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MINI PLUS

M.I.N.I. Plus 5.0.0

Patient's Initials: ☐☐☐ Patient's ID Number (PID): ☐☐☐☐☐☐

Data Entrant (initials): ☐☐☐ Date (Day/Month/Year) ☐☐ / ☐☐ / ☐☐☐☐

Rater's Initials: ☐☐☐

MODULES	TIME FRAME	DSM-IV	ICD-10	Page	Meets Criteria
A. Major Depressive Episode	Current (2 weeks) Recurrent	296.20-296.26 single 296.30-296.36 recurrent	F32.x F33.x	3 4	☐
Mood Disorder due to a Medical Condition	Current Past	293.83 293.83	F06.xx none	4	☐
Substance Induced Mood Disorder	Current Past	29x.xx 29x.xx	none none		☐
MDE with Melancholic	Current (2 weeks)	296.20-296.26 single	F32.x	5	☐
B. Dysthymia	Current (past 2 years) Past	300.4 300.4	F34.1 F34.1	6	☐
C. Suicidality	Current (past month) Risk: ____ Low ____Medium ____High	none	none	7	☐
D. Manic Episode	Current Past	296.00-296.06 296.00-296.06	F30.x-F31.9 F30.x-F31.9	8	☐
Hypomanic Episode	Current Past	296.80-296.89 296.80-296.89	F31.8-F31.9/F34.0 F31.8-F31.9/F34.0	8	☐
Bipolar II Disorder	Current Past	296.89 296.89	F31.8 F31.8		☐
Manic Episode due to a Medical Condition	Current Past	293.83 293.83	F06.30 F06.30		☐
Hypomanic Episode due to a Medical Condition	Current Past	293.83 293.83	none none		☐
Substance Induced Manic Episode	Current Past	291.8-292-84 291.8-292-84	none none		☐
Substance Induced Hypomanic Episode	Current Past	291.8-292.84 291.8-292.84	none none		☐
E. Panic Disorder	Current (past month)	291.8-292.84	none	11	☐
Anxiety Disorder with Panic due to a General Med. Condition	Current	293.89	F06.4	12	☐
Substance induced Anxiety Disorder with Panic Attacks	Current	291.8-292.89	none	12	☐
F. Agoraphobia	Current	300.22	F40.00	13	☐
G. Social Phobia (Soc.AnxDis.)	Current(past month)	300.23	F40.1	14	
H. Specific Phobia	Current	300.3	F42.8	15	☐
OCD due to general medical condition	Current	293.89	F06.4	16	☐
Substance induced OCD	Current	291.8-292.89	none	16	
I. Obsessive-Compulsive Disorder	Current (past month)	300.3	F42.8		☐
J. Posttraumatic Stress Disorder	Current (past month)	309.81	F43.1	17	☐
K. Alcoholic Dependence	Past 12 months	303.9	F10.2x	18	☐
Alcoholic Dependence	Lifetime	303.9	F10.2x	19	☐
Alcoholic Abuse	Past 12 months	305.9	F10.1	18	☐
Alcoholic Abuse	Lifetime	305.00	F10.1	18	☐
L. Substance Dependence (non-alcohol)	Past 12 months	304.00-.9/305.20-.90	F11.0-F19.1	20	☐
Substance Dependence(non-alcohol)	Lifetime	304.00-.9/305.20-.90	F11.0-F19.1	20	☐
M. Psychotic Disorders	Lifetime Current	295.10-295.90//297.1/ 297.3/297.81/293.82/ 293.89/298.8/298.9	F20.xx.F29	24 24	☐
Mood Disorder with Psychotic Features	Current	296.24	F32.3/F33.3	29	☐

