA/No Info 2 - No treatment 3 - Medication 4 -Psychotherapy 5 -Hospitalization 6 - Other**
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	_ _ _	9 ___	_ _ _ _
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	_ _ _	___	_ _ _ _
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	_ _ _	___	_ _ _ _
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	_ _ _	___	_ _ _ _
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	_ _ _	___	_ _ _ _
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	_ _ _	___	_ _ _ _
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	_ _ _	___	_ _ _ _
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	_ _ _	___	_ _ _ _
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	_ _ _	___	_ _ _ _
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	_ _ _	___	_ _ _ _

This category refers to one or more distinct period(s) lasting 2 days or more (or any duration if hospitalized) where the predominant mood was either elevated (unusually good, cheerful, high, expansive) or irritable (easily annoyed).

A. Screening Questions

1. ELATED MOOD

Did you ever have a period that lasted at least 2 days when you felt extremely good or high - clearly different from your normal self, most of the time, day and night?

1 NA/NO INFORMATION
2 NO
3 YES

Did friends or your family think that this was more than just feeling good?

1 NA/NO INFORMATION
2 NO
3 YES

2. IRRITABLE MOOD

What about periods when you felt angry and argumentative, easily triggered for 2 days or more at a time?

1 NA/NO INFORMATION
2 NO
3 YES

SKIP TO SEPARATION ANXIETY DISORDER, PAGE 52

3. DURATION OF ELATED OR IRRITABLE MOOD

How many days does this mood usually last?

[ ][ ][ ] DAYS

How many times a year?

[ ][ ][ ] # EPISODES PER YEAR

Were you ever hospitalized when you were feeling that way?

1 No Information
2 Never hospitalized OR duration of elated or irritable mood less than 2 days
3 Never hospitalized OR duration of elated or irritable mood at least 2 days but less than 1 week
4 Hospitalized OR duration of elated or irritable mood of at least 1 week

SKIP TO SEPARATION ANXIETY DISORDER, PAGE 52

B. Chronology

At this point, the interviewer should establish chronology regarding the number of episodes, duration and severity of each and record this information below. If there are many episodes, clarify which episode is the worst.

_____

_____

_____

_____

_____

C. Symptom Review

Full Manic Syndrome (DSM-III-R + RDC): *3 elated symptoms, or 4 irritable symptoms that endure for a distinct period of time or result in hospitalization.* DSM-IV *specifies that period as at least 1 week. Hypomania* (DSM-III-R) *requires 3 elated or 4 irritable symptoms without impairment.* DSM-IV *specifies duration as 4 days or more.*

	WORST EPISODE		
	NA/NO INFO	**NO**	**YES**
1. INCREASED GOAL-DIRECTED ACTIVITY/PSYCHOMOTOR AGITATION			
a. INCREASED PHYSICAL, WORK, PLAY ACTIVITY			
Were you so active you were constantly on the move, working harder and playing harder than ever before?	1	2	3
b. INCREASED SOCIAL ACTIVITY			
Did you begin to spend much more time with your friends? Were you constantly doing things like joining clubs and making plans much more than before?	1	2	3
c. INCREASED SEXUAL ACTIVITY			
Were you more sexually active?	1	2	3
d. PSYCHOMOTOR AGITATION			
Did you have trouble sitting still? Or were you walking back and forth so that others noticed it?	1	2	3
2. MORE TALKATIVE/PRESSURE OF SPEECH			
Did you talk more than usual, nonstop, or feel you just couldn't stop talking? Was it difficult for people to interrupt you? Did people have trouble following what you said?	1	2	3
3. FLIGHT OF IDEAS			
Did you feel your thoughts going faster than usual or so fast you couldn't keep track?	1	2	3

	WORST EPISODE		
	NA/NO INFO	NO	YES
4. GRANDIOSITY			
Did you feel you were a very important person, had special plans, powers, talents or abilities? Did you feel that you were the greatest person in the world, a star?	1	2	3
5. DECREASED NEED FOR SLEEP			
Did you need less sleep than usual? Did you feel rested, even though you had slept little?	1	2	3
6. DISTRACTIBILITY			
Did you have trouble concentrating on things for long? Did you get distracted very easily? Did you have trouble keeping your mind on things?	1	2	3
7. ACTIONS WITH HIGH POTENTIAL FOR PAINFUL CONSEQUENCES *(Excessive involvement in pleasurable activities with lack of concern for potentially painful consequences, e.g., buying sprees, sexual indiscretions, foolish business investments, reckless driving).*			
Did you do things that could potentially have negative consequences for you like:			
a. Did you use poor judgment?	1	2	3
b. Did you make bad financial decisions?	1	2	3
c. Did you spend or borrow excessively?	1	2	3
d. Did you dress in a loud manner or use too much make-up?	1	2	3

Examples of Symptoms:

Additional Criteria:

1. UNEQUIVOCAL CHANGE IN FUNCTIONING			
Is (was) the (high/irritable) mood very different from how you would usually feel?	1	2	3
Did you do things out of character for you?	1	2	3
2. OBSERVABLE BY OTHERS			
Could others like your family, friends, and co-workers tell that you were feeling high/irritable or behaving in an unusual way and had *(above mentioned symptoms)***?**	1	2	3

	WORST EPISODE		
	NA/NO INFO	NO	YES
D. Other Characteristics of Mania/Hypomania			
MOST SEVERE EPISODE EUPHORIC (NOT IRRITABLE ONLY)	1	2	3
E. Impairment *(for mania)*			
1. SOUGHT HELP			
a. Did you seek help from anyone, like a doctor or other professional?	1	2	3
b. or minister?	1	2	3
c. or even a friend?	1	2	3
d. or did someone suggest that you seek help?	1	2	3
2. TOOK MEDICATION			
a. Did you take medicine? *If yes,* **What did you take?**	1	2	3
b. Did you take more medicine than usual or did you use non-prescription drugs? *If yes,* **What did you take?**	1	2	3
3. HOSPITALIZATION			
Were you hospitalized for how you were feeling?	1	2	3
For how many days?	___ Days		
Did you receive shock treatment?	1	2	3
Did shock treatment terminate your feelings of being high?	1	2	3
4. SIGNIFICANT DISTRESS			
How bothered have you been by your high mood or the symptoms we discussed? Have they caused you much distress?	1	2	3

If yes, please describe:

	WORST EPISODE		
	NA/NO INFO	NO	YES
5. OVERALL ROLE IMPAIRMENT			
Did your mood or the symptoms we discussed interfere with or affect your normal, daily routine in any way?	1	2	3

If yes, please describe:

6. OCCUPATIONAL/ACADEMIC IMPAIRMENT

Did you stay home from work (or school) because of the way you were feeling? Was it harder to do your job because of the way you felt?	1	2	3

If yes, please describe:

7. SOCIAL IMPAIRMENT

Was your social life affected by how you were feeling or acting? Were there any difficulties or problems with friends because of how you were feeling or acting?	1	2	3

If yes, please describe:

8. HOME/FAMILY IMPAIRMENT

Was there a change in the way you interacted with your family or how you performed your household chores?	1	2	3

If yes, please describe:

F. Criteria Check

1. DSM-III-R/IV RULE OUTS FOR MANIA	NA/ No Info	False	True
a. Mood disturbance sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or to others or psychotic features are present.	1	2	3
b. At no time during the disturbance have there been delusions or hallucinations for as long as two weeks in the absence of prominent mood symptoms (i.e., before the mood symptoms developed or after they have remitted).	1	2	3

	NA/ No Info	False	True
c. Not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder NOS.	1	2	3
d. An organic factor did not initiate and maintain the disturbance.	1	2	3

Note: *Antidepressant treatment (drugs, ECT) that appears to precipitate a mood disturbance should not be considered an etiologic organic factor. DSM-IV: Antidepressant induced Manic Disorder*

CRITERIA FOR HYPOMANIA

Symptoms and mood disturbance exists with no marked impairment in functioning, no hospitalization and no psychotic features.

Conclusion:

1. Met criteria for DSM-III-R/IV Mania	1	2	3
2. Met criteria for DSM-III-R Hypomania	1	2	3
3. Met criteria for DSM-IV Hypomania	1	2	3

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LIFECHART

We have already discussed different periods in your life when you had the problems we just talked about. Let's clarify the timing of those periods starting with the worst episode. *Code Manic Disorder: MAN, HYO.*

Code	Onset			Offset			Duration	Status of Episode	Treatment Received
	Month	Year	Age	Month	Year	Age		1 - NA/No Info 2 - Prodromal or Partial Symptoms 3 - Full Syndrome Present	1 - NA/No Info 2 - No treatment 3 - Medication 4 -Psychotherapy 5 -Hospitalization 6 - Other
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___ ___	9 ___	___ ___ ___ ___
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___ ___	___	___ ___ ___ ___
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___ ___	___	___ ___ ___ ___
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___ ___	___	___ ___ ___ ___
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___ ___	___	___ ___ ___ ___
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___ ___	___	___ ___ ___ ___
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___ ___	___	___ ___ ___ ___
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___ ___	___	___ ___ ___ ___
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___ ___	___	___ ___ ___ ___
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___ ___	___	___ ___ ___ ___

A. Screening Questions

Now I am going to ask you about your childhood and early adolescence (before the age of 16). Did you go to local schools (elementary, junior high, high school)? How far away from home? Did you ride a bus, car pool, or walk to school? Did you ever go away for visits with relatives, or stay over at friends' houses, when your family stayed at home? What about camp? If you went to camp, did you get homesick? How about if you stayed at a friend or relative's house, did you get homesick?

Did your family generally do things together (picnics, vacations, movies, etc.)?

Did you often refuse to be separated from your mother or father?

Did you ever feel excessive fear or anxiety when you were separated from your father or mother? How often would you feel strong fear?

Did you refuse to go to school or refuse to sleep at friends' houses?

When you were separated from your mother or father were you preoccupied by thoughts that something bad would happen to one or both of them?

Code YES if subject indicates that excessive fear, anxiety or thoughts of harm to caretakers followed separation on more than 2 occasions.

1	NA/NO INFORMATION
2	NO
3	YES
	SKIP TO PANIC DISORDER, PAGE 62

B. Chronology

Interviewer should determine the onset and duration of each symptom in the symptom review. Establish the frequency of all symptoms. If more than one episode, establish which is worst.

C. Symptom Review

1. PERSISTENT RELUCTANCE OR REFUSAL TO GO TO SCHOOL IN ORDER TO STAY WITH MAJOR ATTACHMENT FIGURES OR AT HOME *(Exclude first few days of kindergarten or 1st grade)*

As a child, did you have any difficulty going to school? For example, did you ever refuse to go to school?

1 NA/No Information

2 No, never refused to go to school

3 Occasionally refused

4 Frequently refused, but parent insisted

5 Frequently refused, and affected attendance

6 Very frequently refused and had a marked effect on attendance (20% of school days missed, i.e., at least one day/week)

Did your mother ever stay in school with you?

1 NA/No Information

2 No, mother never stayed in school

3 Occasionally, for less than an hour

4 Occasionally, for the entire day

5 Frequently, for less than an hour

6 Frequently, for the entire day

2. COMPLAINTS OF PHYSICAL SYMPTOMS ON SCHOOL DAYS UPON SEPARATION

When you were in elementary school, on school days, did you have physical problems such as stomach aches, headaches, nausea, dizziness, or vomiting so that you couldn't go to school, or were sent home from school? Did you have physical problems when you were not with your mother or father? Was there always something to explain the physical symptoms such as a virus, tonsils, or pneumonia?

1 NA/No Information

2 No physical problems

3 Occasional physical symptoms

4 Frequent symptoms, (always explained by illness)

5 Frequent symptoms,(not always explained by illness)

6 Frequent symptoms (not always explained by illness) resulting in missing school, or in being sent home

How was your sleep during childhood? Was there ever a period when you had nightmares? Do you recall any of them? What about when you were in junior high school, or high school?

1 NA/No Information

2 No nightmares

3 Occasionally had nightmares

4 Frequent nightmares (once a week) but unclear if involved theme of separation

5 Frequent nightmares clearly involving theme of separation

6 Almost every night had nightmares involving theme of separation

4. PERSISTENT RELUCTANCE OR REFUSAL TO GO TO SLEEP WITHOUT BEING NEXT TO A MAJOR ATTACHMENT FIGURE

a. In childhood, were you ever afraid to sleep alone? Did you ever insist that your mother or father (brother, sister) stay with you while you fell asleep or that s/he sleep with you?

1 NA/No Information

2 No discomfort or fear

3 Somewhat uncomfortable sleeping alone

4 Afraid, but never expressed fear or occasionally refused to sleep alone

5 Very afraid, but never expressed fear, or frequently refused

6 Terrified, or almost always refused

b. What about sleeping away from home?
Were you ever reluctant to go to camp, or to stay over a friend's house because the thought of being away from home upset you? Did you ever refuse? Did you get very homesick when you were away from home?

1 NA/No Information

2 No reluctance or refusal

3 Somewhat uncomfortable sleeping away from home

4 Occasionally made excuses, or refused

5 Frequently made excuses/refused or felt very homesick

6 Almost always made excuses/refused or was overwhelmed with homesickness.

5. UNREALISTIC WORRY ABOUT POSSIBLE HARM BEFALLING MAJOR ATTACHMENT FIGURES OR FEAR THAT THEY WILL LEAVE AND NOT RETURN

When you were a child, did you worry a lot about bad things happening to your (mother)? Did you worry that she might leave and never return? Or that she might be killed in an accident, or die of a serious illness?

1 NA/No Information

2 No worry about (mother)

3 Occasionally had fleeting thoughts

4 Occasionally brooded

5 Frequently worried

6 Constantly worried

6. UNREALISTIC WORRY THAT AN UNTOWARD CALAMITOUS EVENT WILL SEPARATE THE CHILD FROM A MAJOR ATTACHMENT FIGURE

What about worries concerning yourself? When you were a child, did you worry a lot about being lost or kidnapped? Or about being in an accident, or being killed?

1 NA/No Information

2 No worry about self

3 Occasionally had fleeting thoughts

4 Occasionally brooded

5 Frequently worried

6 Constantly worried

7. PERSISTENT AVOIDANCE OF BEING ALONE IN THE HOME, AND EMOTIONAL UPSET IF UNABLE TO FOLLOW THE MAJOR ATTACHMENT FIGURE AROUND THE HOME

When you were a child, did you ever follow your (mother) around the house? Did you get upset if you couldn't be in the same room with her? (How did you react?) Did you become upset if she left you alone in a room?

1 NA/No Information

2 No shadowing or discomfort

3 No shadowing, but some discomfort (when parent left room)

4 Occasional shadowing, or some discomfort expressed (e.g., crying) (when parent left room)

5 Frequent shadowing, or frequent/intense discomfort expressed (e.g., tantrums) (when parent left room)

6 Frequent shadowing, or frequent/intense always (when parent left room)

(NOTE: If reported before age 6, must be excessive for age)
8. SIGNS OF EXCESSIVE DISTRESS UPON SEPARATION, OR WHEN ANTICIPATING SEPARATION, FROM MAJOR ATTACHMENT FIGURES

How would you react when your (parents) were about to leave the house? (Going shopping, to work, etc.?) Would you ever cry, or plead with them not to leave?

1 NA/No Information
2 No discomfort
3 Some discomfort (not expressed) when parent left
4 Some discomfort expressed (e.g., crying) when parent left
5 Frequent tantrums when parent left
6 Tantrums always when parent left

9. SIGNS OF EXCESSIVE DISTRESS UPON SEPARATION FROM MAJOR ATTACHMENT FIGURE
(Note: In DSM-IV, 8 and 9 are combined)
How would you react when your (parents) left the house? (Going shopping, to work, etc.?) Would you ever cry, or plead with them not to leave?

1 NA/No Information
2 No discomfort
3 Some discomfort (not expressed) when parent left
4 Some discomfort expressed (e.g., crying) when parent left
5 Frequent tantrums when parent left
6 Tantrums always when parent left

Note: For both 8 and 9, if anxiety is reported before age 6, it must be of panic proportions to qualify as clinically significant

D. Criteria Check

(Positive is rating at least 5 or 6 level)

1. HAS HAD AT LEAST 3 OF THE PREVIOUS SYMPTOMS

1 NA/No Information
2 Less than 3 symptoms
3 At least 3 symptoms

2. ESTABLISH THAT AT LEAST 3 OF THE 9 SYMPTOMS COEXISTED OR OCCURRED DURING THE SAME PERIOD *(e.g., within the same year)*
You mentioned (having worries, nightmares, fear of being alone), did you have these feelings around the same time?

1 NA/No Information
2 3 symptoms did not co-exist
3 At least 3 symptoms coexist

3. DURATION OF DISTURBANCE
How long did this go on for? How old were you when it started? The last time it happened?

1 NA/No Information

2 Lasted less than 2 weeks

3 Lasted at least 2 weeks *(DSM-III-R)*

4 Lasted at least 4 weeks *(DSM-IV)*

	NA/NO INFO	FALSE	TRUE
EXCLUSIONS			
The disturbance does not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and is not better accounted for by Panic Disorder with Agoraphobia (in adolescents and adults).	1	2	3

E. Impairment

1. HELP SEEKING
Did you or your (parents) seek help from anyone, or did anyone suggest that you seek help? Did you go to a special school? Did you receive any treatment?

1 NA/No Information

2 Never sought or was referred for help

3 Was referred for help but did not follow through

4 Sought help but did not receive treatment

5 Received treatment but for less than 2 weeks

6 Continuous treatment for 2 weeks to less than 2 months

7 Continuous treatment for 2 months to less than 1 year

8 Continuous treatment for 1 year to less than 3 years

9 Continuous treatment for 3 years or more

	NA/NO INFO	NO	YES
2. TOOK MEDICATION **a. Did you take medicine?**	1	2	3

If yes, **What did you take?**_____

	NA/NO INFO	NO	YES
b. Did you take more than medicine usual or did you use nonprescription drugs?	1	2	3
If yes, **What did you take?**_____			
3. HOSPITALIZATION **Were you hospitalized or sent to a residential treatment school for how you were feeling?**	1	2	3
For how many days?	___ Days		
4. OVERALL ROLE IMPAIRMENT **Did your fears/anxieties and the symptoms we just discussed interfere with or affect your normal, daily routine in any way?**.	1	2	3

If yes, please describe:

5. ACADEMIC IMPAIRMENT

Did you stay home from school because of your fears/ anxieties? Were your grades affected?	1	2	3

If yes, please describe:

6. SOCIAL IMPAIRMENT

Was your social life affected by how you were feeling? Were there any difficulties or problems with friends because of how you were feeling?	1	2	3

If yes, please describe:

7. HOME/FAMILY IMPAIRMENT

Was there a change in your family relations or how you performed your household chores?	1	2	3

If yes, please describe:

	NA/NO INFO	NO	YES
8. SIGNIFICANT DISTRESS **Were you bothered by the anxiety or the symptoms we just discussed? Were you distressed by them?**	1	2	3

If yes, please describe:

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LIFECHART

We have already discussed different periods in your life when you had the problems we just talked about. Let's clarify the timing of those periods starting with the worst episode. *Code Separation Anxiety Disorder: SEP.*

	Onset			Offset				Status of Episode	Treatment Received
Code	**Month**	**Year**	**Age**	**Month**	**Year**	**Age**	**Duration**	1 - NA/No Info 2 - Prodromal or Partial Symptoms 3 - Full Syndrome Present	1 - NA/No Info 2 - No treatment 3 - Medication 4 -Psychotherapy 5 -Hospitalization 6 - Other
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	_ _ _	9 ___	__ __ __ __
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	_ _ _	___	__ __ __ __
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	_ _ _	___	__ __ __ __
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	_ _ _	___	__ __ __ __
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	_ _ _	___	__ __ __ __
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	_ _ _	___	__ __ __ __
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	_ _ _	___	__ __ __ __
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	_ _ _	___	__ __ __ __
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	_ _ _	___	__ __ __ __
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	_ _ _	___	__ __ __ __

1. PANIC ATTACKS

Determine if the subject has ever had panic attacks, i.e., at least 1 circumscribed episode of intense fear or apprehension with sudden onset (not associated with life threatening or clearly frightening situations or due to a known physical cause such as amphetamine use or hyperthyroidism) accompanied by at least 2 of the associated symptoms below, which reaches peak intensity within 10-15 minutes.

Ask all of the questions even if sudden, intense anxiety is denied or different terms are used in association with the physical symptoms.

In this section, we will focus on feelings of anxiety. By anxiety I mean tense, jittery or nervous feelings. Some people have sudden periods or "attacks" of anxiety that build up very rapidly to a peak of extreme terror or panic. Sometimes these attacks seem to come "out-of-the-blue", that is unexpectedly for no apparent reason. At other times, attacks are associated with certain situations.

A. Screening Questions

In this section, we will first discuss sudden spontaneous attacks. Attacks associated with situations will be discussed later.

Have you ever had periods when suddenly, out of the blue, you felt very anxious, fearful and uncomfortable--a surge of fear or terror that reached a peak very rapidly? (Was there anything particularly frightening going on at the time? Had you been taking drugs or exercising? Were there other times?)

1	No Information
2	Never had sudden anxiety
3	Never except in a life-threatening, clearly frightening situation (this does not include phobic situation)
4	Yes, only when under physical exertion
5	Yes, only when on drugs
6	Yes, other than above

SKIP TO NEAR PANIC PAGE 71

B. Chronology

*The interviewer should ask the subject to describe **the first spontaneous attack,** then ask about **the worst** and the **usual** attacks and code below. Also ask how long it took for the symptoms to reach a peak. Clarify the difference between spontaneous, situationally predisposed, and situationally bound attacks. Determine when attacks began and how many, if any, periods of remission have occurred.*

C. Symptom Review - Spontaneous Panic Attacks

During the worst attacks of intense anxiety, did you have any physical symptoms such as: (How about during a usual attack?)	**Worst Past Episode**			**Usual Episode**		
	NA/NO INFO	**NO**	**YES**	**NA/NO INFO**	**NO**	**YES**
1. PALPITATIONS OR FEEL YOUR HEART BEAT RAPIDLY?	1	2	3	1	2	3
2. SWEATING?	1	2	3	1	2	3
3.TREMBLING OR SHAKING?	1	2	3	1	2	3
4. SHORTNESS OF BREATH OR SMOTHERING SENSATIONS?	1	2	3	1	2	3
5. CHOKING FEELINGS?	1	2	3	1	2	3
6. CHEST PAIN OR DISCOMFORT?	1	2	3	1	2	3
7. ABDOMINAL CRAMPS, DIARRHEA, OR NAUSEA?	1	2	3	1	2	3
8. FEELING DIZZY, UNSTEADY, LIGHTHEADED, OR FAINT?	1	2	3	1	2	3
9. A SENSE OF UNREALITY, OR DETACHMENT FROM YOURSELF?	1	2	3	1	2	3
10. FEAR OF GOING CRAZY, OR LOSING CONTROL DURING THE ATTACK?	1	2	3	1	2	3

	Worst Past Episode			Usual Episode		
	NA/NO INFO	NO	YES	NA/NO INFO	NO	YES
11. FEAR OF DYING?	1	2	3	1	2	3
12. TINGLING OR NUMBNESS (PARESTHESIAS)?	1	2	3	1	2	3
13. HOT FLUSHES OR CHILLS?	1	2	3	1	2	3

SYMPTOM SUMMARY COUNT

MAXIMUM NUMBER OF SYMPTOMS USUALLY ASSOCIATED WITH ANXIETY (IN A SINGLE ATTACK) ____ ____

DURATION OF BUILD-UP

How long did it take to build up (reach a peak)? That is, how much time would pass from the beginning of the first physical symptom to most of the other symptoms that you experienced? Was that true for the majority of your attacks?

OCCURRED WITHIN 10 TO 15 MINUTES FOR MOST ATTACKS

1 NA/ No Information

2 No

3 Yes

HAD SUDDEN INTENSE FEAR, APPREHENSION, OR DISCOMFORT, AND AT LEAST:

Limited Panic Attack

1 No associated symptoms (anxiety only)

2 1 symptom

3 2 symptoms

4 3 symptoms

If less than or equal to 3 symptoms skip to section page 6 (Limited spontaneous symptom attacks)

Full Panic Attack

5 4 or more symptoms (DSM-III-R/ DSM-IV)

D. Other Characteristics

1. PRECIPITANT OF ATTACK

Determine if the attacks were spontaneous, mixed or limited to exposure to some phobic object or situation.

I have asked you about panic attacks that were unexpected or "out-of-the-blue". Now, did you ever have other attacks that occurred in one or more specific situations?

1 NA/No Information

2 No

3 Yes

If yes which of the following is true for you?

1 No predicting when or where an attack will occur (i.e., all spontaneous)

2 Most attacks are spontaneous, but some occur in one or more specific situations (e.g., elevators)(Some situationally predisposed attacks.)

3 Attacks are fairly predictable in that the majority but not all occur under specific circumstances (Mostly situationally predisposed attacks.)

4 Attacks are mostly completely predictable and occur under one or more sets of specific circumstances (Situationally bound attacks.)

Skip to Near Panic pg. 71

2. ONSET OF ATTACKS

Age of onset of first spontaneous full panic attack (4 or more associated symptoms)

_____

Age

Date of onset of first spontaneous full panic attack

_____/_____

Month Year

LAST PANIC ATTACK

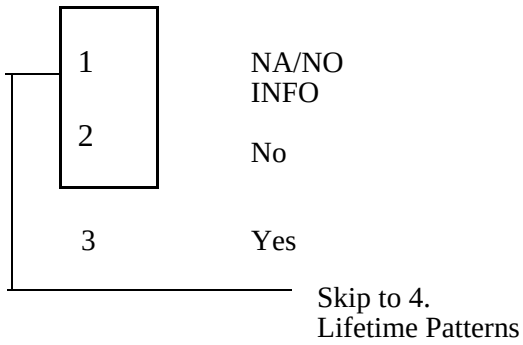
When was your last full panic attack?

_____/_____

Month Year

3. NOCTURNAL PANIC ATTACKS

Have you ever been awakened by a panic attack?



If yes: **Were you having a bad dream at the time?**

1 NA/NO INFO

2 No

3 Yes

DESCRIBE:

_____

_____

_____

4. LIFETIME PATTERN OF SPONTANEOUS PANIC ATTACKS

Approximately how many panic attacks have you had in your lifetime? Too many to count? Only a few? Was there a pattern?

1 NA/No Information

2 Only had 1 in lifetime

3 Only had a few scattered over many years

4 Life pattern of a few attacks per year for several years

5 Panic attacks clustered together over brief period but never enough to meet DSM-III-R criteria (e.g., 2 in 3 weeks)

6 Enough to meet DSM-III-R (4 attacks in 4 weeks) criterion.

5. LIMITED SPONTANEOUS SYMPTOM ATTACKS
If a person reported limited symptom panic attacks continue. If not skip to WORST EPISODE.
You mentioned that you had sudden intense anxiety accompanied by only *(3, 2, or 1)* symptoms

When did you first have that kind of attack?

_____
Age

DATE OF ONSET OF FIRST LIMITED SYMPTOM ATTACK _____/_____
Month Year

FREQUENCY OF LIMITED SYMPTOM ATTACKS

1 = NA/No Information

2 = Once every 3 months

3 = Once a month

4 = A few per month but not weekly

5 = Weekly

6 = More than 1 per week

6. WORST EPISODE OF FULL OR LIMITED SYMPTOM ATTACKS
Frequency of panic attacks during worst period of attacks if one episode or worst episode if two or more episodes(spontaneous and/or situationally predisposed). If person has both full and limited ask about full attacks.

a. For how long did you experience panic attacks? For how many weeks?

WEEKS

Indicate whether spontaneous or situationally predisposed

_____

b. What was the frequency, per day or per week, of your attacks?

1 NA/No Information

2 Once in 3 weeks

3 Twice in 3 weeks

4 Once a week

5 More than once a week but not daily

6 1 or more a day

	WORST EPISODE		
	NA/NO INFO	NO	YES
c. During this time, did you ever experience 4 attacks in 4 weeks?	1	2	3

d. Did you ever find yourself worrying a lot about having additional attacks?

1 NA/No Information

2 No worry or anxiety

3 Yes, some fear/worry but not persistent for at least 1 month

4 Yes, persistent fear/worry of having an attack or consequences of an attack for at least 1 month

e. Were you worried about the consequences of the attacks such as having a heart problem, losing control, or going crazy?

1 NA/No Information

2 No worry or anxiety

3 Yes, some fear/worry but not persistent for at least 1 month

4 Yes, persistent fear/worry of having an attack or consequences of an attack for at least 1 month

f. Did the attacks cause you to change your behavior in any way?

1 NA/No Information

2 No change in behavior

3 Yes, some change but did not last for at least 1 month

4 Yes, some change that lasted for at least 1 month

*If yes, please describe:*_____

_____

_____

_____

Please describe the course of panic attacks over the years, regarding the frequency of attacks in different periods, as well as worry about additional attacks, worry about consequences of attacks or change in behavior:

_____

_____

_____

_____

_____

E. Impairment

	NA/NO INFO	NO	YES
		WORST EPISODE	
1. SOUGHT HELP **Did you seek help from anyone, like a doctor or other professional?**	1	2	3
or minister?	1	2	3
or even a friend?	1	2	3
or did someone suggest that you seek help?	1	2	3
2. TOOK MEDICATION **a. Did you take medicine?** *If yes,* **What did you take?**	1	2	3
b. Did you take more medicine than usual or use nonprescription drugs? *If yes,* **What did you take?**	1	2	3
3. HOSPITALIZATION **a. Did you ever visit the emergency room for the way you were feeling?**	1	2	3
b. Were you hospitalized for how you were feeling?	1	2	3
For how many days?		___ DAYS	
4. OVERALL ROLE IMPAIRMENT **Did panic attacks prevent you from doing things or cause you to be less efficient in what you were doing, or interfere with your normal, daily routine in any way?** *If yes, please describe:*	1	2	3

	WORST EPISODE		
	NA/NO INFO	**NO**	**YES**
5. OCCUPATIONAL/ACADEMIC IMPAIRMENT **Did panic attacks interfere with your ability to do your job (or school)?** *If yes, please describe:*	1	2	3
6. SOCIAL IMPAIRMENT **Did panic attacks interfere with your social life or cause problems with friends?** *If yes, please describe:*	1	2	3
7. HOME/ FAMILY IMPAIRMENT **Was there a change in the way you interacted with your family or how you performed your household chores as a result of panic attacks?** *If yes, please describe:*	1	2	3
8. SIGNIFICANT DISTRESS **Did you find that you were very distressed about how you were feeling or acting?** *If yes, please describe:*	1	2	3

2. NEAR PANIC ATTACKS

Determine if the subject has had somatic only "panic attacks" which consist of sudden onset of physical symptoms such as shortness of breath, palpitations and dizziness which build up rapidly and peak within 10 minutes and go away. Distinguish that there is no accompanying panic or sudden anxiety of any sort. If subject describes fear of any kind such as fear of going crazy or losing control or dying during the attack, this is considered a panic attack or limited symptom attack.

A. Introductory Probe and Screening Questions

IF EVER HAD PANIC DISORDER, PANIC ATTACKS OR LIMITED SYMPTOM ATTACKS SKIP TO AGORAPHOBIA PAGE 79.

In the last section we talked about sudden attacks of fear, anxiety or panic which come out of the blue and build up rapidly to a peak within a few minutes. This section deals with another type of attack which comes on suddenly and builds up rapidly and peaks within a few minutes. This attack consists of <u>only</u> physical symptoms, for instance having your heart race suddenly and feeling short of breath for no particular reason. These symptoms quickly peak and go away. Has anything like that ever happened to you?

If subject describes any type of fear or anxiety present in the somatic only attack, then go back to the panic disorder section and change the screening item to yes and code section. Enter this section only if subject never had any kind of attack of sudden intense anxiety.

SOMATIC SYMPTOMS WITHOUT SUDDEN INTENSE ANXIETY OR FEAR (NOT LIMITED TO ILLNESS, EXERCISE OR DRUGS/ALCOHOL)

1	NA/NO INFORMATION
2	NO
3	YES

SKIP TO AGORAPHOBIA PAGE 79

B. Chronology

At this point, the interviewer should establish chronology for him/herself regarding the number of episodes, duration and severity of each and record this information below. If more than one episode establish which is the worst.

During these attacks what symptoms did you experience?	WORST EPISODE		
	NA/NO INFO	NO	YES
1. Did you experience shortness of breath or couldn't catch your breath or take a deep breath?	1	2	3
2. Did you experience palpitations or feel your heart beat rapidly?	1	2	3
3. Did you experience chest pain or discomfort?	1	2	3
4. Did you experience choking feelings?	1	2	3
5. Did you experience smothering feelings?	1	2	3
6. Did you feel dizzy, light-headed, or have unsteady feeling?	1	2	3
7. Did you feel as if things were unreal or you were in a dream?	1	2	3
8. Did you experience tingling or numbness (paresthesias)?	1	2	3
9. Did you experience hot flushes or chills?	1	2	3
10. Did you experience sweating?	1	2	3
11. Did you experience faintness or fear of passing out?	1	2	3
12. Did you experience abdominal cramps, diarrhea, or nausea?	1	2	3
13. Did you experience trembling or shaking?	1	2	3

C. Symptom Review

1. FREQUENCY OF NEAR PANIC ATTACKS

1 NA/No Information

2 Never had a period of "near panic" without full panic

3 Only 1 or 2 "near panics" during lifetime

4 Numerous "near panics" but never more than 2 or 3 a year

5 Numerous "near panics" but never more than 5 or 6 a year

6 At least 1 "near panic" a month for at least 3 months

7 At least 2 "near panics" a month for at least 3 months

8 At least 3 "near panics" in a 3-week period

9 At least 6 "near panics" in a 6-week period

	WORST EPISODE		
	NA/NO INFO	NO	YES
a. HAD AT LEAST ONE NEAR PANIC IN PAST	1	2	3
b. CURRENTLY HAS (IN PAST 2 MONTHS) NEAR PANIC	1	2	3

2. AVOIDANT BEHAVIOR

Sometimes when people get these near panic attacks, they find that it is uncomfortable for them to do certain things or go to certain places like driving, shopping, being in crowds or crowded places. Has that ever happened to you? What situations make you uncomfortable because of near panic attacks?

(*Score these situations in the agoraphobia section)*

1 NA/No Information

2 "Near panic" attacks with no avoidance behavior

3 "Near panic" attacks with mild avoidance behavior

4 "Near panic" attacks with moderate avoidance behavior

5 “Near panic” attacks with severe avoidance behavior

D. Impairment

	WORST EPISODE		
	NA/NO INFO	NO	YES
1. SOUGHT HELP **Did you seek help from anyone, like a doctor or other professional?**	1	2	3
or minister?	1	2	3
or even a friend?	1	2	3
or did someone suggest that you seek help?	1	2	3
2. TOOK MEDICATION **a. Did you take medicine?** *If yes,* **What did you take?**	1	2	3
b. Did you take more medicine than usual or did you use nonprescription drug? *If yes,* **What did you take?**	1	2	3
3. HOSPITALIZATION **a. Did you go to the emergency room for the way you were feeling?**	1	2	3
b. Were you hospitalized for how you were feeling?	1	2	3
For how many days ?		___ DAYS	
4. OVERALL ROLE IMPAIRMENT **Did these anxiety attacks prevent you from doing things or cause you to be less efficient in what you were doing, or interfere with your normal, daily routine in any way?** *If yes, please describe:*	1	2	3
5. OCCUPATIONAL/ACADEMIC IMPAIRMENT **Did these anxiety attacks interfere with your ability to do your job (or school)?** *If yes, please describe:*	1	2	3
6. SOCIAL IMPAIRMENT **Did these anxiety attacks interfere with your social life or cause problems with friends?** *If yes, please describe:*	1	2	3

	WORST EPISODE		
	NA/NO INFO	NO	YES
7. HOME/ FAMILY IMPAIRMENT **Was there a change in the way you interacted with your family or how you performed your household chores?** *If yes, please describe:*	1	2	3
8. SIGNIFICANT DISTRESS **Did you find that you were very distressed about how you were feeling or acting?** *If yes, please describe:*	1	2	3

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LIFECHART

We have already discussed different periods in your life when you had the problems we just talked about. Let's clarify the timing of those periods starting with the worst episode. *Code Panic Disorder: PAN, Near Panic Disorder: PNR., Isolated Panic Attack: ISO.*

Code	Onset			Offset			Duration	Status of Episode	Treatment Received
	Month	Year	Age	Month	Year	Age		1 - NA/No Info 2 - Prodromal or Partial Symptoms 3 - Full Syndrome Present	1 - NA/No Info 2 - No treatment 3 - Medication 4 -Psychotherapy 5 -Hospitalization 6 - Other
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	9 ___	__ __ __ __
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	___	__ __ __ __
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	___	__ __ __ __
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	___	__ __ __ __
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	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	___	__ __ __ __
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	___	__ __ __ __

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1. AGORAPHOBIA

If subject has had Panic Disorder, panic attacks, limited symptom attacks or near panic attacks determine the avoidance behavior associated with these attacks.
If subject has no history of any type of panic or near panic attack, determine if he/she has ever felt uncomfortable, afraid or avoided situations because of a fear of panic-like symptoms where escape might be difficult or embarrassing.

A. Screening Questions

IF HAS HAD PANIC DISORDER OR PANIC ATTACKS, LIMITED SYMPTOM ATTACKS OR NEAR PANIC ATTACKS ASK:

Since you have been having panic attacks, are there any situations like driving, flying, crowds or being alone which make you nervous or uncomfortable or you avoid for fear of having an attack?

IF HAS NEVER HAD ANY PANIC ATTACKS OF ANY SORT, ASK:

Are there any situations which make you nervous or uncomfortable or you avoid like driving, crowds, enclosed places, traveling, being alone or doing things by yourself?

1	NA/No Information
2	No: evidence of fear, avoidance or endurance with dread
3	Yes: Some evidence of fear, avoidance or endurance with dread

1	NA/No Information
2	No: evidence of fear, avoidance or endurance with dread
3	Yes: Some evidence of fear, avoidance or endurance with dread

SKIP TO SIMPLE PHOBIA PAGE 86

This condensed screening is used to shorten the length of the time needed to score the Phobia section. Use the scale point levels noted below to rate the greatest level of severity of avoidance EVER manifested. If the specific situation has a 5 or higher, the remainder of the line should be completed.

1. Have you ever been nervous, uncomfortable or avoided RIDING IN CARS, BUSES, SUBWAYS, OR DRIVING A CAR? *(If YES , ask*) **Which situation bothers you? What are you afraid of in** (situation)? **How nervous and uncomfortable have you gotten when exposed to** *(situation)* **at its worst?** *(Rate)*

_____

2. Have you ever been nervous, uncomfortable or avoided ELEVATORS, CROWDS, CLOSED SPACES, OR DARK PLACES? *(If YES ask*) **Which situation bothers you? What are you afraid of in** (situation)? **How nervous and uncomfortable have you gotten when exposed to** *(situation)* **at its worst?** *(Rate)*

_____

3. Have you ever been nervous, uncomfortable or avoided HEIGHTS? *(If YES ask*) **What are you afraid of in** (situation)? **How nervous and uncomfortable have you gotten when exposed to** *(situation)* **at its worst?** *(Rate)*

_____

4. Have you ever been nervous, uncomfortable or avoided AIRPLANES OR BOATS? *(If YES ask*) **Which situation bothers you? What are you afraid of in** (situation)? **How nervous and uncomfortable have you gotten when exposed to** *(situation)* **at its worst?** *(Rate)*

_____

6. Have you ever been nervous, uncomfortable or avoided DOCTORS OR DENTISTS? *(If YES ask*) **Which situation bothers you? What are you afraid of in** (situation)? **How nervous and uncomfortable have you gotten when exposed to** *(situation)* **at its worst?** *(Rate)*

_____

7. Have you ever been nervous, uncomfortable or avoided STANDING IN LINE, BEING ALONE, OR BEING FAR FROM HOME? *(If YES ask*) **Which situation bothers you? What are you afraid of in** (situation)? **How nervous and uncomfortable have you gotten when exposed to** *(situation)* **at its worst?** *(Rate)*

_____

8. Are there any other situations that have made you nervous or uncomfortable which I have not already asked about? *(If YES ask)* **Which situation bothers you? What are you afraid of in** (situation)? **How nervous and uncomfortable have you gotten when exposed to** *(situation)* **at its worst?** *(Rate)*

_____

SCALE OF SEVERITY OF FEAR OR AVOIDANCE BEHAVIOR

1 = NA/No Information
2 = No apparent fear or discomfort
3 = Has had no occasion to confront situation
4 = Definite fear or discomfort, but not irrational (in the rater's opinion)
5 = Definite irrational fear or discomfort but no avoidance
6 = Definite irrational fear or discomfort and mild avoidance (e.g., some adaptive behavior to cope with the likelihood of having to deal with the object or situation)
7 = Definite irrational fear or discomfort and moderate avoidance
8 = Definite irrational fear or discomfort and severe avoidance (e.g., must leave area when confronted with phobic object or situation; attempts to avoid confrontation with phobic object or situation prevents subject from working or carrying out duties or attending school)

B. Review of Agoraphobic Fears

Only ask about onset and offset if level of severity of fear/ avoidance is 5+.	**Worst Episode**			**Fear Attributed to Panic Attacks**		**Worst Episode**			**Fear Attributed to Panic Attacks**
	Greatest Level Severity Ever	Date Onset	Date Offset	1=NA/NI 2 =NO 3 =YES		Greatest Level of Severity Ever	Date Onset	Date Offset	1=NA/NI 2= NO 3= YES
1. Riding in cars, buses, subways		/	/	1 2 3	**8. Airplanes**		/	/	1 2 3
2. Driving oneself		/	/	1 2 3	**9. Boats**		/	/	1 2 3
3. Elevators		/	/	1 2 3	**10. Dr./Dentist appointment**		/	/	1 2 3
4. Crowds		/	/	1 2 3	**11. Standing in line**		/	/	1 2 3
5. Closed spaces		/	/	1 2 3	**12. Being alone**		/	/	1 2 3
6. Dark places		/	/	1 2 3	**13. Being far from home**		/	/	1 2 3
7. Heights		/	/	1 2 3	**14. Other**		/	/	1 2 3

If no fear of "5" or higher- SKIP TO SIMPLE PHOBIA, PAGE 86

3. LEVELS OF SEVERITY DURING WORST EPISODE
(Make ratings below for most severe past and/or current episode)
During the worst time how bad did it get? How much did it affect your life? Did you stop going places? Did you stay in the house? Did having someone with you make a difference?

a. SEVERITY WITHOUT TRUSTED COMPANION

1	NA/No Information
2	No avoidance, endurance with dread only
3	Avoids 1 or 2 activities, but continues to be able to leave home alone
4	Avoids many activities, but continues to be able to leave home alone
5	Avoids 1 or 2 activities, and has to force self to leave home alone
6	Avoids many activities, and has to force self to leave home
7	Unable to leave home alone but can carry on work within home
8	Unable to leave home alone and moderately impaired functioning even when at home
9	Unable to leave home alone and severely impaired functioning at home even with others nearby

b. SEVERITY WITH TRUSTED COMPANION

1	NA/No Information
2	No avoidance. Endurance with dread only
3	Avoids 1 or 2 activities, but continues to be able to leave home when accompanied
4	Avoids many activities, but continues to be able to leave home when accompanied
5	Avoids 1 or 2 activities and has to force self to leave home
6	Avoids many activities and has to force self to leave home
7	Unable to leave home, but can carry on work within home
8	Unable to leave home, and functioning is moderately impaired
9	Unable to leave home and functioning is severely impaired

NOTE: A SUBJECT CANNOT BE DIAGNOSED AS HAVING AGORAPHOBIA WITHOUT PANIC DISORDER IF AN EPISODE OF PANIC DISORDER EVER PRECEDED THE EPISODE OF AGORAPHOBIA. HOWEVER, A SUBJECT CAN BE DIAGNOSED AS HAVING AGORAPHOBIA WITHOUT PANIC DISORDER IF AN EPISODE OF PANIC DISORDER FOLLOWED THE EPISODE OF AGORAPHOBIA.

C. Impairment

	NA/NO INFO	NO	YES
1. SOUGHT HELP **Did you seek help from anyone, like a doctor or other professional?**	1	2	3
or minister?	1	2	3
or even a friend?	1	2	3
or did someone suggest that you seek help?	1	2	3
2. TOOK MEDICATION **a. Did you take medicine?** *If yes,* **What did you take?**	1	2	3
b. Did you take more medicine than usual or use nonprescription drugs? *If yes,* **What did you take?**	1	2	3
3. HOSPITALIZATION **Were you hospitalized for how you were feeling?**	1	2	3
For how many days?		___ DAYS	
4. OVERALL ROLE IMPAIRMENT **Did your fears prevent you from doing things or cause you to be less efficient in what you were doing, or interfere with your normal, daily routine in any way?**	1	2	3
5. OCCUPATIONAL/ACADEMIC IMPAIRMENT **Did your fears interfere with your ability to do your job (or school)?**	1	2	3

If yes, please describe:

If yes, please describe:

	NA/NO INFO	NO	YES
6. SOCIAL IMPAIRMENT	1	2	3

Did your fears interfere with your social life or cause problems with friends? *If yes, please describe*:

7. HOME/ FAMILY IMPAIRMENT	1	2	3

Was there a change in the way you interacted with your family or how you performed your household chores? *If yes, please describe*:

8. SIGNIFICANT DISTRESS	1	2	3

Did you find that you were very distressed about how you were feeling or acting? *If yes, please describe*:

CRITERIA CHECK	NA/NO INFO	FALSE	TRUE
a. Has met DSM-III-R criteria for Agoraphobia	1	2	3
b. Has met DSM-IV criteria for Agoraphobia	1	2	3

LIFECHART

We have already discussed different periods in your life when you had the problems we just talked about. Let's clarify the timing of those periods starting with the worst episode. *Code Agoraphobia: AGO.*

	Onset			Offset				Status of Episode	Treatment Received
Code	**Month**	**Year**	**Age**	**Month**	**Year**	**Age**	**Duration**	**1 - NA/No Info** **2 - Prodromal or Partial Symptoms** **3 - Full Syndrome Present**	**1 - NA/No Info** **2 - No treatment** **3 - Medication** **4 -Psychotherapy** **5 -Hospitalization** **6 - Other**
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	_ _ _	9 ___	_ _ _ _
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	_ _ _	___	_ _ _ _
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	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	_ _ _	___	_ _ _ _

2. SIMPLE (SPECIFIC) PHOBIA

This condensed screening is used to shorten the length of the time needed to score the Phobia section. Use the scale point levels noted below to rate the greatest level of severity EVER manifested for each situation the subject fears. If the specific situation has a rating of 5 or higher, the remainder of the line should be completed.

A. Screening Questions

1. Have you ever been nervous, uncomfortable or avoided RIDING IN CARS, BUSES, SUBWAYS OR DRIVING A CAR? *(If YES , ask)* **Which situation bothers you? What are you afraid of in** (situation)? **How nervous and uncomfortable have you gotten when exposed to** *(situation)* **at its worst?** *(Rate)*

2. Have you ever been nervous, uncomfortable or avoided ELEVATORS, CROWDS, CLOSED SPACES, DARK PLACES OR HEIGHTS? *(If YES ask)* **Which situation bothers you? What are you afraid of in** (situation)? **How nervous and uncomfortable have you gotten when exposed to** *(situation)* **at its worst?** *(Rate)*

3. Have you ever been nervous, uncomfortable or avoided AIRPLANES OR BOATS? *(If YES ask)* **Which situation bothers you? What are you afraid of in** (situation)? **How nervous and uncomfortable have you gotten when exposed to** *(situation)* **at its worst?** *(Rate)*

4. Have you ever been nervous, uncomfortable or avoided DOCTORS, DENTISTS, NEEDLES, MEDICAL PROCEDURES, THE SIGHT OF BLOOD OR INJURIES? *(If YES ask)***Which situation bothers you? What are you afraid of in** (situation)? **How nervous and uncomfortable have you gotten when exposed to** *(situation)* **at its worst?** *(Rate)*

5. Have you ever been nervous, uncomfortable or avoided DEAD BODIES, CEMETERIES, OR FUNERALS? *(If YES ask)* **Which situation bothers you? What are you afraid of in** (situation)? **How nervous and uncomfortable have you gotten when exposed to** *(situation)* **at its worst?** *(Rate)*

6. Have you ever been nervous, uncomfortable or avoided SNAKES, INSECTS, BATS, BIRDS, RATS, MICE, RODENTS, CATS, DOGS, OR OTHER ANIMALS? *(If YES ask)* **Which situation bothers you? What are you afraid of in** (situation)? **How nervous and uncomfortable have you gotten when exposed to** *(situation)* **at its worst?** *(Rate)*

7. Have you ever been nervous, uncomfortable or avoided WATER, SWIMMING, THUNDERSTORMS, LIGHTNING, OR WIND? *(If YES ask)***Which situation bothers you? What are you afraid of in** (situation)? **How nervous and uncomfortable have you gotten when exposed to** *(situation)* **at its worst?** *(Rate)*

8. Are there any other situations that have made you nervous or uncomfortable which I have not already asked about? *(If YES ask)* **How about SHARP OBJECTS (E.G., KNIVES, HATCHETS)?Which situation bothers you? What are you afraid of in** (situation)? **How nervous and uncomfortable have you gotten when exposed to** *(situation)* **at its worst?** *(Rate)*

SCALE OF SEVERITY OF FEAR OR AVOIDANCE BEHAVIOR

1= NA/No Information
2= No apparent fear or discomfort
3= Definite fear or discomfort, but not irrational (in the rater's opinion)
4= Definite irrational fear or discomfort. No occasion to confront situation but would avoid it if such occasion arose
5= Definite irrational fear or discomfort but no avoidance
6= Irrational fear or discomfort and some adaptive behavior to cope with the likelihood of having to deal with the object or situation
7= Irrational fear and some avoidance behavior or inconvenience due to the fear
8= Irrational fear and considerable avoidance behavior (e.g., must leave area when confronted with phobic object or situation; attempts to avoid confrontation with phobic object or situation ; prevents subject from working or carrying out duties or attending school)

B. Review of Specific Fears *(Only ask about onset and offset if level of severity of fear/ avoidance is 5+.)*	**Worst Episode**		
	Greatest Level Severity	Date Onset	Date Offset
1. Riding in cars, buses, subways		__/__	__/__
2. Driving oneself		__/__	__/__
3. Elevators		__/__	__/__
4. Crowds		__/__	__/__
5. Closed spaces		__/__	__/__
6. Dark places		__/__	__/__
7. Heights		__/__	__/__
8. Airplanes		__/__	__/__
9. Boats		__/__	__/__
10. Doctors, Dentists, Med. Procedures		__/__	__/__
11. Hypodermic Needles		__/__	__/__
12. Blood		__/__	__/__
13. Dead Bodies, Cemeteries, Funerals		__/__	__/__
14. Snakes		__/__	__/__
15. Insects		__/__	__/__
16. Bats/Birds		__/__	__/__
17. Rats, Mice, Rodents		__/__	__/__
18. Cats		__/__	__/__
19. Dogs		__/__	__/__
20. Other Animals		__/__	__/__
21. Water, Swimming		__/__	__/__
22. Thunderstorms, Lightning, Wind		__/__	__/__
23. Sharp Objects (Knives, Hatchets)		__/__	__/__
25. Other		__/__	__/__

2. DSM III-R/DSM-IV CRITERIA

For each stimulus with a SADS rating of "5" or higher, determine whether each of the following are true.