MODULES	TIME FRAME	DSM-IV	ICD-10	Page	Meet Criteria
Schizophrenia	Current	295.10-295.60	F20.xx		☐
	Lifetime	295.10-295.60	F20.xx		
Schizoaffective Disorder	Current	295.70	F25..x		☐
	Lifetime	295.70	F25.x		
Schizophreniform Disorder	Current	295.40	F20.8		☐
	Lifetime	295.40	F20.8		
Brief Psychotic Disorder	Current	298.8	F23.80-F23.81		☐
	Lifetime	298.8	F23.80-F23.81		
Delusional Disorder	Current	297.1	F22.0		☐
	Lifetime	297.1	F22.0		
Psychotic Disorder due to a	Current	293.xx	F06.0-F06.2		☐
General Medical Condition	Lifetime	293.xx	F06.0-F06.2		
Substance Induced Psychotic	Current	291.5-292.12	none		☐
Disorder	Lifetime	291.5-292.12	none		☐
Psychotic Disorder NOS	Current	298.9	F29		☐
	Lifetime	298.9	F29		
Mood Disorder with Psychotic	Lifetime		F31.X3/F31.X2/		☐
Features			F31.X5		☐
Mood Disorder NOS	Lifetime	296.90	F39		☐
Major Depressive Disorder	Current	296.24	F33.X3		☐
with Psychotic Features	Past	296.24	F33.X3		
Bipolar I Disorder with	Current	296.04-296.64	F31.X2/F31.X5		☐
Psychotic Features	Past	296.04-296.64	F31.X2/F31.X5		
N. Anorexia Nervosa	Current (past 3 months)	307.1	F50.0	30	☐
O. Bulimia Nervosa	Current (past 3 months)	307.51	F50.2	32	☐
Bulimia Nervosa Purging Type	Current	307.51	F50.2		☐
Bulimia Nervosa Non-Purging Type	Current	307.51	F50.2		☐
Anorexia Nervosa, Binge Eating/	Current	307.1	F50.0		☐
Purging Type					☐
Anorexia Nervosa, Restricting Type	Current	307.1	F50.0		☐
P. Generalized Anxiety Disorder	Current (past 6 months)	300.02	F41.1	34	☐
Generalized Anxiety Disorder due	Current	293.89	F06.4		☐
to a General Medical Condition					
Substance induced GAD	Current	291.8-292.89	none		☐
Q. Antisocial Personality Disorder	Lifetime	301.7	F60.2	36	☐
R. Somatization Disorder	Lifetime	330.81	F45.0	37	☐
	Current				
S. Hypochondriasis	Current	300.7	F45.2	38	☐
T. Body Dysmorphic Disorder	Lifetime	300.7	F45.2	39	☐
U. Pain Disorder	Current	300.89/307.8	F45.4	39	☐
V. Conduct Disorder	Past 12 months	312.8	F91.8	40	☐
W. Attention Deficit/Hyperactivity	Past 6 months	314.00/314.01	F90.0/F90.9/	41	☐
Disorder (children/adolescents)			F98.8		☐
Attention Deficit Hyperactivity	Lifetime	314.00/314.01	F90.0/F98.8	42	
Disorder (adults)					
X. Adjustment Disorders	Current	309.xx		43	☐
Y. Premenstrual Dysphoric Disorder	Current			44	☐
Z. Mixed Anxiety-Depressive Disorder	Current			45	☐

=> **MEANS: GO TO THE NEXT DIAGNOSTIC BOX, FILL IN NO IN ALL DIAGNOSTIC BOXES, AND MOVE TO THE NEXT MODULE**

For patients who appear psychotic before starting the interview, or who are suspected to have schizophrenia, please adopt the following order of administration of modules:

1) Part 1 of module M (psychotic disorders M1-M18).
2) Sections A-D (depression to (hypo)manic episode).
3) Part 2 of module M (psychotic disorders M19-M23).
4) Other modules in their usual sequence.

If module M has already been explored and psychotic symptoms have been identified (M1 to M10b), examine for each positive response to the following questions if the depressive symptoms are not better explained by the presence of a psychotic disorder and code accordingly.

A. MAJOR DEPRESSIVE EPISODE

A1 a Have you **ever** been consistently depressed or down, most of the day, nearly every day, for at least two weeks? O No O Yes

IF **A1a = YES**:

b Have you been consistently depressed or down, most of the day, nearly every day, for the past 2 weeks? O No O Yes

A2 a Have you **ever** been much less interested in most things or much less able to enjoy the things you used to enjoy most of the time over at least 2 weeks? O No O Yes

IF **A2a = YES**:

b In the past 2 weeks, have you been much less interested in most things or much less able to enjoy the things you used to enjoy most of the time. O No O Yes

=>

IS **A1a** OR **A2a** CODED YES? O No O Yes

IF CURRENTLY DEPRESSED (A1b OR A2b = YES): EXPLORE ONLY CURRENT EPISODE.
IF **NO:** EXPLORE THE MOST SYMPTOMATIC PAST EPISODE.