If no fear of "5" or higher SKIP TO SOCIAL PHOBIA PAGE 93

a. Fear is persistent and due to a circumscribed stimulus.
b. Exposure almost invariably produces an immediate anxiety response.
c. Stimulus is avoided or endured with intense anxiety.
d. Fear significantly interferes with normal routine, social activities or relationships, or there is marked distress about having the fear.
e. Person recognizes that the fear is irrational.
f. Stimulus is unrelated to symptoms of Obsessive Compulsive Disorder or symptoms of Post Traumatic Stress Disorder.

For episodes occurring at age 18 and younger, duration should be at least 6 months.

Note: Do not include fears that are part of Panic Disorder with Agoraphobia, or Agoraphobia without history of Panic Disorder. Exposure during the phobic period (and subsequent anxiety response) is required for diagnosis. Imagined fear is not enough.

	a. Fear is persistent and marked	**b. Exposure produces anxiety**	**c. Stimulus is avoided or endured with intense anxiety or distress**	**d. Fear interferes with routine or causes marked distress about having fear**	**e. Recog. fear is excessive or unreasonable**	**f. Stimulus unrelated to Disorders**
Phobia with SADS rating 5+	1=No Info 2=No 3=Yes	1=No Info 2=No 3=Yes	1=No Info 2=No 3=Yes	1=No Info 2=No 3=Yes	1=No Info 2=No 3=Yes	1=No Info 2=No 3=Yes

C. Impairment

	NA/NO INFO	NO	YES
1. SOUGHT HELP **Did you seek help from anyone, like a doctor or other professional?**	1	2	3
or minister?	1	2	3
or even a friend?	1	2	3
or did someone suggest that you seek help?	1	2	3

	NA/NO INFO	NO	YES
2. TOOK MEDICATION **a. Did you take medicine?** *If yes,* **What did you take?**	1	2	3
b. Did you take more medicine than usual or use nonprescription drugs? *If yes,* **What did you take?**	1	2	3
3. HOSPITALIZATION **Were you hospitalized for how you were feeling?**	1	2	3
For how many days? ___ ___ ___ DAYS			
4. OVERALL ROLE IMPAIRMENT **Did your fears prevent you from doing things or cause you to be less efficient in what you were doing, or interfere with your normal, daily routine in any way?** *If yes, please describe*:	1	2	3
5. OCCUPATIONAL/ACADEMIC IMPAIRMENT **Did you stay home from work (or school) because of the way you were feeling? For how long?** **Was it harder to do your job?** *If yes, please describe*:	1	2	3
6. SOCIAL IMPAIRMENT **Did your fears affect your social life?** **Were there any difficulties or problems with friends because of how you were feeling?** *If yes, please describe*:	1	2	3
7. HOME/ FAMILY IMPAIRMENT **Did your fears affect your tasks at home, responsibilities, or interactions with family members?** *If yes, please describe*:	1	2	3
8. SIGNIFICANT DISTRESS **Did you find that you were very distressed about how you were feeling or acting?** *If yes, please describe*:	1	2	3

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LIFECHART

We have already discussed different periods in your life when you had the problems we just talked about. Let's clarify the timing of those periods starting with the worst episode. *Code Simple Phobia: SIM.*

	Onset			Offset				Status of Episode	Treatment Received
	Month	Year	Age	Month	Year	Age	Duration	1 - NA/No Info 2 - Prodromal or Partial Symptoms 3 - Full Syndrome Present	1 - NA/No Info 2 - No treatment 3 - Medication 4 -Psychotherapy 5 -Hospitalization 6 - Other
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	9 ___	__ __ __ __
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	___	__ __ __ __
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	___	__ __ __ __
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	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	___	__ __ __ __

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3. SOCIAL PHOBIA

A. Screening Questions

1. SEVERITY OF FEAR OR AVOIDANCE

Use the scale point levels on next page to rate the greatest level of severity EVER manifested. If the specific situation has a rating of '5' or higher, the remainder of the line should be completed.

I have already asked you about certain situations that you might have feared or avoided. Now I would like to ask you more specifically about several social situations or activities that you may now fear, feel uncomfortable about, or that you may have feared at some time during your life.

This condensed screening is used to shorten the length of the time needed to score the Social Phobia section. Use the scale point levels noted below to rate the greatest level of severity EVER manifested. If the specific situation has a rating of 5 or higher, the remainder of the line should be completed.

1. Have you ever been nervous, uncomfortable or avoided PUBLIC SPEAKING, EATING OR WRITING IN PUBLIC? *(If YES , ask*) **Which situation bothers you? What are you afraid of in** (situation)? **How nervous and uncomfortable have you gotten when exposed to** *(situation)* **at its worst?** *(Rate)*

2. Have you ever been nervous, uncomfortable or avoided PUBLIC LAVATORIES OR PERFORMING? *(If YES ask*) **Which situation bothers you? What are you afraid of in** (situation)? **How nervous and uncomfortable have you gotten when exposed to** *(situation)* **at its worst?** *(Rate)*

3. Have you ever been nervous, uncomfortable or avoided ASKING DIRECTIONS OR SPEAKING TO STRANGERS? *(If YES ask*) **Which situation bothers you? What are you afraid of in** (situation)? **How nervous and uncomfortable have you gotten when exposed to** *(situation)* **at its worst?** *(Rate)*

4. Have you ever been nervous, uncomfortable or avoided SOCIAL AFFAIRS OR DEALING WITH AUTHORITY FIGURES? *(If YES ask*) **Which situation bothers you? What are you afraid of in** (situation)? **How nervous and uncomfortable have you gotten when exposed to** *(situation)* **at its worst?** *(Rate)*

5. Are there any other situations that have made you nervous or uncomfortable which I have not already asked about? *(If YES ask)* **Which situation bothers you? What are you afraid of in** (situation)? **How nervous and uncomfortable have you gotten when exposed to** *(situation)* **at its worst?** *(Rate)*

SCALE OF SEVERITY OF FEAR OR AVOIDANCE BEHAVIOR

(Ask for all items on table)

1 = NA/No Information

2 = No apparent fear or discomfort

3 = Definite fear or discomfort, but not irrational (in the rater's opinion)

4 = Definite irrational fear or discomfort. Has had no occasion to confront situation but would avoid it if such occasion arose

5 = Definite irrational fear or discomfort but no avoidance

6 = Irrational fear or discomfort and some adaptive behavior to cope with the likelihood of having to deal with the object or situation

7 = Irrational fear and some avoidance behavior or inconvenience due to the fear

8 = Irrational fear and considerable avoidance behavior (e.g., must leave area when confronted with phobic object or situation; attempts to avoid confrontation with phobic object or situation prevents subject from working or carrying out duties or attending school)

B. Review of Social Fears

Only ask about onset and offset if level of severity of fear/avoidance is 5+.	**Worst Episode**		
	Greatest Level Severity	Date at Onset	Date at Offset
1.Public speaking		__/__	__/__
2.Eating in public		__/__	__/__
3.Writing in public		__/__	__/__
4.Public lavatories		__/__	__/__
5.Performing		__/__	__/__
6.Asking directions		__/__	__/__
7.Speaking to strangers		__/__	__/__
8.Social affairs		__/__	__/__
9.Dealing with authority figures		__/__	__/__
10.Other		__/__	__/__

11. Does the fear include most social situations? (Generalized Phobia)

1 NA/No information

2 No

3 Yes

2. DSM-III-R/ DSM-IV CRITERIA

For each stimulus with a SADS rating of 5 or higher, determine whether each of the following are true.

If no fear of "5" or higher ——— SKIP TO OBSESSIVE-COMPULSIVE DISORDER PAGE 100

a. Fear of humiliation and/or embarrassment is persistent and due to a circumscribed stimulus.
b. Exposure almost invariably produces an immediate anxiety response.
c. Stimulus is avoided or endured with intense anxiety.
d. Fear significantly interferes with normal routine, social activities or relationships, or there is marked distress about having the fear.
e. Person recognizes that the fear is irrational.
f. Stimulus is unrelated to any axis 1 or 3 disorder (e.g. stuttering (Stuttering), trembling (Parkinson's Disease) or exhibiting abnormal eating behavior (Anorexia Nervosa or Bulimia Nervosa)).

Note: Do not include fears that are part of Panic Disorder with Agoraphobia, or Agoraphobia without history of Panic Disorder. Exposure during the phobic period (and subsequent anxiety response) is required for diagnosis. Imagined fear is not enough.

	a. Fear of humiliation is persistent	**b. Exposure produces anxiety**	**c. Stimulus is avoided or endured with intense anxiety**	**d. Fear interferes with routine or causes marked distress about having fear.**	**e. Recog. fear is irrational**	**f. Stimulus unrelated to Disorders**
Phobias with SADS rating of 5+	1 =No Info 2 =No 3 =Yes	1 =No Info 2 =No 3 =Yes	1 =No Info 2 =No 3 =Yes	1 =No Info 2 =No 3 =Yes	1 =No Info 2 =No 3 =Yes	1 =No Info 2 =No 3 =Yes

C. Impairment

	NA/NO INFO	NO	YES
1. SOUGHT HELP			
a. Did you seek help from anyone, like a doctor or other professional?	1	2	3
b. or minister?	1	2	3
c. or even a friend?	1	2	3
d. or did someone suggest that you seek help?	1	2	3
2. TOOK MEDICATION			
a. Did you take medicine? *If yes,* **What did you take?**	1	2	3
b. Did you take more medicine than usual or did you use nonprescription drugs? *If yes,* **What did you take?**			
3. HOSPITALIZATION **Were you hospitalized for how you were feeling?**	1	2	3
For how many days?			
4. OVERALL ROLE IMPAIRMENT **Did your fear cause you to be less efficient in what what you were doing or interfere with your normal, daily routine in any way?** *If yes, please describe*:	1	2	3
5. OCCUPATIONAL/ACADEMIC IMPAIRMENT **Did you stay home from work (or school) because of the way you were feeling? For how long? Was it harder to do your job?** *If yes, please describe*:	1	2	3
6. SOCIAL IMPAIRMENT **Did your fears affect your social life? How? Were there any difficulties or problems with friends because of how you were feeling?** *If yes, please describe*:	1	2	3

DAYS

	NA/NO INFO	NO	YES
7. HOME/FAMILY IMPAIRMENT **Was there a change in the way you interacted with your family or how you performed your household chores?** *If yes, please describe*:	1	2	3
8. SIGNIFICANT DISTRESS **Did you find that you were very distressed about how you were feeling or acting?** *If yes, please describe*:	1	2	3

LIFECHART

We have already discussed different periods in your life when you had the problems we just talked about. Let's clarify the timing of those periods starting with the worst episode. *Code Social Phobia: SOC.*

Code	**Onset**			**Offset**			**Duration**	**Status of Episode**	**Treatment Received**
	Month	**Year**	**Age**	**Month**	**Year**	**Age**		**1 - NA/No Info** **2 - Prodromal or Partial Symptoms** **3 - Full Syndrome Present**	**1 - NA/No Info** **2 - No treatment** **3 - Medication** **4 -Psychotherapy** **5 -Hospitalization** **6 - Other**
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	9 ___	__ __ __ __
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	___	__ __ __ __
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	___	__ __ __ __
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	___	__ __ __ __
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	___	__ __ __ __
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	___	__ __ __ __
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	___	__ __ __ __
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	___	__ __ __ __
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	___	__ __ __ __
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	___	__ __ __ __

Determine if subject has ever had obsessions (recurrent and persistent ideas, thoughts, impulses or images that are intrusive and senseless and which the subject attempts to ignore, suppress or neutralize with some thought or action) or compulsions (repetitive, purposeful and intentional behaviors that are performed in response to an obsession or according to certain rules or in a stereotyped fashion; that are designed to neutralize or to prevent discomfort or some dreaded event or situation and that the subject recognizes as excessive or unreasonable).

A. Screening Questions

1. Have you ever been bothered by thoughts that kept coming back to you, that didn't make sense, that you couldn't get rid of or put out of your mind?
For example: the idea that your hands are dirty or contaminated even though you just washed them or that something terrible might happen to you or someone else?
Obsessive thoughts are usually experienced by subject as irrational and disruptive; (distinguish from brooding as in a mood disorder).

1 NA/NO INFORMATION
2 NO
3 YES

2. Have you ever had to repeat some act over and over which you could not resist repeating-like constantly washing your hands, counting things, or checking on things? Were these acts purposeful and intentional? Did you have to perform the rituals in order to prevent something from happening or do them in a certain way?
Compulsive acts are usually experienced by subject as irrational and disruptive.

1 NA/NO INFORMATION
2 NO
3 YES

SKIP TO POST TRAUMATIC STRESS DISORDER, PAGE 108

B. Chronology

Interviewer should determine the onset, duration, persistence and intrusiveness of obsessions and/or compulsions. If many episodes are described, determine the worst episode for obsessions as well as compulsions.

C. Symptom Review

A. OBSESSIONS

(Exclude if associated with, and limited to, another disorder, e.g., "obsessed" with food in an eating disorder, with drugs in a substance use disorder, with fire in pyromania, with betting in pathological gambling, etc.) Distinguish from brooding (in a mood disorder) and thought insertion (in a psychotic disorder).

	WORST EPISODE		
	NA/NO INFO	**NO**	**YES**
1a. **During the worst period, were you concerned with:**			
a. germs/contamination?	1	2	3
b. harming yourself? (Not in the context of depression)	1	2	3
c. harming someone?	1	2	3
d. sexual urges?	1	2	3
e. other obsessions?	1	2	3

Specify Other:

1b. RECURRENT/PERSISTENT THOUGHTS

Was that only occasionally, or only for a few days, or did these thoughts keep coming into your mind for several weeks?

1 NA/No Info

2 Occasional, not persistent

3 Recurrent/persistent

Please Describe:

1c. INTRUSIVE AND INAPPROPRIATE THOUGHTS

Did these thoughts bother you? Did they keep coming into your mind even though you didn't want them to?	1	2	3

Please Describe:

2. DETERMINE THAT THOUGHTS ARE NOT WORRIES ABOUT REAL-LIFE PROBLEMS *Note: Determine from above responses*	1	2	3

	WORST EPISODE		
	NA/NO INFO	NO	YES
3. PRODUCT OF OWN MIND			
Are these thoughts your own? Do you believe that they are put into your mind by some force from the outside?	1	2	3

Please Describe:

4. ATTEMPTS TO IGNORE/SUPPRESS/NEUTRALIZE

Did you do anything to stop these thoughts or try to block them out of your mind, like trying to ignore them, or humming to prevent you from "hearing" them?	1	2	3

Please Describe:

B. COMPULSIONS

(Exclude if association with, and limited to, another disorder, e.g., compulsive eating in an eating disorder, drug use in a substance use disorder, fire setting in pyromania, betting in pathological gambling, etc. Distinguish from: superstitious acts (e.g., stepping on sidewalk cracks); doing things out of boredom (e.g., counting tiles on the ceiling); and other voluntary acts with no sense of compulsion, and which the individual has no desire to stop)

	WORST EPISODE		
	NA/NO INFO	NO	YES
1a. During the worst period, were you involved in:			
a. washing/cleanliness rituals?	1	2	3
b. checking rituals?	1	2	3
c. counting rituals?	1	2	3
d. dressing rituals?	1	2	3
e. leaving the house/room rituals?	1	2	3
f. work rituals (e.g., cooking, shopping, at job, etc.)?	1	2	3
g. hoarding?	1	2	3
h. other compulsions?	1	2	3

Specify:

	WORST EPISODE		
	NA/NO INFO	**NO**	**YES**
1b. PERSON FEELS DRIVEN TO PERFORM RITUAL			
Did you feel that you could not resist doing (*use subject's own words to describe compulsion*)**? Did you always do** *(compulsion)* **in a particular order?**	1	2	3

Please Describe:

2. RITUALS AIM TO PREVENT DISTRESS			
Did you ever try to stop or to resist? What happened? Were you able to stop? Did you feel very nervous or uncomfortable? Did you think it would prevent something from happening?	1	2	3

Please Describe:

FOR BOTH OBSESSIONS AND COMPULSIONS:

1. RECOGNITION THAT OBSESSIONS/COMPULSIONS ARE EXCESSIVE OR UNREASONABLE			
Did you think that you *(had obsession or performed compulsion)* **more than you should have or more than was necessary? That is, did you feel that** *(obsession or compulsion)* **was excessive or unreasonable?** *(Note: this may not be true for episodes occurring before age 18. Adults who at some point in the course of the disorder stop meeting this criterion are classified under DSM-IV as "poor insight" type).*	1	2	3

If Yes, Please Specify:

1 Obsessions seem excessive

2 Compulsions seem excessive

3 Both 1 and 2

Please Describe:

2. MARKED DISTRESS/TIME CONSUMING/INTERFERES WITH LIFE			
How troubled were you by *(obsessions and compulsions)***? Did** *(obsessions and compulsions)* **create any major problems for you? Was this a big deal in your life? For example, did you find it very disturbing in general or did you lose sleep over or become preoccupied worrying about** *(obsessions and compulsions)*? **Did it take more than 1 hour a day?**	1	2	3

If Yes, Please Specify:

1 Obsessions caused marked distress in the context of the subject's life

2 Compulsions caused marked distress in the context of the subject's life

3 Both 1 and 2

Please Describe:

D. Other Characteristics of Obsessions/Compulsions

1. PREDOMINANT SYMPTOMS

1 NA/No Information

2 Neither (both of approximately equal severity)

3 Obsessions

4 Compulsions

2. RELIEF OF ANXIETY IF GIVES IN TO COMPULSION

Does giving in to *(compulsion)* **relieve the tension? Somewhat? Completely?**

1 NA/No Information

2 No relief of anxiety

3 Somewhat

4 Completely

3. DOUBT ABOUT DOING COMPULSION CORRECTLY

Do you frequently doubt that you did *(compulsions)* **correctly?**

1 Never

2 Sometimes (up to 50% of the time)

3 Most of the time (50% - 90%)

4 Always (90% - 100% of the time)

E. Impairment

	NA/NO INFO	NO	YES
1. SOUGHT HELP			
a. Did you seek help from anyone, like a doctor or other professional?	1	2	3
b. or minister?	1	2	3
c. or even a friend?	1	2	3
d. or did someone suggest that you seek help?	1	2	3
2. TOOK MEDICATION			
a. Did you take medicine?	1	2	3
If yes, **What did you take? _____**			
b. Did you take more medicine than usual or did you use nonprescription drugs?	1	2	3
If yes, **What did you take? _____**			
_____			
3. HOSPITALIZATION			
Were you hospitalized for how you were feeling?	1	2	3
For how many days?	___ DAYS		
4. OVERALL ROLE IMPAIRMENT			
Did obsessions and/or compulsions prevent you from doing things or cause you to be less efficient in what you were doing, or interfere with your normal, daily routine in any way?	1	2	3
If yes, please describe:			
5. OCCUPATIONAL/ACADEMIC IMPAIRMENT			
Did obsessions and/or compulsions interfere with your ability to do your job (or school)?	1	2	3
If yes, please describe:			

	NA/NO INFO	NO	YES
6. SOCIAL IMPAIRMENT			
Did obsessions and/or compulsions interfere with your social life or cause problems with friends?	1	2	3
If yes, please describe:			

7. HOME/ FAMILY IMPAIRMENT

Was there a change in the way you interacted with your family or how you performed your household chores?	1	2	3
If yes, please describe:			

8. SIGNIFICANT DISTRESS

Did you find that you were very distressed about how you were feeling or acting?	1	2	3
If yes, please describe:			

F. Criteria Check

DSM-III-R and DSM-IV CRITERIA

	NA/NO INFO	False	True
Met criteria for DSM III-R OCD	1	2	3
Met criteria for DSM-IV OCD	1	2	3

LIFECHART

We have already discussed different periods in your life when you had the problems we just talked about. Let’s clarify the timing of those periods starting with the <u>worst</u> episode. *Code Obsessive-Compulsive Disorder: OCD.*

Code	Onset			Offset			Duration	Status of Episode	Treatment Received
	Month	Year	Age	Month	Year	Age		1 - NA/No Info 2 - Prodromal or Partial Symptoms 3 - Full Syndrome Present	1 - NA/No Info 2 - No treatment 3 - Medication 4 -Psychotherapy 5 -Hospitalization 6 - Other
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___ ___	9 ___	___ ___ ___ ___
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	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___ ___	___	___ ___ ___ ___

Determine if subject has had a catastrophic experience which anyone would find stressful and which is not a usual lifetime occurrence (e.g., serious car accident, plane crash, surviving active combat or terrorist bombing, being caught in an earthquake, etc.). Or, if the subject had been exposed to a traumatic event in which the subject or somebody close to the subject was confronted with threat of severe injury or death (e.g., violent death of a close relative, victim of violent assault or violent abuse at home).

A. Screening Questions

1. OCCURRENCE OF TRAUMATIC EVENT

Have you ever had an unusually frightening or violent experience?

Have you been involved in a serious accident or disaster (e.g., fire, earthquake)?

Have you (or close family or friends) ever been the victim or witness of a violent or sexual crime (e.g., kidnaping, serious beating, murder, rape, domestic violence)?

Has there ever been a serious threat of these?

Did you ever fight in a war? (Were you involved in active combat)?

Have you ever witnessed a killing or beating? Serious injury or death of someone in an accident?

1	NA/NO INFORMATION
2	NO
3	YES

SKIP TO GENERALIZED ANXIETY DISORDER, PAGE 116

B. Chronology

At this point, the interviewer should establish chronology for him/herself regarding the onset of specific events and the person's reactions subsequent to the traumatic event.

CHARACTERIZATION OF A TRAUMATIC EVENT: SOME INDIVIDUALS MAY REPORT MORE THAN 1 EVENT WHICH MEETS CRITERIA. EACH EVENT SHOULD BE LISTED SEPARATELY IN CHRONOLOGICAL ORDER (E.G., EVENT 1 = EVENT WHICH OCCURRED CHRONOLOGICALLY FIRST, EVENT 2 =CHRONOLOGICALLY NEXT). THEN ASK THE PERSON TO DEFINE WHICH EVENT WAS THE WORST AND HAD THE MOST LASTING EFFECT.