A3 **Over the two week period when you felt depressed or uninterested,**

	Current Episode		Past Episode	
a Was your appetite decreased or increased nearly every day? If unclear, did your weight decrease or increase without trying intentionally (i.e., by +/-5% OF BODY WEIGHT OR +/-8 LBS. OR +/-3.5 KGS. PERSON IN A MONTH)? IF **YES** TO EITHER (increase/decrease), CODE **YES**	O No	O Yes	O No	O Yes
b Did you have trouble sleeping nearly every night (*difficulty falling asleep, waking up in the middle of the night, waking early in the morning*) or sleeping excessively?	O No	O Yes	O No	O Yes
c Did you talk or move more slowly than normal or were you fidgety, restless or having trouble sitting still almost every day?	O No	O Yes	O No	O Yes
d Did you feel tired or without energy almost every day?	O No	O Yes	O No	O Yes
e Did you feel worthless or guilty almost every day?	O No	O Yes	O No	O Yes

IF A3e = YES ASK FOR AN EXAMPLE.
THE EXAMPLE IS CONSISTENT WITH A DELUSIONAL O No O Yes

	Current Episode		Past Episode	
f Did you have difficulty concentrating or making decisions almost every day?	O No	O Yes	O No	O Yes
g Did you repeatedly consider hurting yourself, feel suicidal, or wish that you were dead?	O No	O Yes	O No	O Yes

A4 TO MEET FOR A CURRENT OR PAST EPISODE: AT LEAST ONE SYMPTOM OF **A1** OR **A2** PLUS **4** OF A3 ARE CODED **YES;** OR BOTH **A1 AND A2 PLUS 3** OR MORE ARE CODED **YES** FOR **A3*.**

Current Episode: O No O Yes — Past Episode: => O No O Yes

IF **A4** IS CODED **NO** FOR CURRENT EPISODE ONLY THEN EXPLORE **A3a - A3g** FOR MOST SYMPTOMATIC PAST EPISODE.

Best estimate of duration (in weeks) of the current episode to date from onset of first signs of change in usual condition to time of evaluation. [| |]

A5 Did the symptoms of depression cause you significant distress or impair your ability to function at work, socially, or in some other important way?

=> O No O Yes

A6 Are the symptoms due entirely to the loss of a loved one (bereavement) and are they similar in severity, level of impairement, and duration to what most others would suffer under similar circumstances? If so, this is uncomplicated bereavement.

HAS UNCOMPLICATED BEREAVEMENT BEEN RULED OUT? => O No O Yes

A7 a Were you taking any drugs or medicines just before these symptoms began?

O No O Yes

b Did you have any medical illness just before these symtpoms began?

O No O Yes

IN THE CLINICIAN'S JUDGMENT: ARE EITHER, **A7a** or **A7b**, LIKELY TO BE DIRECT CAUSES OF THE PATIENT'S DEPRESSION? IF NECESSARY ASK

A7 (SUMMARY): HAS AN ORGANIC CAUSE BEEN RULED OUT? O No O Yes O Uncertain

A8 CODE **YES** IF **A7(SUMMARY)=YES** OR **UNCERTAIN.**

SPECIFY IF THE EPISODE IS CURRENT AND/ OR PAST OR BOTH (RECURRENT).

O No O Yes

Major Depressive Episode

Current O

Past O

A9 CODE **YES** IF **A7b=YES** AND **A7(SUMMARY) = NO.**

SPECIFY IF THE EPISODE IS CURRENT AND/ OR PAST OR BOTH (RECURRENT).

O No O Yes

Mood Disorder Due to a General Medical Condition

Current O

Past O

A10 CODE **YES** IF **A7a=YES** AND **A7(SUMMARY)= NO.**

SPECIFY IF THE EPISODE IS CURRENT AND/ OR PAST OR BOTH (RECURRENT).