C. Symptom Review

	WORST EPISODE OF WORST EVENT		
For DSM-IV only:	NA/NO INFO	NO	YES
RESPONSE OF FEAR, HELPLESSNESS OR HORROR **After the** (event)**, how did you feel? Some people experience feelings of fear, helplessness or feel horrified. Did that happen to you?** *(Note: in children, this may be expressed by disorganized or agitated behavior.)*	1	2	3
Symptoms in each category may occur immediately after the trauma OR onset may be delayed by months or years.			
1. RECURRENT AND INTRUSIVE RECOLLECTION OF THE EVENT **Did you find that you had thoughts or memories of the** (event) **which kept coming back to you even though you didn't want to think about it?**	1	2	3
2. RECURRENT DISTRESSING DREAMS OF THE EVENT **After the** (event)**, did you have dreams or nightmares frequently?**	1	2	3
3. SUDDEN ACTING OR FEELING AS IF THE TRAUMATIC EVENT WERE RECURRING **After the** (event)**, did you ever feel as if it were happening all over again, like a flashback or a day-dream? Did you suddenly find yourself acting as though the** (event) **were happening all over again?**	1	2	3
4. INTENSE PSYCHOLOGICAL DISTRESS AT EXPOSURE TO EVENT THAT SYMBOLIZES OR RESEMBLES AN ASPECT OF THE TRAUMATIC EVENT **After the** (event) **, did you find that when you happened to be near something which reminded you of the** (event) **you felt nervous, uncomfortable, upset or very scared?**	1	2	3

Worst Episode of Worst Event

	NA/NO INFO	NO	YES
5. PHYSIOLOGIC REACTIVITY UPON EXPOSURE TO EVENTS THAT SYMBOLIZE OR RESEMBLE AN ASPECT OF THE TRAUMATIC EVENT *Note: In DSM-III-R, this criterion was part of another cluster* **After the** (event)**, would you find that certain situations or reminders such as smells or sounds would make you sweaty, faint or short of breath, etc.?**	1	2	3
6. AVOIDS THOUGHTS OR FEELINGS ASSOCIATED WITH THE TRAUMA **After the** (event)**, did you find yourself trying not to think about the event or trying to block your feelings about it?**	1	2	3
7. AVOIDS ACTIVITIES OR SITUATIONS THAT AROUSE RECOLLECTIONS OF THE TRAUMA **After the** (event)**, did you avoid things which reminded you of the event?**	1	2	3
8. UNABLE TO RECALL AN IMPORTANT ASPECT OF THE TRAUMA **Are there things about the** (event) **which you are unable to remember no matter how much you try?**	1	2	3
9. MARKEDLY DIMINISHED INTEREST IN SIGNIFICANT ACTIVITIES **Have you lost interest in things you used to enjoy before the event? How much?**	1	2	3
10. FEELING OF DETACHMENT OR ESTRANGEMENT FROM OTHERS **After the** (event)**, did you find that you felt left out, like you didn't fit in, you were cut off or distant from others with whom you once felt close?**	1	2	3
11. RESTRICTED RANGE OF AFFECT (e.g., UNABLE TO HAVE LOVE FEELINGS) **After the** (event)**, did you find that you had trouble feeling emotions such as happiness, sadness, or love? Did you feel numb?**	1	2	3
12. SENSE OF FORESHORTENED FUTURE (e.g., DOES NOT EXPECT TO HAVE CAREER, MARRIAGE, CHILDREN, LONG LIFE) **After the** (event)**, was it hard to think about or make plans for the future? Did you feel as if you had no future?**	1	2	3
13. DIFFICULTY FALLING OR STAYING ASLEEP **After the** (event)**, did you have trouble falling asleep or staying asleep? Is this different from how you were sleeping before the** (event)**?**	1	2	3

	Worst Episode of Worst Event		
	NA/NO INFO	NO	YES
14. IRRITABILITY OR OUTBURSTS OF ANGER **After the** (event)**, did you lose your temper more easily than you used to? Were you more irritable than usual?**	1	2	3
15. DIFFICULTY CONCENTRATING **After the** (event)**, did you have trouble concentrating or keeping your mind on the things you were doing?**	1	2	3
16. HYPERVIGILANCE **After the** (event) **did you find that you were more alert to danger, as though you expected something bad to happen?**	1	2	3
17. EXAGGERATED STARTLE RESPONSE **After the** (event)**, would you jump at sudden noises or feel keyed up, jumpy, tense?**	1	2	3
DURATION OF ABOVE IS MORE THAN A MONTH **For how long have you had the** (above symptoms)**? Was it more than one month?** *Please Specify:*_____			

D. Additional Characteristics

1. REDUCTION IN AWARENESS OF SURROUNDINGS **Did you feel less aware of things around you, as if you "were in a daze" after the** (event)**?**	1	2	3
2. DEREALIZATION **Did you feel as if things around you seemed unreal after the** (event)**? As if you were above everything looking down or somehow just an observer rather than a participant in things?**	1	2	3
3. DEPERSONALIZATION **After the** (event), **did you feel as if parts of your body didn't belong to you or felt cut off from some part of yourself?**	1	2	3

F. Impairment (DSM-IV)

1. SOUGHT HELP **Did you seek help from anyone, like a doctor or other professional?**	1	2	3
or minister?	1	2	3
or even a friend?	1	2	3
or did someone suggest that you seek help?	1	2	3

Worst Episode of Worst Event

	NA/NO INFO	NO	YES
2. TOOK MEDICATION			
a. Did you take medicine? *If yes,* **What did you take?**	1	2	3
b. Did you take more medicine than usual or did you use nonprescription drugs? *If yes,* **What did you take?**	1	2	3
3. HOSPITALIZATION **Were you hospitalized for how you were feeling?**	1	2	3
For how many days?	DAYS		
4. OVERALL ROLE IMPAIRMENT **Did your reaction to the** (trauma) **and/or the symptoms we discussed interfere with or affect your normal, daily routine in any way?** *If yes, please describe:*	1	2	3
5. OCCUPATIONAL/ACADEMIC IMPAIRMENT **Did your reaction to the** (trauma) **and/or the symptoms we discussed affect how you did your job or school work? Did you stay home from work (or school) because of the way you were feeling?** *If yes, please describe:*	1	2	3
6. SOCIAL IMPAIRMENT **Was your social life affected by how you were feeling? Were there any difficulties or problems with friends because of how you were feeling?** *If yes, please describe:*	1	2	3
7. HOME/FAMILY IMPAIRMENT **Was there a change in the way you interacted with your family or how you performed your household chores?** *If yes, please describe:*	1	2	3
8. SIGNIFICANT DISTRESS	1	2	3

How bothered have you been by the anxiety, worry or physical symptoms that we discussed? *If yes, please describe:*

E. Criteria Check

DSM-III-R/DSM-IV:

	NA/NO INFO	FALSE	TRUE
1. Exposure to traumatic event which involved actual or threatened death or serious injury to self or others (and caused response of intense fear, helplessness or horror: DSM-IV)	1	2	3
2. The traumatic event is reexperienced indicated by at least 1 symptom	1	2	3
3. Persistent avoidance of stimuli or numbing of general responsiveness indicated by at least 3 symptoms.	1	2	3
4. Persistent symptoms of increased arousal indicated by at least 2 symptoms	1	2	3
5. Duration of at least 1 month	1	2	3
6. Evidence of significant distress or impairment in social, occupational, or other important areas of functioning (DSM-IV).	1	2	3
Met criteria for DSM-III-R Post Traumatic Stress Disorder	1	2	3
Met Criteria for DSM-IV Post Traumatic Stress Disorder	1	2	3
Met Criteria for DSM-IV Acute Stress Disorder	1	2	3

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LIFECHART

We have already discussed different periods in your life when you had the problems we just talked about. Let's clarify the timing of those periods starting with the worst episode. *Code Post Traumatic Stress Disorder: PTS.*

	Onset			Offset				Status of Episode	Treatment Received
	Month	Year	Age	Month	Year	Age	Duration	1 - NA/No Info 2 - Prodromal or Partial Symptoms 3 - Full Syndrome Present	1 - NA/No Info 2 - No treatment 3 - Medication 4 -Psychotherapy 5 -Hospitalization 6 - Other
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	9 ___	__ __ __ __
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	___	__ __ __ __
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	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	___	__ __ __ __

The essential feature of this disorder is excessive anxiety and worry occurring more days than not for at least 6 months, and which the subject finds difficult to control.

A. Screening Questions

Have you ever had a period when you were persistently anxious, nervous, tense or jittery most of the time for at least 6 months?

1	NA/NO INFORMATION
2	NO
3	YES

SKIP TO ALCOHOL USE DISORDER, PAGE 120

B. Chronology

Interviewer should determine if the excessive worry concerned at least two life circumstances. Also, determine the onset and duration of each episode of anxiety as well as which episode was the worst. Finally, establish what events were occurring in the subject's life which may account for the symptoms. If there is more than one episode, establish which is worst. Please describe below.

C. Symptom Review

Note: Interviewer should keep in mind that a clinically significant rating of GAD symptoms should be at the "more days than not " level and should be coded as "4".

We will talk about the worst 6 month period of excessive worry that you had about at least two life circumstances.

	WORST EPISODE			
	NA/NO INFO	NO	YES	MORE DAYS THAN NOT
1. APPREHENSIVE EXPECTATION **During this period of anxiety did you worry much of the time? What did you worry about? Was there any reason for you to worry about that?**	1	2	3	4
2. DIFFICULTY CONTROLLING WORRY **Did you find that you had any trouble controlling or stopping the worry?**	1	2	3	4
3. SYMPTOMS OF MOTOR TENSION **Did you have feelings of shakiness, trembling and twitching?**	1	2	3	4
Were your muscles feeling tense or achy?	1	2	3	4

	WORST EPISODE			
	NA/NO INFO	NO	YES	MORE DAYS THAN NOT
Did you have feelings of restlessness, as though you couldn't sit still? Did you feel keyed up or on edge?	1	2	3	4
Were you easily fatigued, did you tire easily?	1	2	3	4
4. SYMPTOMS OF AUTONOMIC HYPERACTIVITY				
Were you feeling short of breath? Did you have cold or clammy hands?	1	2	3	4
Were you sweating a lot?	1	2	3	4
Did your heart race or pound (tachycardia or palpitations)?	1	2	3	4
Did you have a dry mouth?	1	2	3	4
Were you feeling dizzy or lightheaded?	1	2	3	4
Did you have an upset stomach or diarrhea?	1	2	3	4
Were you urinating or feeling the urge to urinate more often than usual?	1	2	3	4
Were you feeling as though you had a lump in your throat?	1	2	3	4
Did you have hot flushes or chills?	1	2	3	4
5. VIGILANCE AND SCANNING				
Were you so nervous you had trouble concentrating?	1	2	3	4
Did you have difficulty sleeping or was your sleep unsatisfying or restless?	1	2	3	4
Were you irritable or impatient?	1	2	3	4
Were you easily startled or would you jump at the slightest noise?	1	2	3	4

D. Criteria Check

	NA/NO INFO	FALSE	TRUE
EXCLUSIONS			
a. If another Axis I disorder is present, the focus of anxiety and worry is unrelated to it.	1	2	3
b. Disturbance does not occur only during the course of a mood disorder.	1	2	3
c. It cannot be established that an organic factor initiated and maintained the disturbance	1	2	3
Met criteria for DSM III-R Generalized Anxiety Disorder	1	2	3
Met Criteria for DSM IV Generalized Anxiety Disorder	1	2	3

E. Impairment (DSM-IV)

	NA/NO INFO	NO	YES
1. SOUGHT HELP **Did you seek help from anyone, like a doctor or other professional?**	1	2	3
or minister?	1	2	3
or even a friend?	1	2	3
or did someone suggest that you seek help?	1	2	3
2. TOOK MEDICATION **a. Did you take medicine?** *If yes,* **What did you take?**	1	2	3
b. Did you take more medicine than usual or did you use nonprescription drugs? *If yes,* **What did you take?**	1	2	3
3. HOSPITALIZATION **Were you hospitalized for how you were feeling?**	1	2	3
For how many days? ___ ___ ___ DAYS			
4. HOME/FAMILY IMPAIRMENT **Was there a change in the way you interacted with your family or how you performed your household chores?** *If yes, please describe:*	1	2	3
5. OVERALL ROLE IMPAIRMENT **Did the anxiety/ worry and/or symptoms interfere with or affect your normal, daily routine in any way?** *If yes, please describe:*	1	2	3
6. OCCUPATIONAL/ACADEMIC IMPAIRMENT **Did you stay home from work (or school) because of the way you were feeling? Was it harder to do your job when you were anxious/worried?** *If yes, please describe:*	1	2	3
7. SOCIAL IMPAIRMENT **Was your social life affected by how you were feeling? Were there any difficulties or problems with friends because of how you were feeling?** *If yes, please describe:*	1	2	3
8. SIGNIFICANT DISTRESS **How bothered have you been by the anxiety, worry, or the physical symptoms we discussed? Have they caused you much distress?** *If yes, please describe:*	1	2	3

LIFECHART

We have already discussed different periods in your life when you had the problems we just talked about. Let's clarify the timing of those periods starting with the worst episode. *Code Generalized Anxiety Disorder: GAD.*

	___Onset___			___Offset___				Status of Episode	Treatment Received
Code	Month	Year	Age	Month	Year	Age	Duration	1 - NA/No Info 2 - Prodromal or Partial Symptoms 3 - Full Syndrome Present	1 - NA/No Info 2 - No treatment 3 - Medication 4 -Psychotherapy 5 -Hospitalization 6 - Other
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	9 ___	__ __ __ __
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	___	__ __ __ __
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	___	__ __ __ __
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	___	__ __ __ __
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	___	__ __ __ __
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	___	__ __ __ __
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	___	__ __ __ __
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	___	__ __ __ __
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	___	__ __ __ __
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	___	__ __ __ __

1. ALCOHOL USE

A. Patterns of Alcohol Consumption

Now some questions about drinking alcoholic beverages like beer, wine, or liquor.

Have you ever used alcohol 5 or more times in your life?

1. HAS USED ALCOHOL 5 OR MORE TIMES

1	NA/NO INFO
2	NO
3	YES

SKIP TO CANNABIS USE DISORDER, PAGE 128

B. Screening Question

1. PROBLEMS WITH DRINKING

a. Was there ever a period in your life when you drank too much?

b. Was there ever a period in your life that you kept drinking even though it began to cause problems?

c. Has anyone in your family - or anyone else - ever objected to your drinking?

d. Was there ever a time when you often couldn't stop drinking when you wanted to?

1	NA/NO INFO
2	NO
3	YES

2. CONTINUOUS OR EPISODIC USE

Code YES if heaviest alcohol intake was daily or more often for at least one month or heavy episodic drinking (5+ drinks a day for at least 2 days) for at least one month preceded by one or more such periods in the past.

Were you drinking every day for at least one month?

Were there periods of two days or more when you had at least five drinks a day?

1	NA/NO INFO
2	NO
3	YES

SKIP TO CANNABIS USE DISORDER, PAGE 128

What are your current drinking habits like? How much do you usually drink? How often do you drink (*amount specified*)**?How about your drinking at other periods of your life?** *Interviewer should determine onset, duration and severity of drinking periods. If many episodes are described, determine which episode was the worst.*

C. DSM-III-R/IV Alcohol Dependence/Abuse Symptom Review

	WORST EPISODE		
	NA/NO INFO	NO	YES
1. CONSUMES MORE THAN INTENDED **Have you often drunk more than you intended or spent more time drinking than you had intended?**	1	2	3
2. PERSISTENT DESIRE OR INABILITY TO CUT DOWN OR STOP DRINKING **a. Have you ever wanted to cut down, stop drinking or otherwise change your drinking patterns?**	1	2	3
b. Have you ever tried to cut down or stop drinking and found that you couldn't? Have you tried more than twice to stop drinking or to drink less?	1	2	3
3. TIME SPENT GETTING, USING, OR RECOVERING FROM USE OF ALCOHOL **Did/do you spend a great deal of time drinking or making sure you had alcohol available or recovering from the effects of drinking?**	1	2	3
4. SUBSTANCE USE RESULTS IN A FAILURE TO FULFILL MAJOR ROLE OBLIGATIONS *Note: In the DSM-III-R, this criterion is part of Dependence. In the DSM-IV, it is part of Abuse.* **a. Was there ever a time when because of your drinking you often missed work or had trouble on the job?**	1	2	3
b. Did you ever lose a job because of your drinking?	1	2	3
c. Was there ever a time when because of your drinking you were unable to take care of household responsibilities (e.g., getting meals prepared, doing shopping) or to take care of your children?	1	2	3
(Ask if heaviest period during high school or college years, otherwise code "1") **d. Did your drinking or being hung over cause you to miss school or do poorly on your school work?**	1	2	3
e. Have you ever been suspended or expelled from school for drinking?	1	2	3
5. USE IN HAZARDOUS CONDITIONS *Note: In the DSM-III-R, this criterion is part of Dependence (second part of criterion 4). In the DSM-IV, it is part of Abuse.* **Did you ever drink a lot in situations when it was dangerous to do so such as driving, operating machinery or power tools, swimming, boating, etc.?**	1	2	3
6. USUAL ACTIVITIES GIVEN UP **Have you ever been drinking so much that you would drink instead of working or spending time on hobbies or with family or friends?**	1	2	3
Examples of activities given up:			

	WORST EPISODE		
	NA/NO INFO	NO	YES
7. DRINKS DESPITE RECOGNITION THAT A PHYSICAL AND PSYCHOLOGICAL PROBLEM HAS BEEN CAUSED OR EXACERBATED **a. Did you notice, or did a doctor ever tell you that you had developed a physical problem caused by or made worse from drinking alcohol, like gastritis, pancreatitis, cirrhosis, or neuritis? Did you continue drinking?** *Include good evidence of Korsakoff's Syndrome - chronic brain syndrome with anterograde anmesia as the predominant feature. Code symptom present if has physical complication and did not stop drinking.*	1	2	3
b. Have you noticed, or has a health or mental health professional ever told you that drinking will make a emotional problem of yours worse? Did you continue drinking? *Code 'yes' if has problem and did not stop drinking.*	1	2	3
8. CONTINUED USE DESPITE SOCIAL PROBLEMS CAUSED OR EXACERBATED BY SUBSTANCE *Note: In DSM-III-R, this criterion is part of criterion 6 of Dependence. In DSM-IV, it is part of Abuse.***Did drinking cause or worsen problems in your relationships with your spouse, family or friends? Did you continue using alcohol in spite of having such problems?**	1	2	3
9. TOLERANCE **Did you find that you had to drink more and more in order to get high or that you didn't get as high when you drank your usual amount?** *Code 'yes' if had to drink at least 50 % more.*	1	2	3
10. WITHDRAWAL **a. Have you ever had tremors (that were most likely due to drinking)?**	1	2	3
b. Have you ever had the DT's? *Definition: Confusional state following stopping drinking that includes disorientation and illusions or hallucinations.*	1	2	3
c. When you were drinking did you ever hear voices or see things that weren't really there? *(Hallucinations)*	1	2	3
d. Have you ever had a seizure or fit after you stopped drinking? *(In a non-epileptic)*	1	2	3
11. SUBSTANCE USE TO AVOID WITHDRAWAL *Note: In DSM-IV, 10 and 11 are part of the same criterion (2).* **a. After not drinking for a few hours or more, did you start drinking again to keep yourself from getting the shakes or from becoming sick?**	1	2	3
b. Did you ever use other psychoactive substances such as Valium or sedatives to relieve the shakes, DT's or symptoms?	1	2	3
12. RECURRENT SUBSTANCE RELATED LEGAL PROBLEMS **Did you get arrested or go to jail for the way you behaved while intoxicated?**	1	2	3
13. CRAVING **a. Was there ever time when you had strong urge or desire to smoke?**	1	2	3
b. Was there ever a time you wanted to smoke so badly, you couldn't think of anything else? **When was that (age)?_____**	1	2	3

DURATION
For how long have you had these problems with drinking?

Please Specify

E. Impairment

	WORST EPISODE		
	NA/NO INFO	NO	YES
1. SOUGHT HELP **a. Because of your drinking did you ever seek help from anyone, like a octor or other profes1.sional?**	1	2	3
b. Or a minister?	1	2	3
c. Or a self-help group such as A.A.?	1	2	3
d. Or even a friend?	1	2	3
e. Or did someone suggest that you seek help?	1	2	3
2. MEDICATION **a. Did you ever take medication to alleviate symptoms due to drinking?**	1	2	3
If yes, **What did you take?**_____			
b. Did you take more medication than usual or did you use nonprescription drugs?	1	2	3
If yes, **What did you take?**_____			
3. HOSPITALIZATION **a. Were you hospitalized for your drinking problem?**	1	2	3
b. For how many days?	___ Days		
4. OTHER TREATMENT **a. Did you receive any other type of treatment for your drinking problem?**	1	2	3
b. For how many weeks ?	___ Weeks		
5. TOTAL TIMES IN TREATMENT **How many times in your life have you been treatment for alcohol problems?**	_____		
6. SUBJECT'S PERCEIVED NEED FOR TREATMENT **How important to you now is getting treatment (further treatment) for your alcohol problem?**	1 NA/No Information 2 Not at all 3 Slightly 4 Moderately 5 Considerably 6 Extremely		

	WORST EPISODE		
	NA/NO INFO	**NO**	**YES**
7. OVERALL ROLE IMPAIRMENT **Did the alcohol use or the symptoms related to it prevent you from doing things, cause you to be less efficient in what you were doing, or interfere with your normal, daily routine in any way?**	1	2	3
If yes, please describe:			
8. OCCUPATIONAL/ACADEMIC IMPAIRMENT **Did you stay home from work (or school) because of the way you were feeling? For how long? Was it harder to do your job when you used alcohol?**	1	2	3
If yes, please describe:			
9. SOCIAL IMPAIRMENT **Did the alcohol use and/or symptoms affect your social life? Were there any difficulties or problems with friends because of how you were feeling?**	1	2	3
If yes, please describe:			
10. HOME/ FAMILY IMPAIRMENT **Did the alcohol use and/or symptoms affect your tasks at home, responsibilities, or interactions with family members?**	1	2	3
If yes, please describe:			
11. SIGNIFICANT DISTRESS **Did you find that you were very distressed about how you were feeling or acting?**	1	2	3
If yes, please describe:			

F. Criteria Check

Note: Abuse and Dependence are mutually exclusive. If episode meets criteria for Dependence, the diagnosis of Abuse is not given.

	NO INFO	FALSE	TRUE
1. MET CRITERIA FOR DSM-III-R ALCOHOL DEPENDENCE (3 Criteria out of 9: 1, 2, 3, 4+5, 6, 7+8, 9, 10, 11)	1	2	3
2. MET CRITERIA FOR DSM-IV ALCOHOL DEPENDENCE (3 Criteria out of 7: 1, 2, 3, 6, 7, 9, 10+11)	1	2	3
3. MET CRITERIA FOR DSM-III-R ALCOHOL ABUSE (1 Criterion out of 2: 7+8, 5)	1	2	3
3. MET CRITERIA FOR DSM-IV ALCOHOL ABUSE (1 Criterion out of 4: 4, 5, 8, 12)	1	2	3

LIFECHART

We have already discussed different periods in your life when you had the problems we just talked about. Let's clarify the timing of those periods starting with the worst episode. *Code Alcohol Dependence: ALD, Alcohol Abuse: ALA.*

Code	Onset			Offset			Duration	Status of Episode	Treatment Received
	Month	Year	Age	Month	Year	Age		1 - NA/No Info 2 - Subsyndromal or Partial Symptoms 3 - Full Syndrome Present	1 - NA/No Info 2 - No treatment 3 - Medication 4 -Psychotherapy 5 -Hospitalization 6 - Other
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	_ _ _	9___	_ _ _ _
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	_ _ _	___	_ _ _ _
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	_ _ _	___	_ _ _ _
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	_ _ _	___	_ _ _ _
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	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	_ _ _	___	_ _ _ _
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	_ _ _	___	_ _ _ _
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	_ _ _	___	_ _ _ _

2. CANNABIS USE DISORDER

A. Patterns of Cannabis Use

Now some questions about using marijuana or hashish.

Have you ever used marijuana or hashish 5 or more times in your life?

1. HAS USED MARIJUANA OR HASHISH 5 OR MORE TIMES

1	NA/NO INFO
2	NO
3	YES

SKIP TO COCAINE USE DISORDER, PAGE 136

B. Screening Questions

1. PROBLEMS WITH CANNABIS USE

a. Was there ever a period in your life that you used marijuana or hashish too much?

b. Was there ever a period in your life that you kept using marijuana or hashish even though it began to cause problems?

c. Has anyone in your family - or anyone else - ever objected to your use of marijuana or hashish?

d. Was there ever a time when you couldn't stop using marijuana or hashish when you wanted to?

1	NA/NO INFO
2	NO
3	YES

2. CONTINUOUS OR EPISODIC USE

Code YES if heaviest marijuana or hashish use 3+ times weekly or more often for at least one month or if heavy episodic use (daily for several continuous days) with some impairment of normal functioning for at least one month.
Were you using marijuana or hashish at least three times a week for at least a month?
Were you using marijuana or hashish every day for several days in a row?
Did this cause any problems in your professional life that lasted for more than at least one month?