O No O Yes

Substance-Induced Mood Disorder

Current O

Past O

CHRONOLOGY

A11 How old were you when you first began having symptoms of depression? : ☐☐ years

A12 During your lifetime, how many distinct times did you have these symptoms of depression (daily for at least 2 weeks)? ☐☐☐

MAJOR DEPRESSIVE EPISODE WITH MELANCHOLIC FEATURES

=> **MEANS: GO TO THE NEXT DIAGNOSTIC BOX, FILL IN NO IN ALL DIAGNOSTIC BOXES, AND MOVE TO THE NEXT MODULE**

IF THE PATIENT CODES POSITIVE FOR A CURRENT MAJOR DEPRESSIVE EPISODE (A8=YES, CURRENT) EXPLORE THE FOLLOWING:

A13
a IS **A2b** CODED **YES**? — O No O Yes

b During the most severe period of the current depressive episode, did you lose your ability to respond to things that previously gave you pleasure, or cheered you up? — O No O Yes
IF NO, DOUBLE CHECK ANSWER BY ASKING:
When something good happens, does it fail to make you feel better, even temporarily?

IS EITHER **A13a** OR **A13b** CODED YES? — => O No O Yes

A14 **Over the past two week period, when you felt depressed and uninterested:**

a Did you feel depressed in a way that is different from the kind of feeling you experienced when someone close to you dies? — O No O Yes

b Did you regularly feel worse in the morning, almost every day? — O No O Yes

c Did you wake up at least 2 hours before the usual time of awakening and have difficulty getting back to sleep, almost every day? — O No O Yes

d IS A3c CODED YES (PSYCHOMOTOR RETARDATION OR AGIATION)? — O No O Yes

e IS A3a CODED YES FOR ANOREXIA OR WEIGHT LOSS? — O No O Yes

f Did you feel excessive guilt or guilt out of proportion to the reality of the situation? — O No O Yes

ARE **3 OR MORE A14 ANSWERS CODED YES**?

O No O Yes
Major Depressive Episode with Melancholic Features Current

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IF **A8** OR **A9** OR **A10** = **YES**, SKIP TO SUICIDALITY => **PLEASE NOTE: This section is for administrative purposes only**

SUBTYPES OF MAJOR DEPRESSIVE EPISODE **(Mark all that apply)**

Mild	O	296.21/296.31
Moderate	O	296.22/296.32
Severe without psychotic features	O	296.23
Severe with psychotic features	O	296.24
In partial remission	O	296.25
In full remission	O	296.26
Chronic	O	
With catatonic features	O	
With melancholic features	O	
With atypical features	O	
With postpartum onset	O	
With seasonal pattern	O	
With full interepisode recovery	O	
Without full interepisode recovery	O	

B. DYSTHYMIA

=> MEANS: GO TO THE NEXT DIAGNOSTIC BOX, FILL IN NO IN ALL DIAGNOSTIC BOXES, AND MOVE TO THE NEXT MODULE

If symptoms <u>currently</u> meet criteria for major depressive episode, <u>do NOT</u> explore <u>current</u> dysthymia, but <u>do</u> explore <u>past</u> dysthymia.

Make sure that the past dysthymia explored is not one of the past major depressive episodes, and that it was separated from any prior major depressive episode by at least 2 months of full remission. [APPLY THIS RULE ONLY IF YOU ARE INTERESTED IN EXPLORING DOUBLE DEPRESSION.]

SPECIFY WHICH TIME FRAME IS EXPLORED BELOW: O Current
O Past

B1 Have you felt sad, low or depressed most of the time for the last two years? (OR IF EXPLORING PAST DYSTHYMIA: "In the past, did you every feel sad, low or depressed for 2 years continuously?") => O No O Yes

B2 Was this period interrupted by your feeling OK for two months or more? O No => O Yes

B3 **During this period of feeling depressed most of the time:**

a	Did your appetite change significantly?	O No	O Yes
b	Did you have trouble sleeping or sleep excessively?	O No	O Yes
c	Did you feel tired or without energy?	O No	O Yes
d	Did you lose your self-confidence?	O No	O Yes
e	Did you have trouble concentrating or making decisions?	O No	O Yes
f	Did you feel hopeless?	O No	O Yes

ARE **2** OR MORE **B3** ANSWERS CODED **YES?** => O No O Yes

B4 Did the symptoms of depression cause you significant distress or impair your ability to function at work, socially, or in some other important way?