1	NA/NO INFO
2	NO
3	YES

SKIP TO COCAINE USE DISORDER
PAGE 136

What is your current use of marijuana or hashish like? How much marijuana or hashish do you usually use? How often do you use marijuana or hashish? How about your use of marijuana or hashish at other periods of your life? *Interviewer should determine onset, duration and severity of cannabis use periods. If many episodes are described, determine which episode was the worst.*

C. DSM-III-R/IV Cannabis Dependence/Abuse Symptom Review

	WORST EPISODE		
	NA/NO INFO	NO	YES
1. CONSUMES MORE THAN INTENDED **Have you ever found that once you started using marijuana or hashish, you ended up using more than you intended or for a longer time than you intended?**	1	2	3
2. PERSISTENT DESIRE OR INABILITY TO CUT DOWN OR STOP USING CANNABIS **a. Have you ever wanted to cut down, stop using, or otherwise change your use of marijuana or hashish?**	1	2	3
b. Have you ever tried to cut down or stop using marijuana or hashish and found that you couldn't? Have you tried more than twice to stop using or to use less?	1	2	3
3. TIME SPENT GETTING, USING, OR RECOVERING FROM USE OF CANNABIS **Did/do you spend a great deal of time using marijuana or hashish or making sure you had marijuana or hashish available or recovering from the effects of marijuana or hashish?**	1	2	3
4. SUBSTANCE USE RESULTS IN A FAILURE TO FULFILL MAJOR ROLE OBLIGATIONS *Note: In the DSM-III-R, this criterion is part of Dependence. In the DSM-IV, it is part of Abuse.* **a. Was there ever a time when because of your use of marijuana/hashish, you often missed work or had trouble on the job?**	1	2	3
b. Did you ever lose a job because of your use of marijuana or hashish?	1	2	3
c. Was there ever a time when because of your use of marijuana or hashish you were unable to take care of household responsibilities (e.g., getting meals prepared, doing shopping) or to take care of your children? *(Ask if heaviest period during high school or college years, otherwise code "1")* **d. Did your use of marijuana or hashish cause you to miss school or do poorly on your school work?**	1	2	3
e. Have you ever been suspended or expelled from school for using marijuana or hashish?	1	2	3
5. USE IN HAZARDOUS CONDITIONS *Note: In the DSM-III-R, this criterion is part of Dependence (second part of criterion 4). In the DSM-IV, it is part of Abuse.* **Have you ever used marijuana or hashish when it was dangerous to do so such as driving, operating machinery or power tools, swimming, boating, etc.?**	1	2	3

	WORST EPISODE		
	NA/NO INFO	NO	YES
6. USUAL ACTIVITIES GIVEN UP **Have you ever used marijuana or hashish so much that you used it instead of working or spending time at hobbies or with family or friends?** *Examples of activities given up:*	1	2	3
7. USES DRUG DESPITE RECOGNITION THAT A PHYSICAL OR PSYCHOLOGICAL PROBLEM HAS BEEN CAUSED OR EXACERBATED **a. Did you notice, or did a doctor ever tell you that you had developed a physical problem caused by or made worse from using marijuana or hashish? Did you continue using marijuana or hashish despite the problem?** *Code symptom present if has physical complication and did not stop using drug.*	1	2	3
b. Have you noticed, or has a health or mental health professional ever told you that marijuana or hashish will make an emotional problem of yours worse? Did you continue using marijuana or hashish? *Code symptom present if has problem and did not stop using marijuana or hashish.*	1	2	3
8. CONTINUED USE DESPITE SOCIAL PROBLEMS CAUSED OR EXACERBATED BY SUBSTANCE *Note: In DSM-III-R, this criterion is part of criterion 6 of Dependence. In DSM-IV, it is part of Abuse.* **Did using marijuana or hashish cause or worsen problems with your relationships with your spouse, family or friends? Did you continue using marijuana or hashish in spite of having such problems?**	1	2	3
9. TOLERANCE **Did you find that you had to use more marijuana or hashish in order to get high or that you didn't get as high when you used your usual amount?** *Code symptom present if 50 % or more.*	1	2	3
10. WITHDRAWAL **a. Did you ever have withdrawal symptoms when not using marijuana or hashish or taking it in smaller amounts or less often?***(Note: there is weak clinical evidence that there are withdrawal symptoms in cannabis use. However, some studies report: headache, malaise, or weakness lasting 3 or 4 days)*	1	2	3
11. SUBSTANCE USE TO AVOID WITHDRAWAL *Note: In DSM-IV, 10 and 11 are part of the same criterion (2).* **a. After not using marijuana or hashish for a time, did you start using again to keep yourself from getting headaches or other symptoms that appeared when you stopped using marijuana or hashish?**	1	2	3
b. Did you ever use any other drugs or medications to relieve other symptoms you developed when you stopped using marijuana or hashish?	1	2	3
12. RECURRENT SUBSTANCE RELATED LEGAL PROBLEMS **Did you get arrested or go to jail for the way you behaved while intoxicated?**	1	2	3
13. CRAVING **a. Was there ever time when you had strong urge or desire to use marijuana or hashish?**	1	2	3
b. Was there ever a time you wanted to use marijuana or hashish so badly, you couldn't think of anything else? **When was that (age)?_____**	1	2	3

	WORST EPISODE		
	NA/NO INFO	NO	YES
DURATION **For how long have you had these problems with using marijuana or hashish?** *Please Specify:* _____			

E. Impairment

1. SOUGHT HELP **a. Because of your use of marijuana or hashish did you ever seek help from anyone, like a doctor or other professional?**	1	2	3
b. Or a minister?	1	2	3
c. Or a self-help group such as N.A.?	1	2	3
d. Or even a friend?	1	2	3
e. Or did someone suggest that you seek help?	1	2	3
2. MEDICATION **a. Because of your use of marijuana or hashish did you ever take medication?**	1	2	3
If yes, **What did you take?**_____			
b. Did you take more medication than usual or did you use nonprescription drugs?	1	2	3
If yes, **What did you take?**_____			
3. HOSPITALIZATION **a. Were you hospitalized for using marijuana or hashish?**	1	2	3
b. For how many days?	☐☐☐ Days		
4. OTHER TREATMENT **a. Did you receive any other type of treatment for problems with using marijuana or hashish?**	1	2	3
b. For how many weeks ?	☐☐☐ Weeks		
5. TOTAL TIMES IN TREATMENT **How many times in your life have you been in treatment for problems with using marijuana or hashish?**	☐☐		

	WORST EPISODE		
	NA/NO INFO	**NO**	**YES**
6. SUBJECT'S PERCEIVED NEED FOR TREATMENT **How important to you now is getting treatment (further treatment) for problems with using marijuana or hashish?**	1 NA/No Information 2 Not at all 3 Slightly 4 Moderately 5 Considerably 6 Extremely		
7. OVERALL ROLE IMPAIRMENT **Did the marijuana or hashish use or the symptoms related to it prevent you from doing things, cause you to be less efficient in what you were doing, or interfere with your normal, daily routine in any way?** *If yes, please describe*:	1	2	3
8. OCCUPATIONAL/ACADEMIC IMPAIRMENT **Did you stay home from work (or school) because of using marijuana or hashish? For how long? Was it harder to do your job when you used marijuana or hashish?** *If yes, please describe*:	1	2	3
9. SOCIAL IMPAIRMENT **Did the marijuana or hashish use and/or symptoms affect your social life? Were there any difficulties or problems with friends because of using marijuana or hashish?** *If yes, please describe*:	1	2	3
10. HOME/ FAMILY IMPAIRMENT **Did the marijuana or hashish use and/or symptoms affect your tasks at home, responsibilities, or interactions with family members?** *If yes, please describe*:	1	2	3
11. SIGNIFICANT DISTRESS **Did you find that you were very distressed about how you were feeling or acting?** *If yes, please describe*:	1	2	3

F. Criteria Check

Note: Abuse and Dependence are mutually exclusive. If episode meets criteria for Dependence, the diagnosis of Abuse is not given.

	NO INFO	FALSE	TRUE
1. MET CRITERIA FOR DSM-III-R CANNABIS DEPENDENCE (3 Criteria out of 9: 1, 2, 3, 4+5, 6, 7+8, 9, 10, 11)	1	2	3
2. MET CRITERIA FOR DSM-IV CANNABIS DEPENDENCE (3 Criteria out of 7: 1, 2, 3, 6, 7, 9, 10+11)	1	2	3
3. MET CRITERIA FOR DSM-III-R CANNABIS ABUSE (1 Criterion out of 2: 7+8, 5)	1	2	3
3. MET CRITERIA FOR DSM-IV CANNABIS ABUSE (1 Criterion out of 4: 4, 5, 8, 12)	1	2	3

LIFECHART

We have already discussed different periods in your life when you had the problems we just talked about. Let's clarify the timing of those periods starting with the worst episode. *Code Cannabis Dependence: CAD, Cannabis Abuse: CAA.*

Code	**Onset**			**Offset**			**Duration**	**Status of Episode**	**Treatment Received**
	Month	**Year**	**Age**	**Month**	**Year**	**Age**		**1 - NA/No Info** **2 - Subsyndromal or Partial Symptoms** **3 - Full Syndrome Present**	**1 - NA/No Info** **2 - No treatment** **3 - Medication** **4 -Psychotherapy** **5 -Hospitalization** **6 - Other**
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	9___	__ __ __ __
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	___	__ __ __ __
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3. COCAINE USE DISORDER

A. Patterns of Cocaine Use

(Includes cocaine crystal, crack, rock cocaine, free-base cocaine. Ask only if subject has used cocaine 5+ times, otherwise skip to next drug used 5+ times)

Now some questions about using cocaine.

Have you ever used cocaine 5 or more times in your life?

1. HAS USED COCAINE 5 OR MORE TIMES

1 NA/NO INFO
2 NO
3 YES

SKIP TO OPIATE USE DISORDERS, PAGE 144

B. Screening Questions

1. PROBLEMS WITH COCAINE USE

a. Was there ever a period in your life that you used cocaine too much?

1 NA/NO INFO
2 NO
3 YES

b. Was there ever a period in your life that you kept using cocaine even though it began to cause problems?

1 NA/NO INFO
2 NO
3 YES

c. Has anyone in your family - or anyone else - ever objected to your use of cocaine?

1 NA/NO INFO
2 NO
3 YES

d. Was there ever a time when you couldn't stop using cocaine when you wanted to?

1 NA/NO INFO
2 NO
3 YES

2. CONTINUOUS OR EPISODIC USE

Code YES if heaviest cocaine use 3+ times weekly or more often for at least one month or if heavy episodic use (daily for several continuous days) with some impairment of normal functioning for at least one month.

Were you using cocaine at least three times a week for at least a month? Were you using cocaine every day for several days in a row? Did this cause any problems in your professional life that lasted for more than at least one month?

1 NA/NO INFO
2 NO
3 YES

SKIP TO OPIATE USE DISORDERS
PAGE 144

What is your current use of cocaine like? How much cocaine do you usually use? How often do you use cocaine? How about your use of cocaine at other periods of your life? *Interviewer should determine onset, duration and severity of cocaine use. If many episodes are described, determine which episode was the worst.*

C. DSM-III-R/IV Cocaine Dependence - Symptom Review

	WORST EPISODE		
	NA/NO INFO	**NO**	**YES**
1. CONSUMES MORE THAN INTENDED **Have you ever found that once you started using cocaine, you ended up using more than you intended or for a longer time than you intended?**	1	2	3
2. PERSISTENT DESIRE OR INABILITY TO CUT DOWN OR STOP USING COCAINE **a. Have you ever wanted to cut down, stop using, or otherwise change your use of cocaine?**	1	2	3
b. Have you ever tried to cut down or stop using cocaine and found that you couldn't? Have you tried more than twice to stop using or to use less?	1	2	3
3. TIME SPENT GETTING, USING, OR RECOVERING FROM USE OF COCAINE **Did/do you spend a great deal of time using cocaine or making sure you had cocaine available or recovering from the effects of cocaine?**	1	2	3
4. SUBSTANCE USE RESULTS IN A FAILURE TO FULFILL MAJOR ROLE OBLIGATIONS *Note: In the DSM-III-R, this criterion is part of Dependence. In the DSM-IV, it is part of Abuse.* **a. Was there ever a time when because of your use of cocaine, you often missed work or had trouble on the job?**	1	2	3
b. Did you ever lose a job because of your use of cocaine?	1	2	3
c. Was there ever a time when because of your use of cocaine you were unable to take care of household responsibilities (e.g., getting meals prepared, doing shopping) or to take care of your children?	1	2	3
(Ask if heaviest use during high school or college years, otherwise code "1") **d. Did your use of cocaine or being hung over from using cocaine cause you to miss school or do poorly on your school work?**	1	2	3
e. Have you ever been suspended or expelled from school for using cocaine?	1	2	3
5. USE IN HAZARDOUS CONDITIONS *Note: In the DSM-III-R, this criterion is part of Dependence (second part of criterion 4). In the DSM-IV, it is part of Abuse.* **Have you ever used cocaine when it was dangerous to do so such as driving, operating machinery or power tools, swimming, boating, etc.?**	1	2	3
6. USUAL ACTIVITIES GIVEN UP **Have you ever used cocaine so much that you used it instead of working or spending time at hobbies or with family or friends?**	1	2	3

Examples of activities given up:

	WORST EPISODE		
	NA/NO INFO	**NO**	**YES**
7. USES DRUG DESPITE RECOGNITION THAT A PHYSICAL OR PSYCHOLOGICAL PROBLEM HAS BEEN CAUSED OR EXACERBATED **a. Did you notice, or did a doctor ever tell you that you had developed a physical problem caused by or made worse from using cocaine? Did you continue using cocaine despite the problem?** *Code symptom present if has physical complication and did not stop using drug.*	1	2	3
b. Have you noticed, or has a health or mental health professional ever told you that cocaine will make a emotional problem of yours worse? Did you continue using cocaine? *Code symptom present if has problem and did not stop using marijuana or hashish.*	1	2	3
8. CONTINUED USE DESPITE SOCIAL PROBLEMS CAUSED OR EXACERBATED BY SUBSTANCE *Note: In DSM-III-R, this criterion is part of criterion 6 of Dependence. In DSM-IV, it is part of Abuse.* **Did using cocaine cause or worsen problems with your relationships with your spouse, family or friends? Did you continue using cocaine in spite of having such problems?**	1	2	3
9. TOLERANCE **Did you find that you had to use more cocaine in order to get high or that you didn't get as high when you used your usual amount?** *Code symptom present if 50 % or more.*	1	2	3
10. WITHDRAWAL **Did you ever have withdrawal symptoms when not using cocaine or taking it in smaller amounts or less often?***(manifested by depression, irritability or anxiety, and either fatigue, insomnia or hypersomnia, or psychomotor agitation, persisting more than 24 hours)*	1	2	3
11. SUBSTANCE USE TO AVOID WITHDRAWAL *Note: In DSM-IV, 10 and 11 are part of the same criterion (2).* **a. After not using cocaine for a time, did you start using again to prevent developing the symptoms we just discussed?**	1	2	3
b. Did you ever use any other drugs or medications to relieve the symptoms we discussed?	1	2	3
12. RECURRENT SUBSTANCE RELATED LEGAL PROBLEMS **Did you get arrested or go to jail for the way you behaved while intoxicated with cocaine?**	1	2	3
13. CRAVING **a. Was there ever time when you had strong urge or desire to use cocaine?**	1	2	3
b. Was there ever a time you wanted to use cocaine so badly, you couldn't think of anything else? **When was that (age)?_____**	1	2	3

DURATION

For how long have you had these problems with cocaine?

Please Specify:

E. Impairment

	WORST EPISODE		
	NA/NO INFO	NO	YES
1. SOUGHT HELP **a. Because of your use of cocaine, did you ever seek help from anyone, like a doctor or other professional?**	1	2	3
b. Or a minister?	1	2	3
c. Or a self-help group such as N.A., or C.A.?	1	2	3
d. Or even a friend?	1	2	3
e. Or did someone suggest that you seek help?	1	2	3
2. MEDICATION **a. Because of your use of cocaine did you ever take medication?**	1	2	3
If yes, **What did you take?**_____			
b. Did you take more medication than usual or did you use nonprescription drugs?	1	2	3
If yes, **What did you take?**_____			
3. HOSPITALIZATION **a. Were you hospitalized for using cocaine?**	1	2	3
b. For how many days? ☐☐☐ Days			
4. OTHER TREATMENT **a. Did you receive any other type of treatment for your use of cocaine?**	1	2	3
b. For how many weeks ? ☐☐☐ Weeks			
5. TOTAL TIMES IN TREATMENT **How many times in your life have you been treated for problems with using cocaine?** ☐☐			

6. SUBJECT'S PERCEIVED NEED FOR TREATMENT
How important to you now is getting treatment (further treatment) for problems with using cocaine?

1 NA/No Information
2 Not at all
3 Slightly
4 Moderately
5 Considerably
6 Extremely

	WORST EPISODE		
	NA/NO INFO	**NO**	**YES**
7. OVERALL ROLE IMPAIRMENT **Did the cocaine use or the symptoms related to it prevent you from doing things, cause you to be less efficient in what you were doing, or interfere with your normal, daily routine in any way?**	1	2	3
If yes, please describe:			
8. OCCUPATIONAL/ACADEMIC IMPAIRMENT **Did you stay home from work (or school) because of using cocaine? For how long? Was it harder to do your job when you used cocaine?**	1	2	3
If yes, please describe:			
9. SOCIAL IMPAIRMENT **Did the cocaine use and/or symptoms affect your social life? Were there any difficulties or problems with friends because of using cocaine?**	1	2	3
If yes, please describe:			
10. HOME/ FAMILY IMPAIRMENT **Did the cocaine use and/or symptoms affect your tasks at home, responsibilities, or interactions with family members?**	1	2	3
If yes, please describe:			
11. SIGNIFICANT DISTRESS **Did you find that you were very distressed about how you were feeling or acting?**	1	2	3
If yes, please describe:			

F. Criteria Check

Note: Abuse and Dependence are mutually exclusive. If episode meets criteria for Dependence, the diagnosis of Abuse is not given.

	NO INFO	FALSE	TRUE
1. MET CRITERIA FOR DSM-III-R COCAINE DEPENDENCE (3 Criteria out of 9: 1, 2, 3, 4+5, 6, 7+8, 9, 10, 11)	1	2	3
2. MET CRITERIA FOR DSM-IV COCAINE DEPENDENCE (3 Criteria out of 7: 1, 2, 3, 6, 7, 9, 10+11)	1	2	3
3. MET CRITERIA FOR DSM-III-R COCAINE ABUSE (1 Criterion out of 2: 7+8, 5)	1	2	3
3. MET CRITERIA FOR DSM-IV COCAINE ABUSE (1 Criterion out of 4: 4, 5, 8, 12)	1	2	3

LIFECHART

We have already discussed different periods in your life when you had the problems we just talked about. Let's clarify the timing of those periods starting with the worst episode. *Code Cocaine Dependence: COD, Cocaine Abuse: COA.*

	___Onset___			___Offset___				Status of Episode	Treatment Received
Code	**Month**	**Year**	**Age**	**Month**	**Year**	**Age**	**Duration**	**1 - NA/No Info 2 - Subsyndromal or Partial Symptoms 3 - Full Syndrome Present**	**1 - NA/No Info 2 - No treatment 3 - Medication 4 -Psychotherapy 5 -Hospitalization 6 - Other**
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	9___	__ __ __ __
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	___	__ __ __ __
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4. OPIATE USE DISORDER

A. Patterns of Opiate Use

(Includes heroin, speedball, methadone, morphine, m-tabs, opium, codine, hits, demerol, percodan, dilaudid, talwin, blues. Consider only use without a legitimate doctor's prescription or use for longer than prescribed..)

Now some questions about using heroin or other narcotics.

Have you ever used heroin or other narcotics 5 or more times in your life?

1. HAS USED HEROIN OR OTHER NARCOTICS MORE THAN 5 TIMES

- 1 NA/NO INFO
- 2 NO
- 3 YES

SKIP TO OTHER DRUG USE DISORDERS, PAGE 152

B. Screening Questions

1. PROBLEMS WITH OPIATE USE

a. Was there ever a period in your life that you used heroin or other narcotics too much?

1 NA/NO INFO
2 NO
3 YES

b. Was there ever a period in your life that you kept using heroin or other narcotics even though it began to cause problems?

1 NA/NO INFO
2 NO
3 YES

c. Has anyone in your family - or anyone else - ever objected to your use of heroin or other narcotics?

1 NA/NO INFO
2 NO
3 YES

d. Was there ever a time when you couldn't stop using heroin or other narcotics when you wanted to?

1 NA/NO INFO
2 NO
3 YES

2. CONTINUOUS OR EPISODIC USE

Code YES if heaviest opiate use 3+ times weekly or more often for at least one month or if heavy episodic use (daily for several continuous days) with some impairment of normal functioning for at least one month.
Were you using heroin or other narcotics at least three times a week for at least a month?
Were you using heroin or other narcotics every day for several days in a row?
Did this cause any problems in your professional life that lasted for more than at least one month?

1 NA/NO INFO
2 NO
3 YES

SKIP TO OTHER DRUG USE DISORDERS, PAGE 152

What is your current use of heroin or other narcotics like? How much heroin or other narcotics do you usually use? How often do you use heroin or other narcotics ? How about your use of heroin or other narcotics at other periods of your life? *Interviewer should determine onset, duration and severity of heroin use periods. If many episodes are described, determine which episode was the worst.*

C. DSM-III-R/IV Opiate /Abuse Dependence - Symptom Review

Note: substitute "heroin or other narcotics" if subject reports use of multiple opiates. Otherwise refer to specific substance used during worst episode.

	WORST EPISODE		
	NA/NO INFO	**NO**	**YES**
1. CONSUMES MORE THAN INTENDED **Have you ever found that once you started using heroin or other narcotics, you ended up using more than you intended or for a longer time than you intended?**	1	2	3
2. PERSISTENT DESIRE OR INABILITY TO CUT DOWN OR STOP USING SUBSTANCE **a. Have you ever wanted to cut down, stop using, or otherwise change your use of heroin or other narcotics?**	1	2	3
b. Have you ever tried to cut down or stop using heroin or other narcotics and found that you couldn't? Have you tried more than twice to stop using or to use less?	1	2	3
3. TIME SPENT GETTING, USING, OR RECOVERING FROM USE OF OPIOIDS **Did/do you spend a great deal of time using heroin or other narcotics, making sure you had heroin or other narcotics available or recovering from the effects of heroin or other narcotics?**	1	2	3
4. SUBSTANCE USE RESULTS IN A FAILURE TO FULFILL MAJOR ROLE OBLIGATIONS *Note: In the DSM-III-R, this criterion is part of Dependence. In the DSM-IV, it is part of Abuse.* **a. Was there ever a time when because of your use of heroin or other narcotics you often missed work or had trouble on the job?**	1	2	3
b. Did you ever lose a job because of your use of heroin or other narcotics?	1	2	3
c. Was there ever a time when because of your use of heroin or other narcotics you were unable to take care of household responsibilities (e.g., getting meals prepared, doing shopping) or to take care of your children?	1	2	3
(Ask if heaviest period during high school or college years, otherwise code "1") **d. Did your use of heroin or other narcotics or being high from using heroin or other narcotics cause you to miss school or do poorly on your school work?**	1	2	3
e. Have you ever been suspended or expelled from school for using heroin or other narcotics?	1	2	3
5. USE IN HAZARDOUS CONDITIONS *Note: In the DSM-III-R, this criterion is part of Dependence (second part of criterion 4). In the DSM-IV, it is part of Abuse.* **Have you ever used heroin or other narcotics when it was dangerous to do so such as driving, operating machinery or power tools, swimming, boating, etc.?**	1	2	3

	WORST EPISODE		
	NA/NO INFO	NO	YES
6. USUAL ACTIVITIES GIVEN UP **Have you ever been using heroin or other narcotics so much that you used it instead of working or spending time at hobbies or with family or friends?** *Examples of activities given up:*	1	2	3
7. USES SUBSTANCE DESPITE RECOGNITION THAT A PHYSICAL AND PSYCHOLOGICAL PROBLEM HAS BEEN CAUSED OR EXACERBATED **a. Did you notice, or did a doctor ever tell you that you had developed a physical problem caused by or made worse from using heroin or other narcotics? Did you continue using heroin or other narcotics despite the problem?** *Code symptom present if has physical complication and did not stop using drug.*	1	2	3
b. Have you noticed, or has a health or mental health professional ever told you that heroin or other narcotics will make a emotional problem of yours worse? Did you continue using heroin or other narcotics? *Code symptom present if has problem and did not stop using heroin or other narcotics.*	1	2	3
8. CONTINUED USE DESPITE SOCIAL PROBLEMS CAUSED OR EXACERBATED BY SUBSTANCE *Note: In DSM-III-R, this criterion is part of criterion 6 of Dependence. In DSM-IV, it is part of Abuse.* **Did use of heroin cause or worsen problems with your relationships with your spouse, family or friends? Did you continue using heroin in spite of having such problems?**	1	2	3
9. TOLERANCE **Did you find that you had to use more heroin in order to get high or that you didn't get as high when you used your usual amount?** *Code symptom present if 50 % or more.*	1	2	3
10. WITHDRAWAL **a. Did you ever have withdrawal symptoms when not using heroin or other narcotics or taking it in smaller amounts or less often?** *(at least 4 symptoms: insomnia, sweating, flushing, runny nose, stomach cramps, diarrhea, muscle pains, nausea, gooseflesh, chills, or twitching, appearing within 24 hours)*	1	2	3
11. SUBSTANCE USE TO AVOID WITHDRAWAL *Note: In DSM-IV, 10 and 11 are part of the same criterion (2).* **a. After not using heroin or other narcotics for a time, did you start using again to keep yourself from getting symptoms that appeared when you stopped using?**	1	2	3
b. Did you ever use any other drugs or medications to relieve symptoms that appeared when you stopped using heroin or other narcotics?	1	2	3

	NA/NO INFO	NO	YES
12. RECURRENT SUBSTANCE RELATED LEGAL PROBLEMS **Did you get arrested or go to jail for the way you behaved while intoxicated with heroin or other narcotics?**	1	2	3
13. CRAVING **a. Was there ever time when you had strong urge or desire to use heroin or other narcotics ?**	1	2	3
b. Was there ever a time you wanted to use heroin or other narcotics so badly, you couldn't think of anything else? **When was that (age)?_____**	1	2	3

DURATION
For how long have you had these problems with using heroin?