=> O No O Yes

B5 Were you taking any "street" drugs or medicines just before these symptoms began?
Did you have any medical illness just before these symptoms began?
IN THE CLINICIAN'S JUDGMENT: ARE EITHER OF THESE LIKELY TO BE DIRECT CAUSES OF THE PATIENT'S DEPRESSION?

HAS AN ORGANIC CAUSE BEEN RULED OUT? O No O Yes

IS **B5** CODED **YES?**

O No O Yes
DYSTHYMIA
O Current
O Past

CHRONOLOGY

B6 How old were you when you first began having symptoms of 2 years of continuous depression? [ ][ ] years

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C. SUICIDALITY

In the past month did you:

				Points
C1	Think you would be better off dead or wish you were dead?	O No	O Yes	1
C2	Want to harm yourself?	O No	O Yes	2
C3	Think about suicide?	O No	O Yes	6
C4	Have a suicide plan?	O No	O Yes	10
C5	Attempt suicide?	O No	O Yes	10
C6	**In your lifetime:** Did you ever make a suicide attempt?	O No	O Yes	4

IS AT LEAST **1** OF THE ABOVE CODED **YES?**

IF **YES,** ADD THE TOTAL NUMBER OF POINTS FOR THE ANSWERS (C1-C6) CHECKED 'YES' AND SPECIFY THE LEVEL OF SUICIDE RISK AS FOLLOWS:

O No O Yes
SUICIDE RISK CURRENT
1-5 points Low O
6-9 points Moderate O
>=10 points High O

D. (HYPO) MANIC EPISODE

=> MEANS: GO TO THE NEXT DIAGNOSTIC BOX, FILL IN NO IN ALL DIAGNOSTIC BOXES, AND MOVE TO THE NEXT MODULE

FOR PATIENTS WHO APPEAR PSYCHOTIC BEFORE STARTING THE INTERVIEW OR WHO ARE SUSPECTED TO HAVE SCHIZOPHRENIA, PLEASE ADOPT THE FOLLOWING ORDER OF ADMINISTRATION OF MODULES:

1) PART I OF MODULE M (PSYCHOTIC DISORDERS M1-M18).
2) SECTIONS A-D (DEPRESSION TO (HYPO)MANIC EPISODE).
3) PART 2 OF MODULE M (PSYCHOTIC DISORDERS M19-M23).
4) OTHER MODULES IN THEIR USUAL SEQUENCE.

IF THE MODULE M HAS ALREADY BEEN EXPLORED AND PSYCHOTIC SYMPTOMS HAVE BEEN IDENTIFIED (M1 T M10b), EXAMINE FOR EACH POSITIVE RESPONSE TO THE FOLLOWING QUESTIONS IF THE (HYPO)MANIC SYMPTOMS ARE NOT BETTER EXPLAINED BY THE PRESENCE OF A PSYCHOTIC DISORDER AND CODE ACCORDINGLY.

D1 a Have you **ever** had a period of time when you were feeling 'up' or 'high' or so full of energy or full of yourself that you got into trouble, or that other people thought you were not your usual self? (Do not consider times when you were intoxicated on drugs or alcohol.) ○ No ○ Yes

IF **YES** TO **D1a:**

b Are you **currently** feeling 'up' or 'high' or full of energy? ○ No ○ Yes

IF THE PATIENT IS PUZZLED OR UNCLEAR ABOUT WHAT YOU MEAN BY 'UP OR 'HIGH', CLARIFY AS FOLLOWS: BY 'UP' OR 'HIGH' MEAN: HAVING ELATED MOOD; INCREASED ENERGY; NEEDING LESS SLEEP;HAVING RAPID THOUGHTS; BEING FULL OF IDEAS; HAVING AN INCREASE IN PRODUCTIVITY, MOTIVATION, CREATIVITY, OR IMPULSE BEHAVIOUR.

D2 a Have you **ever** been persistently irritable, for several days, so that you had arguments or verbal or physical fights, or shouted at people outside your family? Have you or others noticed that you have been more irritable or over reacted, compared to other poeple, even in situations that you felt were justified? ○ No ○ Yes

IF **YES** TO **D2a:**

b Are you **currently** feeling persistently irritable? ○ No ○ Yes

IS **D1a** OR **D2a** CODED **YES?** => ○ No ○ Yes

D3 IF **D1b** OR **D2b** = **YES:** EXPLORE ONLY **CURRENT** EPISODE, OTHERWISE
IF **D1b** AND **D2b = NO**: EXPLORE THE MOST SYMPTOMATIC **PAST** EPISODE

During the times when you felt high, full of energy, or irritable did you:	**Current Episode**	**Past Episode**
a Feel that you could do things others couldn't do, or that you were an especially important person? If YES, ASK FOR EXAMPLES.	○ No ○ Yes	○ No ○ Yes
THE EXAMPLES ARE CONSISTENT WITH A DELUSIONAL IDEA. ○ No ○ Yes		
b Need less sleep (for example, feel rested after only a few hours sleep)?	○ No ○ Yes	○ No ○ Yes
c Talk too much without stopping, or so fast that people had difficulty understanding?	○ No ○ Yes	○ No ○ Yes
d Have racing thoughts?	○ No ○ Yes	○ No ○ Yes

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	Current		Past Episode	
e Become easily distracted so that any little interruption could distract you?	O No	O Yes	O No	O Yes
f Become so active or physically restless that others were worried about you?	O No	O Yes	O No	O Yes
g Want so much to engage in pleasurable activities that you ignored the risks or consequences (for example, spending sprees, reckless driving, or sexual indescretions)?	O No	O Yes	O No	O Yes
D3(SUMMARY): ARE **3** OR MORE **D3** ANSWERS CODED **YES** (OR 4 OR MORE IF **D1a** IS **NO**(IN RATING PAST EPISODE) OR D1b IS NO(IN RATING CURRENT EPISODE))? RULE: ELATION/EXPANSIVENESS REQUIRES ONLY THREE D3 SYMPTOMS WHILE IRRITABLE MOOD ALONE REQUIRES **4** OF THE **D3** SYMPTOMS.	O No	O Yes	=> O No	O Yes

VERIFY IF THE SYMPTOMS OCCURRED DURING THE SAME TIME PERIOD.

D4

a Were you taking any drugs or medicines just before these symptoms began?

O No O Yes

b Did you have any medical illness just before these symptoms began?

O No O Yes

IN THE CLINICIAN'S JUDGEMENT: ARE EITHER OF THESE LIKELY TO BE DIRECT CAUSES OF THE PATIENT'S (HYPO)MANIA? IF NECESSARY, ASK ADDITIONAL OPEN ENDED QUESTIONS.

	Current Episode			Past Episode		
D4(SUMMARY): HAS AN ORGANIC CAUSE BEEN RULED OUT?	O No	O Yes	O Uncertain	O No	O Yes	O Uncertain
D5 Did these symptoms last at least a week and cause problems beyond your control at home, work school, or were you hospitalized for these problems?	O No	O Yes		O No	O Yes	

IF **D5** IS CODED **NO** FOR CURRENT EPISODE, THEN EXPLORE **D3,** D4 AND **D5** FOR THE MOST SYMPTOMATIC PAST EPISODE.

D6 IF **D3(SUMMARY)=YES** AND **D4(SUMMARY)=YES** OR **UNCERTAIN** AND **D5=NO**, AND **NO DELUSIONAL IDEA** WAS DESCRIBED IN **D3a,** CODE **YES** FOR HYPOMANIAC EPISODE.

SPECIFY IF THE EPISODE INDENTIFIED IS CURRENT OR PAST.

O No O Yes

HYPOMANIC EPISODE

Current O
Past O

D7 IF **D3(SUMMARY)=YES** AND **D4(SUMMARY)=YES** OR UNCERTAIN AND EITHER **D5=YES** OR A DELUSIONAL IDEA WAS DESCRIBED IN **D3a,** CODE **YES** FOR MANIC EPISODE.

SPECIFY IF THE EPISODE IDENTIFIED IS CURRENT OR PAST.

O No O Yes

MANIC EPISODE

Current O
Past O

D8 IF **D3(SUMMARY**) AND **D4b** AND **D5=YES** AND **D4(SUMMARY)=NO**, CODE **YES.**
SPECIFY IF THE EPISODE IDENTIFIED IS CURRENT OR PAST.