Please Specify

E. Impairment

1. SOUGHT HELP **a. Because of your use of heroin or other narcotics did you ever seek help from anyone, like a doctor or other professional?**	1	2	3
b. Or a minister?	1	2	3
c. Or a self-help group such as N.A.?	1	2	3
d. Or even a friend?	1	2	3
e. Or did someone suggest that you seek help?	1	2	3
2. MEDICATION **a. Because of your use of heroin or other narcotics did you ever take medication?**	1	2	3
If yes, **What did you take?_____**			
b. Did you take more medication than usual or did you use nonprescription drugs?	1	2	3
If yes, **What did you take?_____**			
3. HOSPITALIZATION **a. Were you hospitalized for using heroin or other narcotics?**	1	2	3
b. For how many days?	___ Days		
4. OTHER TREATMENT **a. Did you receive any other type of treatment for your use of heroin or other narcotics?**	1	2	3
b. For how many weeks ?	___ Weeks		
5. TOTAL TIMES IN TREATMENT **How many times in your life have you been treated for problems with using heroin or other narcotics?**	__		

	WORST EPISODE		
	NA/NO INFO	NO	YES
6. SUBJECT'S PERCEIVED NEED FOR TREATMENT **How important to you now is getting treatment (further treatment) for problems with using heroin or other narcotics?**	1 NA/No Information 2 Not at all 3 Slightly 4 Moderately 5 Considerably 6 Extremely		
7. OVERALL ROLE IMPAIRMENT **Did the heroin or other narcotics use or the symptoms related to it prevent you from doing things, cause you to be less efficient in what you were doing, or interfere with your normal, daily routine in any way?**	1	2	3
If yes, please describe:			
8. OCCUPATIONAL/ACADEMIC IMPAIRMENT **Did you stay home from work (or school) because of using heroin or other narcotics? For how long? Was it harder to do your job when you used heroin or other narcotics?**	1	2	3
If yes, please describe:			
9. SOCIAL IMPAIRMENT **Did the heroin or other narcotics use and/or symptoms affect your social life? Were there any difficulties or problems with friends because of using heroin or other narcotics?**	1	2	3
If yes, please describe:			
10. HOME/ FAMILY IMPAIRMENT **Did the heroin or other narcotics use and/or symptoms affect your tasks at home, responsibilities, or interactions with family members?**	1	2	3
If yes, please describe:			

	WORST EPISODE		
	NA/NO INFO	NO	YES
11. SIGNIFICANT DISTRESS **Did you find that you were very distressed about how you were feeling or acting?**	1	2	3

If yes, please describe:

F. Criteria Check

Note: Abuse and Dependence are mutually exclusive. If episode meets criteria for Dependence, the diagnosis of Abuse is not given.

	NO INFO	FALSE	TRUE
1. MET CRITERIA FOR DSM-III-R OPIOID DEPENDENCE (3 Criteria out of 9: 1, 2, 3, 4+5, 6, 7+8, 9, 10, 11)	1	2	3
2. MET CRITERIA FOR DSM-IV OPIOID DEPENDENCE (3 Criteria out of 7: 1, 2, 3, 6, 7, 9, 10+11)	1	2	3
3. MET CRITERIA FOR DSM-III-R OPIOID ABUSE (1 Criterion out of 2: 7+8, 5)	1	2	3
3. MET CRITERIA FOR DSM-IV OPIOID ABUSE (1 Criterion out of 4: 4, 5, 8, 12)	1	2	3

LIFECHART

We have already discussed different periods in your life when you had the problems we just talked about. Let's clarify the timing of those periods starting with the worst episode. *Code Opiate Dependence: OPD, Opiate Abuse: OPA.*

	___________Onset___________			___________Offset___________				**Status of Episode**	**Treatment Received**
Code	**Month**	**Year**	**Age**	**Month**	**Year**	**Age**	**Duration**	**1 - NA/No Info 2 - Subsyndromal or Partial Symptoms 3 - Full Syndrome Present**	**1 - NA/No Info 2 - No treatment 3 - Medication 4 -Psychotherapy 5 -Hospitalization 6 - Other**
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	9___	__ __ __ __
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	___	__ __ __ __
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	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	___	__ __ __ __

1. OTHER DRUGS

A. Patterns of Use

The following section is for other drugs: Stimulants, Sedatives, Hallucinogens, PCP, Inhalants or other drugs subject has taken 5+ times. Ask about the use of each substance, referring to specific drug or drugs reported, using terminology (e.g. ask about "speed" rather than "amphetamines" .

1. Have you ever used any of the following drugs 5+ times in your life? *(For stimulants, and sedatives, count YES only if used without legitimate doctor's prescription or used for longer or in greater amounts than prescribed. Circle actual drug(s) used within category. If a drug is mentioned during the interview that you can't classify, record it and we will classify it on review.)*

	NA/ NO INFO	NO	YES, Less than 5 times	YES, 5+ times
1. Stimulants: Amphetamine, Methadrine, Dexedrine, speed, crank, uppers, diet pills	1	2	3	4
2. Sedatives: Barbiturates, downers, tranquilizers, valium, Librium, Quaalude, seconal, sleeping pills	1	2	3	4
3. Hallucinogens: Psychedelics, LSD, acid, mescaline, peyote	1	2	3	4
4. Phencyclidine: PCP, Dust, angel dust	1	2	3	4
5. Inhalants or Solvents: poppers, glue, gasoline, chloroform, ether, paint, aerosol sprays	1	2	3	4
6.Other drugs *(specify):*_____	1	2	3	4

HAS USED AT LEAST ONE DRUG 5+ TIMES

1 NA/NO INFO

2 NO

3 YES

SKIP TO NICOTINE DISORDERS, PAGE 166

Notes

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B. Screening Questions

1. PROBLEMS WITH DRUG USE (PLEASE CODE IN NEXT PAGE)

a. Was there ever a period in your life that you used (drug) too much?

b. Was there ever a period in your life that you kept using (drug) even though it began to cause problems?

c. Has anyone in your family - or anyone else - ever objected to your use of (drug)?

d. Was there ever a time when you couldn't stop using (drug) when you wanted to?

2. CONTINUOUS OR EPISODIC USE

Code YES if heaviest (drug) use 3+ times weekly or more often for at least one month or if heavy episodic use (daily for several continuous days) with some impairment of normal functioning for at least one month.
Did you ever use *(drug)* **three times a week or more, for at least one month? Were there periods when you were using** *(drug)* **daily? How did this affect your life?** *Interviewer should determine onset, duration and severity of drug using periods. If many drugs are described, determine the course for each drug separately. Also determine which episode for each drug was the worst.*

Question	Stimulants	Sedatives	Hallucinogens	Phencyclidine	Inhalants	Other
	1 = NA/NO INFO 2 = NO 3 = YES	1 = NA/NO INFO 2 = NO 3 = YES	1 = NA/NO INFO 2 = NO 3 = YES	1 = NA/NO INFO 2 = NO 3 = YES	1 = NA/NO INFO 2 = NO 3 = YES	1 = NA/NO INFO 2 = NO 3 = YES
B. 1.a. Used drug too much	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3
B.1.b. Using drug even though problems	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3
B. 1. c. family/ anyone objected to use of drug	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3
B. 1. d. Could not stop when wanted to	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3
B. 2. Continuous or Episodic use	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3

If yes, describe

C. DSM-III-R/IV Drug Dependence/Abuse - Symptom Review

1. CONSUMES MORE THAN INTENDED
Have you ever found that once you started using (drug), you ended up using more than you intended or for a longer time than you intended?

2. PERSISTENT DESIRE OR INABILITY TO CUT DOWN OR STOP USING (DRUG)
a. Have you ever wanted to cut down, stop using, or otherwise change your use of (drug)?

b. Have you ever tried to cut down or stop using (drug) and found that you couldn't? Have you tried more than twice to stop using or to use less?

3. TIME SPENT GETTING, USING, OR RECOVERING FROM USE OF (DRUG)
Did/do you spend a great deal of time using (drug)
or making sure you had (drug) available or
recovering from the effects of (drug)?

4. SUBSTANCE USE RESULTS IN A FAILURE TO FULFILL MAJOR ROLE OBLIGATIONS
a. Was there ever a time when because of your use of (drug) you often missed work or had trouble on the job?

b. Did you ever lose a job because of your use of (drug)?

c. Was there ever a time when because of your use of (drug) you were unable to take care of household responsibilities (e.g., getting meals prepared, doing shopping) or to take care of your children?

(Ask if heaviest use during high school or college years, otherwise code "1")
d. Did your use of (drug) or being hung over from using (drug) cause you to miss school or do poorly on your school work?

e. Have you ever been suspended or expelled from school for using (drug)?

5. USE IN HAZARDOUS CONDITIONS
Note: In the DSM-III-R, this criterion is part of Dependence (second part of criterion 4). In the DSM-IV, it is part of Abuse.
a. Have you ever used (drug) when it was dangerous to do so such as driving, operating machinery or power tools, swimming, boating, etc.?

6. USUAL ACTIVITIES GIVEN UP
Have you ever been using (drug) so much that you used it instead of working or spending time at hobbies or with family or friends?

Question	Stimulants	Sedatives	Hallucinogens	Phencyclidine	Inhalants	Other
	1 = NA/NO INFO 2 = NO 3 = YES	1 = NA/NO INFO 2 = NO 3 = YES	1 = NA/NO INFO 2 = NO 3 = YES	1 = NA/NO INFO 2 = NO 3 = YES	1 = NA/NO INFO 2 = NO 3 = YES	1 = NA/NO INFO 2 = NO 3 = YES
C. 1. Consumes more than intended	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3
C. 2. Inability to cutdown/stop	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3
C. 3. Time getting/ using/ recovering	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3
C.4.a. Missed work/ Trouble on job	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3
C.4.b. Lose a job	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3
C.4.c. Unable to do household/ take care of children	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3
C. 4. d. Miss school/ poorly on school work	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3
C. 4. e. Suspended or expelled	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3
C.5. Hazardous conditions	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3
C.6. Activities given up	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3

Give examples of usual activities given up:

7. USES DRUG DESPITE RECOGNITION THAT A PHYSICAL OR PSYCHOLOGICAL PROBLEM HAS BEEN CAUSED OR EXACERBATED

a. Did you notice, or did a doctor ever tell you that you had developed a physical problem caused by or made worse from using (drug)?
Did you continue using (drug) despite the problem?
Code symptom present if has physical complication and did not stop using drug.

b. Have you noticed, or has a health or mental health professional ever told you that (drug) will make a emotional problem of yours worse?
Did you continue using (drug)? *Code symptom present if has problem and did not stop using (drug).*

8. CONTINUED USE DESPITE SOCIAL PROBLEMS CAUSED OR EXACERBATED BY SUBSTANCE

Note: In DSM-III-R, this criterion is part of criterion 6 of Dependence. In DSM-IV, it is part of Abuse.
Did using (drug) cause or worsen problems with your relationships with your spouse, family or friends?
Did you continue using (drug) in spite of having such problems?

9. TOLERANCE

Did you find that you had to use more (drug) in order to get high or that you didn't get as high when you used your usual amount? *Code symptom present if 50 % or more.*

10. WITHDRAWAL

Has stopping or cutting down on (drug) made you sick or given you withdrawal symptoms?
Have you ever experienced (specific symptoms) after stopping or cutting down?
*(**circle specific symptoms experienced**)*
STIMULANTS: depressed mood, fatigue, hypersomnia or insomnia, increased dreaming.
SEDATIVES: delirium, seizure, short-term amnesia, syndrome of tremulousness- weakness- malaise, severe insomnia or the shakes, tachycardia and sweating.

11. SUBSTANCE USE TO AVOID WITHDRAWAL

Note: In DSM-IV, 10 and 11 are part of the same criteria.
a. After not using (drug) for a time, did you start using again to keep yourself from having symptoms that appeared when you stopped using?

b. Did you ever use any other drugs or medications to relieve physical or emotional symptoms that you experienced when you stopped using (drug)?

12. RECURRENT SUBSTANCE RELATED LEGAL PROBLEMS

Did you get arrested or go to jail for the way you behaved while intoxicated with (drug)?

13. CRAVING

a. Was there ever time when you had strong urge or desire to use (drug)?

b. Was there ever a time you wanted to use (drug) so badly, you couldn't think of anything else?
When was that (age)?_____

DURATION

For how long have you had these problems with (drug)?

Please Specify:

_____

Question	Stimulants	Sedatives	Hallucinogens	Phencyclidine	Inhalants	Other
	1 = NA/NO INFO 2 = NO 3 = YES	1 = NA/NO INFO 2 = NO 3 = YES	1 = NA/NO INFO 2 = NO 3 = YES	1 = NA/NO INFO 2 = NO 3 = YES	1 = NA/NO INFO 2 = NO 3 = YES	1 = NA/NO INFO 2 = NO 3 = YES
C. 7.a. Continue - physical problem	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3
C. 7. b. Continue - emotional problem	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3
C.8. Continue - social problem	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3
C.9. Tolerance	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3
C.10 Withdrawal	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3
C.11.a. Substance to prevent withdrawal	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3
C.11.b. Other substance to relieve withdrawal	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3
C.12 Legal problems	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3
C.13.a. Craving- urge or desire	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3
C.13.b. Craving- couldn't think of anything else	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3
AGE	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___
Duration (specify)						

E. Impairment

1. SOUGHT HELP
   a. Because of your use of (drug) did you ever seek help from anyone, like a doctor or other professional?

   b. Or a minister?

   c. Or a self-help group such as N.A.?

   d. Or even a friend?

   e. Or did someone suggest that you seek help?

2. MEDICATION
   Because of your use of (drug) did you ever take medication? *If yes,* **What did you take?**

3. HOSPITALIZATION
   a. Were you hospitalized for using (drug)?

   b. For how many days?

4. OTHER TREATMENT
   a. Did you receive any other type of treatment for your use of (drug)?

   b. **For how many weeks**?

5. TOTAL TIMES IN TREATMENT

   How many times in your life have you been treated for problems with using (drug)?

Question	Stimulants	Sedatives	Hallucinogens	Phencyclidine	Inhalants	Other
	1 = NA/NO INFO 2 = NO 3 = YES	1 = NA/NO INFO 2 = NO 3 = YES	1 = NA/NO INFO 2 = NO 3 = YES	1 = NA/NO INFO 2 = NO 3 = YES	1 = NA/NO INFO 2 = NO 3 = YES	1 = NA/NO INFO 2 = NO 3 = YES
E. 1.a. Help from M.D. or professional	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3
E.1.b. Help from minister	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3
E.1.c. Help from self help group	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3
E.1.d. Help form a friend	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3
E.1.e. Someone suggested help	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3
E.2. Took medication If yes , describe:	1 2 3 _____	1 2 3 _____	1 2 3 _____	1 2 3 _____	1 2 3 _____	1 2 3 _____
E. 3. Hospitalized. How many days?	1 2 3 _____ _____	1 2 3 _____ _____	1 2 3 _____ _____	1 2 3 _____ _____	1 2 3 _____ _____	1 2 3 _____ _____
E. 4. Other treatment How many weeks?	1 2 3 _____ _____	1 2 3 _____ _____	1 2 3 _____ _____	1 2 3 _____ _____	1 2 3 _____ _____	1 2 3 _____ _____
E. 5. How many times in treatment	_____ _____	_____ _____	_____ _____	_____ _____	_____ _____	_____ _____

Specify medications taken :

_____

6. SUBJECT'S PERCEIVED NEED FOR TREATMENT
How important to you now is getting treatment (further treatment) for problems with using (drug)?

Use the following codes:

1 = NA/NO INFORMATION
2 = NOT AT ALL
3 = SLIGHTLY
4 = MODERATELY
5 = CONSIDERABLY
6 = EXTREMELY

7. OVERALL ROLE IMPAIRMENT
Did the (drug) use or the symptoms related to it prevent you from doing things, cause you to be less efficient in what you were doing, or interfere with your normal, daily routine in any way? *If yes, please describe.*

8. OCCUPATIONAL/ACADEMIC IMPAIRMENT
Did you stay home from work (or school) because of using (drug)? For how long?
Was it harder to do your job when you used (drug)?*If yes, please describe.*

9. SOCIAL IMPAIRMENT
Did the (drug) use and/or symptoms affect your social life? Were there any difficulties or problems with friends because of using (drug)?*If yes, please describe.*

10. HOME/ FAMILY IMPAIRMENT
Did the (drug) use and/or symptoms affect your tasks at home, responsibilities, or interactions with family members? *If yes, please describe.*

11. SIGNIFICANT DISTRESS
Did you find that you were very distressed about how you were feeling or acting? *If yes, please describe.*

Question	Stimulants	Sedatives	Hallucinogens	Phencyclidine	Inhalants	Other
E. 6. Perceived need for treatment	1 2 3 4 5 6	1 2 3 4 5 6	1 2 3 4 5 6	1 2 3 4 5 6	1 2 3 4 5 6	1 2 3 4 5 6

	1 = NA/NO INFO 2 = NO 3 = YES	1 = NA/NO INFO 2 = NO 3 = YES	1 = NA/NO INFO 2 = NO 3 = YES	1 = NA/NO INFO 2 = NO 3 = YES	1 = NA/NO INFO 2 = NO 3 = YES	1 = NA/NO INFO 2 = NO 3 = YES
E.7. Overall Role Impairment	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3
E. 8. Occupational/ Academic Impairment	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3
E. 9 Social Impairment	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3
E. 10. Home/Family Impairment	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3
E. 11. Significant distress	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3

Please describe overall role, occupational/academic, social, home/family impairment and significant distress below.

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LIFECHART

We have already discussed different periods in your life when you had the problems we just talked about. Let's clarify the timing of those periods starting with the <u>worst</u> episode. *Code Other Drug Dependence: ODD, Other Drug Abuse: ODA.*

	___Onset___			___Offset___				Status of Episode	Treatment Received
Code	Month	Year	Age	Month	Year	Age	Duration	1 - NA/No Info 2 - Subsyndromal or Partial Symptoms 3 - Full Syndrome Present	1 - NA/No Info 2 - No treatment 3 - Medication 4 -Psychotherapy 5 -Hospitalization 6 - Other
	__ __	__ __	__ __	__ __	__ __	__ __	_ _ _	9__	_ _ _ _
	__ __	__ __	__ __	__ __	__ __	__ __	_ _ _	__	_ _ _ _
	__ __	__ __	__ __	__ __	__ __	__ __	_ _ _	__	_ _ _ _
	__ __	__ __	__ __	__ __	__ __	__ __	_ _ _	__	_ _ _ _
	__ __	__ __	__ __	__ __	__ __	__ __	_ _ _	__	_ _ _ _
	__ __	__ __	__ __	__ __	__ __	__ __	_ _ _	__	_ _ _ _
	__ __	__ __	__ __	__ __	__ __	__ __	_ _ _	__	_ _ _ _
	__ __	__ __	__ __	__ __	__ __	__ __	_ _ _	__	_ _ _ _
	__ __	__ __	__ __	__ __	__ __	__ __	_ _ _	__	_ _ _ _
	__ __	__ __	__ __	__ __	__ __	__ __	_ _ _	__	_ _ _ _

1. NICOTINE USE DISORDER

A. Patterns of Smoking

Note to Interviewer:
Nicotine use should be assessed over life-time regardless of whether this is a life-time or catch-up interview.

Now some questions about using tobacco:

Have you in your entire life ever smoked 5 packs (100 cigarettes) or more?

(Note to interviewer: Each pack contains 20 cigarettes.)

1. HAS SMOKED 5 OR MORE TIMES PACKS, OR USED TOBACCO 5 OR MORE TIMES

1 NA/NO INFO
2 NO
3 YES

IF NO OR NO INFO SKIP TO PSYCHOTIC DISORDERS, PAGE 174

B. Screening Question

1. PROBLEMS WITH SMOKING

a. Was there ever a period in your life when you smoked too much?

b. Was there ever a period in your life that you kept smoking even though it began to cause problems?

c. Has anyone in your family - or anyone else - ever objected to your smoking?

d. Was there ever a time when you couldn't stop smoking when you wanted to?

1	NA/NO INFO
2	NO
3	YES

IF NO INFO, SKIP TO PSYCHOTIC DISORDERS, PAGE 174

Interviewer should determine onset, duration and severity of smoking/tobacco use. If many episodes are described, determine which episode was the worst.

How old were you when you smoked your first cigarette?
How old were you when you first started smoking everyday?
Thinking back over the entire period when you were smoking every day, about how many cigarettes did you usually smoke in a single day? When was the most recent time?
What is your current use like? How much do you usually smoke? How often do you smoke?
How about at other times of your life?

C. DSM-III-R/IV Smoking Dependence - Symptom Review

	WORST EPISODE		
	NA/NO INFO	NO	YES
1. CONSUMES MORE THAN INTENDED Have you ever found that once you started smoking/using tobacco, you ended up using more than you intended or for a longer time than you intended?	1	2	3
2. PERSISTENT DESIRE OR INABILITY TO CUT DOWN OR STOP USING TOBACCO a. Have you ever wanted to cut down, stop smoking, or otherwise change your smoking?	1	2	3
b. Have you ever tried to cut down or stop smoking and found that you couldn't? Have you tried more than once/twice to stop smoking or smoke less?	1	2	3
3. TIME SPENT OBTAINING CIGARETTES OR SMOKING Did or do you spend a great deal of time smoking (e.g., chain smoking) or trying to find places to smoke?	1	2	3
4. SUBSTANCE USE RESULTS IN A FAILURE TO FULFIL MAJOR ROLE OBLIGATIONS *Did smoking interfere with taking care of your work, school work, work at home?*	1	2	3
Work: a. Did smoking ever cause you to miss work or have trouble on the job?	1	2	3
b. Did it cause you to lose your job?	1	2	3
Home: c. Was there ever a time when because of your smoking you were unable to take care of household responsibilities (e.g., getting meals prepared, doing shopping) or to take care of your children?	1	2	3
School: d. Did smoking ever result in missing school or doing poorly on school work?	1	2	3
e. Did smoking ever result in suspension or expulsion from school?	1	2	3
5. USE IN HAZARDOUS CONDITIONS Have you ever smoked when it was dangerous to do so (e.g, near things that could catch fire, such as in your bed while you were sleepy, or near flammable chemicals)?	1	2	3
6. USUAL ACTIVITIES GIVEN UP a. Have you ever smoked so much that you used to smoke instead of working or spending time at hobbies or with family or friends?	1	2	3
b. Have you given up or cut down on activities that are important to you – like associating with friends or relatives, or attending social activities, because smoking was not permitted at the activity?	1	2	3

Examples of activities given up:

	WORST EPISODE		
	NA/NO INFO	NO	YES
7. USES NICOTINE DESPITE RECOGNITION THAT A PHYSICAL OR PSYCHOLOGICAL PROBLEM HAS BEEN CUASED OR EXACERBATED **a. Did you notice, or did a doctor ever tell you, that you had developed a physical problem caused by, or made worse from, smoking? (e.g., cancer, heart disease, bronchitis, chronic obstructive pulmonary disease (COPD)? Did you continue smoking despite the problem?** ***Code symptom present if has physical complication and did not smoking.***	1	2	3
b. Have you noticed, or has a health or mental health profession told you that smoking will make an emotional problem of yours worse? Did you continue smoking? *Code symptom present if has problem and did not stop smoking.*	1	2	3
8. CONTINUED USE DESPITE SOCIAL PROBLEMS CAUSED BY OR EXACERBATED BY SUBSTANCE **Did smoking cause or worsen problems with your relationship with your spouse, family, or friends? Did your smoking make them angry or unhappy? Did you continue smoking despite these problems?**	1	2	3
9. TOLERANCE **a. Did you find that you had to smoke more in order to feel the effect, or that you didn't feel the effect when you smoked the usual amount*? (Code symptom present if 50% or more.)***	1	2	3
b. Did you find that the most intense effect of smoking was felt for the first cigarette you smoked during the day?	1	2	3
c.Did you have initial nausea or dizziness when you first started to smoke which became less with repeated smoking?	1	2	3
10. WITHDRAWAL **Did you ever have withdrawal symptoms when not smoking or when smoking in smaller amounts or less often?** **For Example, did you:** **feel more depressed? have difficulty falling asleep or staying asleep? have difficulty concentrating? eat more than usual or gain weight? become easily irritated, angry or frustrated? feel anxious or nervous? feel your heart beating more slowly than usual? feel more restless than usual? *Circle endorsed items and code positive if at least 4 of these symptoms are endorsed***	1	2	3
11. SUBSTANCE USE TO AVOID WITHDRAWAL **(*Note: In DSM-IV, 10 and 11 are part of the same criterion).*** **a. After not smoking for a time, did you start smoking again to prevent developing the symptoms we just discussed?**	1	2	3
b. Did you ever use any other drugs or medications to relieve the symptoms we discussed?	1	2	3
c. Did you often wake up in the middle of the night to smoke? Did you smoke just or shortly after getting up in the morning? Did you find yourself smoking just after being in a situation where smoking was not permitted- like after being on a plane, at a meeting, or shopping at the mall?	1	2	3

	WORST EPISODE		
	NA/NO INFO	NO	YES
12. RECURRENT SUBSTANCE RELATED LEGAL PROBLEMS Did you get arrested or go to jail for the way you behaved while smoking?	1	2	3
13. CRAVING a. Was there ever a time when you had a strong urge or desire to smoke?	1	2	3
b. Was there ever a time you wanted to smoke so badly, you couldn't think of anything else? When was that (age)?	1	2	3
DURATION How long have you had these problems with smoking? *Please Specify:*_____			

D. Impairment

	WORST EPISODE		
	NA/NO INFO	NO	YES
1. SOUGHT HELP a. Because of your smoking, did you ever seek help from anyone, like a doctor or other health professional?	1	2	3
b. Or a minister	1	2	3
c. Or a self-help group?	1	2	3
d. Or even a friend?	1	2	3
e. Or did someone suggest that you seek help?	1	2	3
2. MEDICATION Because of your smoking did you ever take medication? *If yes,* what did you take? _____	1	2	3
b. Did you take more medication than usual or did you use nonprescription drugs?	1	2	3
If yes, What did you take?_____			
3. HOSPITALIZATION a. Were you hospitalized for using smoking?	1	2	3
b. For how many days?			
	Days		
4. OTHER TREATMENT a. Did you receive any other type of treatment for your smoking?	1	2	3
b. For how many weeks?			
	Weeks		
5. TOTAL TIMES IN TREATMENT How many times in your life have you been treated for problems with smoking?			

6. SUBJECT'S PERCEIVED NEED FOR TREATMENT **How important to you now is getting treatment (further treatment) for problems with using smoking?**	**1 NA/No Information** **2 Not at all** **3 Slightly** **4 Moderately** **5 Considerably** **6 Extremely**		
	WORST EPISODE		
	NA/NO INFO	**NO**	**YES**
7. OVERALL ROLE IMPAIRMENT **Did smoking use or the symptoms related to it prevent you from doing things, cause you to be less efficient in what you were doing, or interfere with your normal, daily routine in any way?**	**1**	**2**	**3**
***If yes, please describe*:**			
8. **OCCUPATIONAL/ACADEMIC IMPAIRMENT** **Did you stay home from work (or school) because of using smoking?** **For how long? Was it harder to do your job?**	**1**	**2**	**3**
***If yes, please describe*:**			
9. SOCIAL IMPAIRMENT **Did smoking affect your social life? Were there any difficulties or problems with friends because of using smoking?**	**1**	**2**	**3**
***If yes, please describe*:**			
10. HOME/ FAMILY IMPAIRMENT **Did smoking use and/or symptoms affect your tasks at home, responsibilities, or interactions with family members?**	**1**	**2**	**3**
***If yes, please describe*:**			
11. SIGNIFICANT DISTRESS **Did you find that you were very distressed about how you were feeling or acting?**	**1**	**2**	**3**
***If yes, please describe*:**			

F. Criteria Check

Note: DSM-IV only encodes nicotine dependence.

	NO INFO	FALSE	TRUE
1. MET CRITERIA FOR DSM-IV SMOKING DEPENDENCE (3 Criteria out of 7: 1, 2, 3, 6, 7, 9, 10+11)	**1**	**2**	**3**

LIFECHART

We have already discussed different periods in your life when you had the problems we just talked about. Let's clarify the timing of those periods starting with the <u>worst</u> episode. *Code Nicotine Dependence: ND, Nicotine Abuse: NA.*

Code	Onset			Offset			Duration	Status of Episode	Treatment Received
	Month	Year	Age	Month	Year	Age		1 - NA/No Info 2 - Subsyndromal or Partial Symptoms 3 - Full Syndrome Present	1 - NA/No Info 2 - No treatment 3 - Medication 4 -Psychotherapy 5 -Hospitalization 6 - Other
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	9___	__ __ __ __
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	___	__ __ __ __
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	___	__ __ __ __
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	___	__ __ __ __
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	___	__ __ __ __
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	___	__ __ __ __
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	___	__ __ __ __
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	___	__ __ __ __
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	___	__ __ __ __
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	___	__ __ __ __

This section is structured to achieve a diagnosis of the following functional disorders: Schizophrenic Disorders; Schizo-Affective Disorders; Mood Disorder with Psychotic Features; Delusional Disorder; and Unspecified Functional Psychosis.

1. HALLUCINATIONS

A. Screening Questions

1. Has there ever been a time when you saw things that other people couldn't see or had strange feelings in your body?

2. Has there ever been a time when you heard voices that other people couldn't hear?

3. Has there ever been a time when you smelled odors others couldn't or tasted strange things?

1	NA/NO INFORMATION
2	NO
3	YES

SKIP TO DELUSIONS PAGE 176

IF YES:

4. Did others in your family or your religion (spirituality) have the same experience? Who was that? What was the experience like?

1	NA/NO INFORMATION
2	NO
3	YES

SKIP TO DELUSIONS, PAGE 176

Please specify:

_____

_____

5. RULE OUT QUESTIONS

When these experiences (referred to above) occurred:

	INFO	NO	YES
a. Were you drinking a lot then or had you just stopped?	1	2	3
b. Were you taking drugs - like LSD, speed?	1	2	3
c. Were you physically ill then?	1	2	3
d. Were you awake, half awake or asleep?	1	2	3

NA/NO

B. Chronology

At this point, the interviewer should establish chronology for him/herself regarding the number of episodes, duration and severity of each, identify the worst episode, and record this information below.

C. Symptom Review

To be rated positively, a hallucination should have been present throughout the day for several days or intermittently throughout a one-week period.

IF HAD AUDITORY HALLUCINATIONS **When these experiences (referred to above) occurred:**	WORST EPISODE NA/NO INFO	NO	YES
1. Did you hear a voice speaking to you? What was it saying?	1	2	3
2. Did you hear two or more voices that were talking to each other?	1	2	3

FOR ALL TYPES OF HALLUCINATIONS ASK:
How long did this experience last? Was it just a few minutes? Did it continue for days or weeks?

HALLUCINATIONS OCCURRED IN THE CONTEXT OF WHICH DISORDER?

1. MAJOR DEPRESSION	1	2	3
2. MANIA	1	2	3
3. ALCOHOL DEPENDENCE/ABUSE	1	2	3
4. OTHER SUBSTANCE USE DISORDER	1	2	3
5. OTHER (i.e., PSYCHOTIC DISORDER)	1	2	3
6. CONTENT WAS NON-AFFECTIVE (I.E., MOOD-INCONGRUENT OR UNRELATED TO DEPRESSION OR MANIA)	1	2	3
7. EVIDENCE OF HALLUCINATIONS	1	2	3

D. Summary

Hallucinations throughout the day for several days or several times a week for several weeks (each hallucinatory experience not being limited to a few brief moments)	1	2	3

2. DELUSIONS

A. Screening Questions

1. Has there ever been a time when you had beliefs or ideas that you were convinced were true, but which you later found were not true and that other people didn't seem to share or understand? For example did you believe that people were out to get you, or talking about you or controlling you against your will?

Were you sure of that at that time? Did you change your mind after talking to others about your beliefs?

1 NA/NO INFORMATION
2 NO
3 YES

SKIP TO FORMAL THOUGHT DISORDER, PAGE 178

IF YES:
2. Did others in your family or religion (spirituality) have the same beliefs or ideas? Who was that? What did they think about it?

Part of shared religious or cultural or subcultural belief system

1 NA/NO INFORMATION
2 NO
3 YES

SKIP TO FORMAL THOUGHT DISORDER, PAGE 178

3. RULE OUT QUESTIONS **When you had the (referred to above) beliefs:**	NA/NO INFO	NO	YES
a. Were you drinking a lot then or had you just stopped?	1	2	3
b. Were you taking drugs - like LSD, speed?	1	2	3
c. Were you physically ill then?	1	2	3
4. EVIDENCE OF DELUSIONS	1	2	3

B. Chronology

At this point, the interviewer should establish chronology regarding the number of episodes, date of onset, duration, severity of each. Note worst episode. Record this information below.

C. Symptom Review

DESCRIBE TYPE OF DELUSION

How long did you have those beliefs?

DELUSIONS OCCURRED IN THE CONTEXT OF WHICH DISORDER?	NA/NO INFO	NO	YES
1. MAJOR DEPRESSION	1	2	3
2. MANIA	1	2	3
3. ALCOHOL DEPENDENCE/ABUSE	1	2	3
4. OTHER SUBSTANCE USE DISORDER	1	2	3
5. OTHER (i.e., PSYCHOTIC DISORDER)	1	2	3

3. FORMAL THOUGHT DISORDER

A. Screening Questions

1. Have there ever been times when people said they had trouble understanding what you were saying? Was your speech mixed up? Did you make sense? Could you make yourself understood if people told you that you couldn't be understood? Were you "high" at the time? Were you sick? Had you taken pills? Did people have trouble understanding you when you weren't "high"?

1 NA/NO INFORMATION
2 NO
3 YES

IF HAD HALLUCINATIONS OR DELUSIONS SKIP TO IMPAIRMENT.
IF NEVER HAD HALLUCINATIONS OR DELUSIONS SKIP TO ANTISOCIAL PERSONALITY DISORDER, PAGE 184

IF YES:
Formal thought disorder occured in the context of which disorder

	DEP	MAN	ALC	DRU	OTH
NO INFO	1	1	1	1	1
NO	2	2	2	2	2
YES	3	3	3	3	3

B. Chronology

At this point, the interviewer should establish chronology for him/herself regarding the number of episodes, duration and severity of each and record this information below.

C. Additional Characteristics

If thought disorder was present, was it associated with any of the following?

	NA/NO INFO	NO	YES
1. CATATONIA **Did you find that you couldn't move? Were you immobilized?**	1	2	3
2. GROSSLY BIZARRE BEHAVIOR **Did you do anything that called attention to yourself? Like the way you dressed, acted or the things you said?**	1	2	3
3. INAPPROPRIATE OR FLAT AFFECT **Was your face as expressive as before? Did people have trouble figuring out how you were feeling by looking at your expression?**	1	2	3

D. Prodromal/Residual Role Impairment

Includes evidence of deterioration in functioning in interpersonal relationships at home, work, or school. This could have occurred before (Prodromal) or after (Residual) acute psychotic symptomatology was present.

During the months before or after the episode of illness we have just discussed:

1. MARKED SOCIAL ISOLATION OR WITHDRAWAL **How much did you socialize with other people? Did you have any close friends, people that you really trusted**?	1	2	3
2. BLUNTED, FLAT OR INAPPROPRIATE AFFECT **Did you react to things with different emotions than other people or feel "numb" emotionally other than times when you were on medication?**	1	2	3
3. DIGRESSIVE, VAGUE, OVERELABORATE, OR CIRCUMSTANTIAL SPEECH, OR POVERTY OF SPEECH, OR POVERTY OF CONTENT OF SPEECH **Did people have trouble understanding what you were saying or did you have trouble maintaining a conversation? Sometimes people have trouble staying on the topic being discussed or need to use a lot of words to make themselves understood, but others still have trouble understanding them. Did that ever happen to you?**	1	2	3

	NA/NO INFO	NO	YES
4. UNUSUAL PERCEPTUAL EXPERIENCES *(such as recurrent illusions or sensing the presence of a force or person not actually present)* **Did you often feel that the world looked different or had changed in some way, or that you could feel the presence of a person or force that others could not see, or have any other strange experience?**	1	2	3
5. MARKED IMPAIRMENT IN ROLE FUNCTIONING **Were you able to keep up with your usual responsibilities (e.g., school, work, home care)?**	1	2	3

E. Rule Outs or Differentiation

1. MANIC and had DELUSIONS or HALLUCINATIONS **Did delusions or hallucinations persist after your high/euphoric mood had significantly improved?** *If yes, please describe onset and duration:*	1	2	3
2. DEPRESSED and had DELUSIONS or HALLUCINATIONS **Did delusions or hallucinations persist after your depressed mood had significantly improved?** *If yes, please describe onset and duration:*	1	2	3
3. All episodes were associated with pregnancy or childbirth (within 2 months of pregnancy or child birth)	1	2	3

F. Criteria Check

1. DSM-III-R/IV CRITERIA FOR SCHIZOPHRENIA

2 or more of the characteristic symptoms during a one month period (only 1 symptom is required if delusions are bizarre or there are hallucinations or a running commentary or two voices conversing with each other.

A. Delusions

B. Hallucinations (througout the day for several times a week for several weeks)

C. Disorganized speech (incoherence, marked loosening of associations)

D. Grossly disorganized or catatonic behavior

E. Negative symptoms (flat or grossly inappropriate affect, alogia or avolition)

F. Duration of disturbance (together with prodromal or residual symptoms) is 6 months.

	NA/NO INFO	NO	YES
Met criteria for DSM-III-R Schizophrenia	1	2	3
Met criteria for DSM-IV Schizophrenia	1	2	3

G. Impairment

	NA/NO INFO	NO	YES
1. SOUGHT HELP			
a. Did you seek help from anyone, like a doctor or other professional?	1	2	3
b. or minister?	1	2	3
c. or even a friend?	1	2	3
d. or did someone suggest that you seek help?	1	2	3
2. TOOK MEDICATION			
a. Did you take medicine? *If Yes,* **What did you take?**	1	2	3
b. Did you take more medicine than usual or did you use nonprescription drugs? *If yes,* **What did you take?**	1	2	3
3. HOSPITALIZATION			
Were you hospitalized for how you were feeling?	1	2	3

For how many days? | | | |

	NA/NO INFO	NO	YES
4. OVERALL ROLE IMPAIRMENT **Did how you were feeling interfere with your normal, daily routine in any way?** *If yes, please describe*:	1	2	3
5. OCCUPATIONAL/ACADEMIC IMPAIRMENT **Did you stay at home from work (or school) because of the way you were feeling? Were your grades affected? How?** *If yes, please describe*:	1	2	3
6. SOCIAL IMPAIRMENT **Was your social life affected by how you were feeling? How? Were there any difficulties or problems with friends because of how you were feeling?** *If yes, please describe*:	1	2	3
7. HOME/ FAMILY IMPAIRMENT **Was there a change in the way you interacted with your family or how you performed your household chores?** *If yes, please describe*:	1	2	3
8. SIGNIFICANT DISTRESS **Did you find that you were very distressed about how you were feeling or acting?** *If yes, please describe*:	1	2	3

LIFECHART

We have already discussed different periods in your life when you had the problems we just talked about. Let's clarify the timing of those periods starting with the worst episode. *Code Psychosis: PSY.*

	Onset			Offset				Status of Episode	Treatment Received
Code	Month	Year	Age	Month	Year	Age	Duration	1 - NA/No Info 2 - Prodromal or Partial Symptoms 3 - Full Syndrome Present	1 - NA/No Info 2 - No treatment 3 - Medication 4 -Psychotherapy 5 -Hospitalization 6 - Other
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	9 ___	__ __ __ __
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	___	__ __ __ __
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	___	__ __ __ __
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	___	__ __ __ __
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	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	___	__ __ __ __

This category is for subjects with a chronic or recurrent disorder characterized by a failure to conform to social norms in many areas always beginning in the early teens (or earlier) and persisting into adulthood. The diagnosis should not be made in individuals below the age of 18. If the subject has had a serious alcohol or drug problem, the diagnosis of Antisocial Personality Disorder is not made unless signs of the disorder were also present in childhood and continued in adulthood. If both disorders began in childhood, both disorders should be diagnosed. Do not count symptoms that occur in the context of mania or schizophrenia.

A. Screening Questions

(Probe for age when behavior began and how long it lasted)

1. When you were a teenager before 15, did you get into trouble at school, did you skip school, get suspended or expelled from school, or did you break or steal things or get into trouble with the police?

1 NA/NO INFO
2 NO
3 YES

2. Since the age of 15, have you had difficulty with the law or have you ever been arrested? Have you gotten into repeated fights? Have you found it necessary to lie frequently or use false names? Have you often changed your life circumstances suddenly? For instance, have you moved, changed jobs or ended relationships with no warning?

1 NA/NO INFO
2 NO
3 YES

SKIP TO EATING DISORDERS, PAGE 192

B. Chronology

Antisocial Personality is, by definition a chronic rather than episodic condition. Note here the age of onset of first antisocial behavior, the problem behavior described and briefly state the progression and types of problem behaviors up to the present time.

C. Symptom Review: Before age 15

	NA/NO INFO	NO	YES
1. TRUANCY (BEFORE AGE 13) **Were you often truant from school?** **When did that first start?** **How often did you cut school?**	1	2	3
2. OFTEN STAYS OUT AT NIGHT DESPITE PARENTAL PROHIBITIONS (DSM-IV only) **Did you stay out at night often, even against your parents' wishes?**	1	2	3
3. RAN AWAY AT LEAST TWICE **Did you ever run away from home overnight more than once before age 15?**	1	2	3
4. PERSISTENT LYING **Did you lie a lot when you were younger?** **What did you lie about?** **How often? When was that?**	1	2	3
5. THEFT WITHOUT CONFRONTATION **Before age 15, did you often steal things from stores, cars, or houses; your parents or other people?** **What did you steal and from whom?**	1	2	3
6. THEFT WITH CONFRONTATION **Did you ever confront someone to get their money or belongings?**	1	2	3
7. INITIATES PHYSICAL FIGHTS (MORE THAN TWICE) **Did you start a lot of physical fights before the age of 15?** **How often? When?**	1	2	3
8. USED WEAPONS THAT CAUSE SERIOUS HARM **Did you ever use a weapon in any of these fights?** **What kind of weapon? How often? When?**	1	2	3
9. OFTEN BULLIES, THREATENS OR INTIMIDATES OTHERS (DSM-IV only) **Did you often threaten others or cause others to be frightened of you ? What did you do? How often did that happen?**	1	2	3
10. BREAKING AND ENTERING (DSM-IV only) **Before age 15, did you break into someone's house, building or car? What did you break into? How many times did you do things like that?** **When was that?**	1	2	3
11. VANDALISM **When you were younger, did you ever intentionally destroy or damage someone's property, like breaking windows, tearing down signs?**	1	2	3

	NA/NO INFO	NO	YES
12. FIRE SETTING **Did you ever intentionally set fires? When was that? What did you do? How often did that happen?**	1	2	3
13. PHYSICAL CRUELTY TO ANIMALS **Before you were 15, did you ever hurt, torture or kill animals such as setting a dog on fire, or throwing a cat out of the window?**	1	2	3
14. PHYSICAL CRUELTY TO HUMANS **Before you were 15, did you ever intentionally cause physical pain to other people? What did you do? How often did you do that? When did that happen?**	1	2	3
15. FORCED SEXUAL BEHAVIOR **When you were younger, did you ever force someone to have sex with you? How old were you then? How often did you do that?**	1	2	3

D. Symptom Review: Adulthood

1. UNSTABLE WORK HISTORY **Since 18, have you had periods when you were not working? Was there any reason why you couldn't work? Did you not work for at least 6 months in the last 5 years?**	1	2	3
Did you take off much time from work when you had a job? Was that more than was allowed? Did your supervisor complain? Did you get fired?	1	2	3
Have you changed jobs often or left a job before you had another one lined up?	1	2	3
2. FAILURE TO HONOR FINANCIAL OBLIGATIONS (in DSM-IV, 1 and 2 are combined) **Have you ever failed to provide child support or support for others dependent on you? When was that? How often did that happen? Have you been sued for a bad debt or had things you bought taken back because you didn't meet payments?**	1	2	3
3. ILLEGAL ACTIVITIES **Have you ever been arrested since age 15? What for? When? Have you been involved in anything for which you could have been arrested? What kinds of things?**	1	2	3
4. IRRITABLE AND AGGRESSIVE BEHAVIOR **Do you have a bad temper? Has it caused you to get involved in physical fights since age 15? Did you use a weapon? How often did that happen? Have you ever physically abused your partner (spouse) or children?**	1	2	3

	NA/NO INFO	NO	YES
5. FAILURE TO PLAN AHEAD/IMPULSIVE **Have you ever had a period of time when you had no permanent residence (being homeless) ?**	1	2	3
Have you ever travelled or wandered from place to place with no pre-arranged plans (other than a vacation)?	1	2	3
6. DISREGARD FOR TRUTH **Have you told a lot of lies since age 15? Have you ever used a different name such as an alias in order to con or swindle money from others?**	1	2	3
7. RECKLESSNESS **Since age 15, have you done wild, reckless things in general like reckless driving or driving while intoxicated? Have you done other things which placed yourself or others in danger?**	1	2	3
8. PARENTAL IRRESPONSIBILITY (deleted in DSM-IV) **Have you ever left a young child in your care alone for more than a few minutes? Did you ever neglect children in your care where they weren't being fed, clothed, or medically cared for properly? Did you ever run out of money for food for your family because you used it on yourself for going out, drinking or drugs?**	1	2	3
9. INABILITY TO SUSTAIN MONOGAMOUS RELATIONSHIP (deleted in DSM-IV) **Have you found it impossible to have a totally monogamous relationship with your partner for more than one year?**	1	2	3
10. LACKS REMORSE **Have you ever felt sorry about or regretted some of the things you have done such as** *(refer to above symptoms)***?**	1	2	3
11. IS RATER CONFIDENT OF RATINGS If no, explain: _____	1	2	3

E. Criteria Check

	NA/NO INFO	NO	YES
1. DSM-III-R/ DSM-IV RULE OUTS			
a. Occurrence of antisocial behavior is not exclusively during the course of Schizophrenia, a mood disorder with psychotic features, another psychotic disorder or a Pervasive Developmental Disorder	1	2	3
b. Current age is at least 18	1	2	3
2. DSM-III-R CRITERIA			
a. Has 3 of 12 symptoms beginning before age 15	1	2	3
b. Has 4 of 10 symptoms beginning after age 15	1	2	3
c. Met DSM-III-R criteria for Antisocial Personality Disorder	1	2	3
3. DSM-IV CRITERIA			
a. Met criteria for Conduct Disorder	1	2	3
b. Has 3 of 7 symptoms since age 15	1	2	3
c.Met DSM-IV criteria for Antisocial Personality Disorder	1	2	3

F. Impairment

	NA/NO INFO	NO	YES
1. SOUGHT HELP			
a. Did you seek help from anyone, like a doctor or other professional?	1	2	3
b. or minister?	1	2	3
c. or even a friend?	1	2	3
d. or did someone suggest that you seek help?	1	2	3
2. TOOK MEDICATION			
a. Did you take medicine? *If yes,* **What did you take?**	1	2	3
b. Did you take more medicine than usual or did you use nonprescription drugs? *If yes,* **What did you take?**	1	2	3

	NA/NO INFO	NO	YES
3. HOSPITALIZATION **Were you hospitalized for how you were feeling?**	1	2	3
For how many days?	___ DAYS		
4. OVERALL ROLE IMPAIRMENT **Did the behavior or the symptoms related to it prevent you from doing things, cause you to be less efficient in what you were doing, or interfere with your normal, daily routine in any way?** *If yes, please describe*:	1	2	3
5. OCCUPATIONAL/ACADEMIC IMPAIRMENT **Did you stay home from work (or school) because of the way you were behaving or feeling? For how long?** *If yes, please describe*:	1	2	3
6. SOCIAL IMPAIRMENT **Did the problems we just discussed affect your social life? Were there any difficulties or problems with friends because of how you were feeling?** *If yes, please describe*:	1	2	3
7. HOME/ FAMILY IMPAIRMENT **Did the problems we just discussed affect your tasks at home, responsibilities, or interactions with family members?** *If yes, please describe*:	1	2	3
8. SIGNIFICANT DISTRESS **Did you find that you were very distressed about how you were feeling or acting?** *If yes, please describe*:	1	2	3

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LIFECHART

We have already discussed different periods in your life when you had the problems we just talked about. Let's clarify the timing of those periods starting with the worst episode. *Code Antisocial Personality Disorder: APD, Conduct Disorder (only): CON.*

	Onset			Offset				Status of Episode	Treatment Received
Code	**Month**	**Year**	**Age**	**Month**	**Year**	**Age**	**Duration**	**1 - NA/No Info** **2 - Prodromal or Partial Symptoms** **3 - Full Syndrome Present**	**1 - NA/No Info** **2 - No treatment** **3 - Medication** **4 -Psychotherapy** **5 -Hospitalization** **6 - Other**
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	9 ___	__ __ __ __
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1. ANOREXIA NERVOSA

A. Screening Questions

1. WEIGHED LESS THAN EXPECTED

Have you ever weighed much less than people expected you should weigh?

1	NA/NO INFO
2	NO
3	YES

SKIP TO BULIMIA
PAGE 197

B. Chronology

At this point rater should establish some chronology regarding number of episodes of severe weight loss, and when they occurred. If the subject scored positive on depressive or psychotic disorders inquire if the episodes of weight loss coincided or were independent from other episodes of psychiatric disorder. If more than one episode, establish which is worst.

C. Symptoms

	WORST EPISODE		
	NA/NO INFO	NO	YES
1.REFUSAL TO MAINTAIN BODY WEIGHT AT MINIMALLY NORMAL WEIGHT (BODY WEIGHT LESS THAN 85% OF THAT EXPECTED).	1	2	3

What was the reason you lost so much weight?
Did you refuse to eat?
What did you do if people forced you to eat?

What was the lowest you weighed? *Record lowest weight in lbs*

Lowest weight in lbs

How tall were you at the time?

Height in inches

2. INTENSE FEAR OF BECOMING OBESE EVEN THOUGH UNDERWEIGHT	1	2	3

Were you afraid you would become fat if you ate?

3. DISTURBED BODY IMAGE

Did you feel fat even when others said you were thin? Did any part of your body feel fat? Did your weight or shape of your body influence how you thought about yourself?	1	2	3
4. AMENORRHEA *Absence of at least 3 consecutive menstrual cycles when otherwise expected (score present if periods occur only after hormone administration*)	1	2	3

During that time did you have your periods? Did you ever miss 3 periods in a row?

D. Other Characteristics

1. VOMITING

Did you vomit a lot or make yourself vomit?	1	2	3

	WORST EPISODE		
	NA/NO INFO	NO	YES
Did you use laxatives, diuretics or enemas (not prescribed by a doctor)? *If Yes: DSM-IV: Binge Eating - Purging Type* *If No: DSM-IV: Restricting Type*	1	2	3
2. GROWTH OF "DOWN"			
Did thin, light colored hair begin to grow on your face, head or other parts of your body?	1	2	3

3. GREATEST LEVEL OF SEVERITY

Determine subject's Body Mass Index (Weight/ height^2) during the Worst Episode:

A. ☐☐☐

Weight in lbs. X .025 during worst episode

B. ☐☐☐

Height in inches x .025

C. ☐☐☐

Body Mass Index = A / B^2

1 NA/NO INFO

2 Mild: Body Mass Index is greater than 17.5

3 Moderate: Body Mass Index is 16 - 17.4

4 Severe: Body Mass Index is less than 16

E. Impairment

1. SOUGHT HELP

a. Did you seek help from anyone, like a doctor or other professional?	1	2	3
b. or minister?	1	2	3

	WORST EPISODE		
	NA/NO INFO	NO	YES
c. or even a friend?	1	2	3
d. or did someone suggest that you seek help?	1	2	3
2. TOOK MEDICATION			
a. Did you take any medication?	1	2	3
If yes: **What did you take?**_____			
b. Did you take more medicine than usual or did you use nonprescription drugs?	1	2	3
If yes: **What did you take?**_____			
c. Did you take a food supplement?	1	2	3
If yes: **What did you take?** _____			
Were you tube fed?	1	2	3
3. HOSPITALIZATION			
Were you hospitalized for your eating problems?	1	2	3
For how many days?	___ Days		
4. OVERALL ROLE IMPAIRMENT			
Did the eating problems or your low weight or the symptoms related to it prevent you from doing things, cause you to be less efficient in what you were doing, or interfere with your normal, daily routine in any way?	1	2	3
If yes, describe			
5. OCCUPATIONAL/ACADEMIC IMPAIRMENT			
Did you stay home from work (or school) because of the way you were feeling? For how long? Was it harder to do your job when you had eating problems or your weight was low?	1	2	3
If yes, describe:			

	WORST EPISODE		
	NA/NO INFO	NO	YES
6. SOCIAL IMPAIRMENT			
Did the your eating problems or low weight affect your social life? Were there any difficulties or problems with friends because of how you were feeling?	1	2	3
If yes, describe:			
7. HOME/ FAMILY IMPAIRMENT			
Did the these symptoms affect your tasks at home, responsibilities, or interactions with family members?	1	2	3
If yes, describe:			
8. SIGNIFICANT DISTRESS			
Did you find that you were very distressed about your eating problems or your low weight?	1	2	3
If yes, describe:			

2. BULIMIA

A. Screening Questions

(Probe for recurrent episodes)

RECURRENT EPISODES OF BINGE EATING

Have you ever gone on an eating binge when you ate extraordinary amount of food in a short period of time? When was that? How many times did this occur?

- 1 NA/No Information
- 2 No
- 3 Yes, only once or twice
- 4 Yes, more than twice

At those times, did you feel your eating was out of control?

- 1 NA/No Information
- 2 No
- 3 Yes

SKIP TO OTHER PSYCHIATRIC DISORDERS PAGE 202

B. Chronology

At this point, the interviewer should establish chronology for him/herself regarding the number of episodes, duration and severity of each and record this information below. If more than one episode, establish which is the worst.

C. Symptom Review

	WORST EPISODE		
	NA/NO INFO	NO	YES
1. REPEATED ATTEMPTS TO LOSE WEIGHT BY SEVERELY RESTRICTED DIETS, SELF-INDUCED VOMITING, LAXATIVES, DIURETICS OR EXCESSIVE EXERCISE.			
Have you attempted to lose weight on a number of occasions? Did you make yourself vomit? Did you use laxatives, diuretics, enemas or other medications (not prescribed by a doctor)? Did you fast? Did you exercise a lot in order to lose weight?	1	2	3
2. FREQUENCY OF BINGES			
Did your eating binges and (name purging behavior) occur at least two times a week for at least three months?	1	2	3
3. SELF-EVALUATION UNDULY INFLUENCED BY BODY SHAPE AND WEIGHT			
Was your opinion about yourself influenced a lot by your body shape and your weight?	1	2	3

D. Other Characteristics of Bulimia

Determine subject's frequency of binging/purging per week during the worst episode and record below.

Binges per week

GREATEST LEVEL OF SEVERITY

1 NA/No Information

2 Mild (2-4 binges per week)

3 Moderate (5-10 binges per week)

4 Severe (11 or more binges per week)

E. Impairment

	WORST EPISODE		
	NA/NO INFO	NO	YES
1. HELP SEEKING			
a. Did you seek help from anyone, like a doctor or other professional?	1	2	3
b. or minister?	1	2	3
c. or even a friend?	1	2	3
d. or did someone suggest that you seek help?	1	2	3
2. TOOK MEDICATIONS			
a. **Did you take any medication?** *If yes,* **What did you take?**	1	2	3
b. **Did you take more medication than usual or did you use nonprescription drugs?** *If yes,* **What did you take?**	1	2	3
3. HOSPITALIZATION			
a. Were you hospitalized for how you were feeling?	1	2	3
b. For how many days?	___ DAYS		
4. OVERALL ROLE IMPAIRMENT **Did your eating problems or the symptoms related to it prevent you from doing things, cause you to be less efficient in what you were doing, or interfere with your normal, daily routine in any way?** *If yes, please describe:*	1	2	3
5. OCCUPATIONAL/ACADEMIC IMPAIRMENT **Did you stay home from work (or school) because of your eating problems? For how long?** **Was it harder to do your job when you had these eating problems?** *If yes, please describe*:	1	2	3

	WORST EPISODE		
	NA/NO INFO	NO	YES
6. SOCIAL IMPAIRMENT **Did your eating problems affect your social life? How? Were there any difficulties or problems with friends because of how you were feeling?** *If yes, please describe*:	1	2	3
7. HOME/ FAMILY IMPAIRMENT **Did your eating problems affect your tasks at home, responsibilities, or interactions with family members?** *If yes, please describe*:	1	2	3
8. SIGNIFICANT DISTRESS **Did you find that you were very distressed about your eating problems?** *If yes, please describe*:	1	2	3

LIFECHART

We have already discussed different periods in your life when you had the problems we just talked about. Let's clarify the timing of those periods starting with the worst episode. *Code Anorexia: ANO, Bulimia: BUL.*

	Onset			Offset				Status of Episode	Treatment Received
Code	**Month**	**Year**	**Age**	**Month**	**Year**	**Age**	**Duration**	**1 - NA/No Info 2 - Prodromal or Partial Symptoms 3 - Full Syndrome Present**	**1 - NA/No Info 2 - No treatment 3 - Medication 4 -Psychotherapy 5 -Hospitalization 6 - Other**
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___ ___	9 ___	___ ___ ___ ___
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	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___ ___	___	___ ___ ___ ___

A. Screening Question

1. SPECIFIC DISORDER NOT COVERED IN THIS INSTRUMENT (ADJUSTMENT DISORDER, OR OTHERS)

Are there any other serious difficulties in your life that you have not already told me about?

1 NA/NO INFO
2 NO
3 YES

SKIP TO SUICIDAL IDEATION, PAGE 208

B. Chronology

The interviewer should establish chronology and symptoms which may meet criteria for a DSM III-R/IV disorder. Establish onset, offset and duration and code accordingly.

C. Symptom Review

	WORST EPISODE		
	NA/NO INFO	NO	YES
1. SYMPTOMS MEET CRITERIA FOR A DSM-III-R OR DSM-IV DIAGNOSIS THAT IS NOT COVERED IN THE SADS *If yes, specify disorder and chronology:*	1	2	3
2. DIFFICULTIES MEET CRITERIA FOR "V" CODE *If yes, specify V-code condition and chronology:*	1	2	3
3. THERE IS INADEQUATE INFORMATION ABOUT PHENOMENOLOGY TO ESTABLISH A DIAGNOSIS *If yes, specify:*	1	2	3
4. A KNOWN ORGANIC FACTOR IS A LIKELY ETIOLOGY E.G., ALCOHOL ABUSE, AMPHETAMINE INTOXICATION, INGESTION OF A HALLUCINOGEN, FEVER *If yes, specify:*	1	2	3
5. HAD A RECOGNIZED PSYCHIATRIC SYMPTOM, SUCH AS EXTREME SUSPICIOUSNESS, CONVERSION REACTION, OR AMNESIA *If yes, specify:*	1	2	3
6. EXHIBITED CLEARLY PSYCHOTIC PHENOMENA *If yes, specify:*	1	2	3

D. Impairment

	WORST EPISODE		
	NA/NO INFO	NO	YES
1. SOUGHT HELP			
a. Did you seek help from anyone, like a doctor or other professional?	1	2	3
b. or minister?	1	2	3
c. or even a friend?	1	2	3
d. or did someone suggest that you seek help?	1	2	3
2. TOOK MEDICATION			
a. Did you take medicine? *If yes,* **What did you take?**	1	2	3
b. Did you take more medicine than usual or did you use nonprescription drugs? *If yes,* **What did you take?**	1	2	3
3. HOSPITALIZATION			
a. Were you hospitalized for how you were feeling?	1	2	3
b. For how many days?		DAYS	
4. OVERALL ROLE IMPAIRMENT **Did the (disorder or symptoms) interfere with or affect your normal, daily routine in any way?** *If yes, please describe*:	1	2	3
5. OCCUPATIONAL/ACADEMIC IMPAIRMENT **Did you stay home from work (or school) because of the way you were feeling? Was it harder to do your job?** *If yes, please describe*.	1	2	3

	WORST EPISODE		
	NA/NO INFO	**NO**	**YES**
6. SOCIAL IMPAIRMENT **Was your social life affected by how you were feeling? How? Were there any difficulties or problems with friends because of how you were feeling?** *If yes, please describe.*	1	2	3
7. HOME/FAMILY IMPAIRMENT **Was there a change in the way you interacted with your family or how you performed your household chores?** *If yes, please describe:*	1	2	3
8. SIGNIFICANT DISTRESS **How bothered have you been by how you were feeling?** *If yes, please describe:*	1	2	3

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LIFECHART

We have already discussed different periods in your life when you had the problems we just talked about. Let's clarify the timing of those periods starting with the worst episode. *Code Other Psychiatric Disorder: OTH.*

Code	Onset			Offset			Duration	Status of Episode	Treatment Received
	Month	Year	Age	Month	Year	Age		1 - NA/No Info 2 - Prodromal or Partial Symptoms 3 - Full Syndrome Present	1 - NA/No Info 2 - No treatment 3 - Medication 4 -Psychotherapy 5 -Hospitalization 6 - Other
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___ ___	9 ___	___ ___ ___ ___
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___ ___	___	___ ___ ___ ___
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___ ___	___	___ ___ ___ ___
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	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___ ___	___	___ ___ ___ ___
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___ ___	___	___ ___ ___ ___

Suicidal tendencies, including preoccupation with thoughts of death or suicide. (Do not include mere fears of dying. Rate the worst episode in past and in past month).

A. Screening Questions

If no knowledge of suicidality ask:
1.Have you ever wished you were dead or thought about dying or even killing yourself?

Have you thought how you would do it? Have you told anybody about your suicidal thoughts?

Have you actually done anything?

Ever? *(Circle appropriate number)*

If ever suicidal ask:
You mentioned earlier that you felt like/attempted to harm yourself. How many times have you felt like that?

1	No Information
2	Not at all
3	Slight, e.g., occasional thoughts of his/her death (without suicidal thoughts), "I would be better off dead" or "I wish I were dead"
4	Mild, e.g., frequent thoughts that he/she would be better off dead or occasional thoughts of suicide but has not thought of a specific method
5	Moderate, e.g., often thinks of suicide or has thought of a specific method
6	Severe, e.g., often thinks of suicide and has thought of, or mentally rehearsed a specific plan or has made a suicidal gesture
7	Extreme, e.g., has made preparations for a potentially serious suicidal attempt
8	Very extreme, e.g., suicide attempt with definite intent to die or behavior potentially medically harmful

SKIP TO PERSONAL INFORMATION, PAGE 212

2. In the past month? *Use above ratings*

B. Chronology

At this point, the interviewer should establish chronology regarding suicidal thoughts, intentions, or acts and obtain descriptions of each.

C. Suicidal Behavior

	NA/NO INFO	NO	YES
1. GESTURES AND ATTEMPTS			
a. Have you ever tried to kill yourself or done anything that could have killed you?		1 2	3
b. How many times have you tried to kill yourself?		☐☐	
c. When did this happen the first time?		☐☐ / ☐☐ (MONTH / YEAR)	
d. Were you treated for a suicide attempt?		1	2 3
e. Were you hospitalized for a suicide attempt?		1	2 3
f. Duration of hospitalization?		☐☐☐ (WEEKS)	

SKIP TO PERSONAL INFORMATION, PAGE 212

2. SUICIDAL INTENT AT TIME OF MOST SERIOUS ATTEMPT

Determine circumstances and rate seriousness of intent for the most serious attempt by considering such factors as likelihood of being rescued, precautions against discovery, acting to gain help during or after attempt, degree of planning of attempt, and the apparent purpose of attempt (manipulative versus killing self).

1 No information or not sure
2 Obviously no intent, purely manipulative gesture
3 Not sure or only minimal intent
4 Definite but very ambivalent
5 Serious
6 Very serious
7 Extreme (careful planning and every expectation of death)

3. ACTUAL MEDICAL THREAT TO LIFE OR PHYSICAL CONDITION FOLLOWING THE MOST SERIOUS GESTURE(S) OR ATTEMPT(S)

Consider the method (gunshot wound more serious than knife wound), impaired consciousness at or during time of rescue, seriousness of lesion or toxicity of ingested substances, reversibility (amount of time expected for complete recovery), and amount of treatment required. NOTE ages, circumstances of attempts.

1 No information or not sure
2 No danger, e.g., held pills in hand
3 Minimal, e.g., scratch on wrist
4 Mild, e.g., took 10 aspirins, mild gastritis
5 Moderate, e.g., took 10 seconals briefly unconscious
6 Severe, e.g., cut throat
7 Extreme, e.g., respiratory arrest or prolonged coma

D. Summary of Suicidal Behavior

Suicidal behavior occurred during episodes of illness recorded under the following diagnostic categories:

	NA/NO INFO	NO	YES
1. ANY ANXIETY DISORDER *(specify)*_____	1	2	3
2. DEPRESSION	1	2	3
3. ALCOHOLISM	1	2	3
4. DRUG ABUSE	1	2	3
5. PSYCHOSIS	1	2	3
6. OTHER *(specify)*_____	1	2	3

LIFECHART

We have already discussed different periods in your life when you had the problems we just talked about. Let's clarify the timing of those periods starting with the worst episode. *Code Suicidal Ideation: SUI, Suicidal Attempt: SUA.*

	___________Onset___________			___________Offset___________				Status of Episode	Treatment Received
Code	**Month**	**Year**	**Age**	**Month**	**Year**	**Age**	**Duration**	**1 - NA/No Info** **2 - Prodromal or Partial Symptoms** **3 - Full Syndrome Present**	**1 - NA/No Info** **2 - No treatment** **3 - Medication** **4 -Psychotherapy** **5 -Hospitalization** **6 - Other**
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	9 ___	__ __ __ __
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	___	__ __ __ __
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	___	__ __ __ __
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	___	__ __ __ __
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	___	__ __ __ __
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	___	__ __ __ __
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	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	___	__ __ __ __
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	___	__ __ __ __
	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	__ __ __	___	__ __ __ __

Thank you so much for your time and for sharing your experiences.

A. Written/Verbal Consent

For phone interviews:

In a week or so, you will be receiving in the mail a written consent form which is identical to the one I read to you at the beginning of this interview. Will you sign it and return it to us in the stamped, addressed envelope we will provide? *Reiterate importance of signed consent if subject has questions*.

Indicate that subject returned consent form:

1 NA/No Information

2 Subject has agreed to sign interview consent form

3 Subject has given signed interview consent to interviewer

4 Other *(specify)*_____

B. Medical Care

In addition, so that we can fully understand any of the health problems or other difficulties that you may have had, we would like to have permission to contact your doctors about problems they may have treated you for. Would that be all right with you? *If not, explain the rationale and answer any questions subject may have. When consent is given, proceed.*

For phone interviews

For us to contact your doctors, we need your written consent. If you will give me the names and addresses of your doctors past and present, I'll write them on the forms I have here and send them to you for your signature. Could you give me those names and addresses now?

Just so you know what to expect: you will be receiving a form giving your written consent to participate in our research, and you will also be receiving medical release forms with your doctors' names on them. Please sign and return all of these forms to us in the stamped envelope provided.

For face to face interviews:

For us to contact your doctors, we need your written consent. If you will give me the names and addresses of your doctors, past and present, I'll write them on the appropriate forms and you can read and sign them now. Could you give me those names and addresses? *Record names and addresses on PERSONAL INFORMATION FORM and obtain signatures on MEDICAL CONSENT FORM(S).*

1 NA/No Information

2 Subject has agreed to sign medical consent form.

3 Subject has given signed medical consent to interviewer

4 Subject has refused to sign medical consent form

5 Other *(specify)*_____

C. Names, Addresses And Phone Numbers

I would like to confirm the information I have. *(Read name provided by Office)* **Is this your full name and have we spelled it correctly? Is there any other name that you sometimes use like your maiden name or even a nickname?** *(Correct name or add AKA on PERSONAL INFORMATION FORM)*

How about your current address? *(Read address provided by Office)* **Is this the place where you usually live, do you live somewhere else, or do you stay at different places?**

May I have the address where you usually live? *(Record address on PERSONAL INFORMATION FORM.)*
What is the best place to contact you again? *(Record address on PERSONAL INFORMATION FORM.)*

	NA/NO INFO	NO	YES
1. Corrections, additions to Subject's Name	1	2	3
2. Corrections, additions to Subject's Address	1	2	3
3. Subject stays at different places, no single address	1	2	3
4. Current address is not best place to reach subject	1	2	3
5. Personal address information refused	1	2	3

And what's the best phone number to reach you in the daytime and in the evening? Under what name is the phone number(s)? *(Record phone numbers on PERSONAL INFORMATION FORM.)*

1 NA/No Information

2 Subject has own phone, number given

3 Subject does not have own phone but provides phone number where s/he can be reached

4 Subject cannot be reached by phone

5 Phone number information refused

6 Other *(specify)* _____

1. OTHERS PRESENT DURING INTERVIEW

1 NA/NO INFORMATION

2 NO

3 YES

If yes:
Record the names of any family members (or others) present or within earshot during part of all of the interview.

2. LENGTH OF INTERVIEW

HOURS MINUTES

3. INTERVIEWER RATING
Based on your observation and interaction with this subject, rate the reliability and completeness of information.

1 Very good

2 Good

3 Fair

4 Poor

5 Totally unusable information

ADULT GLOBAL ASSESSMENT SCALE

Rate the subject's lowest level of functioning in the last week by selecting the lowest range which describes the subjects functioning on a hypothetical continuum of mental health-illness. For example, a subject whose "behavior is considerably influenced by delusions" (range 21-30) should be given a rating in that range even though he has "major impairment in several areas" (range 31-40). Use intermediary levels when appropriate (eg, 35, 58, 63). Rate actual functioning independent of whether or not subject is receiving and may be helped by medication or some other form of treatment.

☐☐☐ CURRENT

Rate the subject's level of general functioning for the *past two weeks* by selecting the level which describes his/her functioning on hypothetical continuum of health-illness.

☐☐☐ MOST SEVERE

Rate the subject's level of general functioning during his/her *most severe past episode of psychiatric illness*.

☐☐☐ Record age at most severe level of functioning.

☐☐☐ HIGHEST PAST

During the past year, rate the *highest* level of functioning.

100 - 91	No symptoms, superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his warmth and integrity.
90 - 81	Transient symptoms may occur, but good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, "everyday" worries that only occasionally get out of hand.
80 - 71	Minimal symptoms may be present but no more than slight impairment in functioning, varying degrees of "everyday" worries and problems that sometimes get out of hand.
70 - 61	Some mild symptoms (eg, depressive mood and mild insomnia) OR some difficulty in several areas of functioning, but generally functioning pretty well, has some meaningful interpersonal relationships and most untrained people would not consider subject "sick."
60 - 51	Moderate symptoms OR generally functioning with some difficulty (eg, few friends and flat affect, depressed mood, and pathological self-doubt, euphoric mood and pressure of speech, moderately severe antisocial behavior).
50 - 41	Any serious symptomatology or impairment in functioning that most clinicians would think obviously requires treatment or attention (eg, suicidal preoccupation or gesture, severe obsessional rituals, frequent anxiety attacks, serious antisocial behavior, compulsive drinking).
40 - 31	Major impairment in several areas, such as work, family relations, judgment, thinking, or mood (eg, depressed woman avoids friends, neglects family, unable to do housework), OR some impairment in reality testing or communication (eg, speech is at times obscure, illogical, or irrelevant), OR single serious suicide attempt.
30 - 21	Unable to function in almost all areas (eg, stays in bed all day), OR behavior is considerably influenced by either delusions or hallucinations, OR serious impairment in communication (eg, sometimes incoherent or unresponsive) or judgment (eg, acts grossly inappropriately).
20 - 11	Needs some supervision to prevent hurting self or others, or to maintain minimal personal hygiene (eg, repeated suicide attempts, frequently violent, manic excitement, smears feces), OR gross impairment in communication (eg, largely incoherent or mute).
10 - 1	Needs constant supervision for several days to prevent hurting self or others, or makes no attempt to maintain minimal personal hygiene.
0	Inadequate information.