O No O Yes

(Hypo) Manic Episode Due to a General Medical Condition

Current O
Past O

D9 IF **D3(SUMMARY)** AND **D4a** AND **D5=YES** AND **D4(SUMMARY)=NO,** CODE **YES.**
SPECIFY IF THE EPISODE IDENTIFIED IS CURRENT OR PAST.

IF **D8** OR **D9=YES,** GO TO NEXT MODULE.

O No O Yes
Substance Induced (Hypo)Manic Episode
Current O
Past O

SUBTYPES

Rapid Cycling
Have you had four or more episodes of mood disturbance in 12 months?

O No O Yes
Rapid Cycling

Mixed Episode
PATIENT MEETS CRITERIA FOR BOTH MANIC EPISODE AND MAJOR DEPRESSIVE EPISODE NEARLY EVERY DAY DURING AT LEAST A ONE WEEK PERIOD.

O No O Yes
Mixed Episode

Seasonal Pattern
THE ONSET AND REMISSIONS OR SWITCHES FROM DEPRESSION TO MANIA OR HYPOMANIA CONSISTENTLY OCCUR AT A PARTICULAR TIME OF YEAR.

O No O Yes
Seasonal Pattern

With Full Interepisode Recovery
Between the two most recent mood episodes did you fully recover?

O No O Yes
With Full Interepisode Recovery

MOST RECENT EPISODE WAS A:
O Manic Episode O Hypomanic Episode O Mixed Episode O Depressed Episode

SEVERITY
O X1 Mild
O X2 Moderate
O X3 Severe without psychotic features
O X4 Severe with psychotic features
O X5 In partial remission
O X6 In full remission

CHRONOLOGY

D10 How old were you when you first began having symptoms of manic/hypomanic episodes? Age ☐☐

D11 Since the first onset how many distinct times did you have significant symptoms of mania/hypomania? ☐☐

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E. PANIC DISORDER

=> MEANS: GO TO THE NEXT DIAGNOSTIC BOX, FILL IN NO IN ALL DIAGNOSTIC BOXES, AND MOVE TO THE NEXT MODULE

E1 a	Have you, on more than one occasion, had spells or attacks when you suddenly felt anxious, frightened, uncomfortable or uneasy, even in situations where most people would not feel that way?	=> O No	O Yes
b	Did the spells peak within 10 minutes?	=> O No	O Yes
E2	At any time in the past, did any of those spells or attacks come on unexpectedly or spontaneously, or occur in an unpredictable or unprovoked manner?	=> O No	O Yes
E3	Have you ever had one such attack followed by a month or more of persistent concern about having another attack, or worries about the consequences of the attacks?	O No	O Yes
E4	During the worst spell that you can remember:		
a	Did you have skipping, racing or pounding of your heart?	O No	O Yes
b	Did you have sweating or clammy hands?	O No	O Yes
c	Were you trembling or shaking?	O No	O Yes
d	Did you have shortness of breath or difficulty breathing?	O No	O Yes
e	Did you have a choking sensation or a lump in your throat?	O No	O Yes
f	Did you have chest pain, pressure or discomfort?	O No	O Yes
g	Did you have nausea, stomach problems or sudden diarrhea?	O No	O Yes
h	Did you feel dizzy, unsteady, lightheaded or faint?	O No	O Yes
i	Did things around you feel strange, unreal, detached or unfamiliar, or did you feel outside of or detached from part or all of your body?	O No	O Yes
j	Did you fear that you were losing control or going crazy?	O No	O Yes
k	Did you fear that you were dying?	O No	O Yes
l	Did you have tingling or numbness in parts of your body?	O No	O Yes
m	Did you have hot flushes or chills?	O No	O Yes
	E4 (SUMMARY): ARE 4 OR MORE E4 ANSWERS CODED YES?	O No	O Yes
E5			
a	Were you taking any drugs or medicines just before these symptoms began?	O No	O Yes
b	Did you have any medical illness just before these symptoms began?	O No	O Yes
	In the clinician's judgement: are either of these likely to be direct causes of the patient's panic disorder?	O No	O Yes
	E5 (SUMMARY): HAS AN ORGANIC CAUSE BEEN RULED OUT? IF **E5 (SUMMARY)** IS CODED **NO,** SKIP TO **E9.**	O No	O Yes

E6 DO **E3** AND **E4 (SUMMARY)** AND **E5 (SUMMARY)=YES**?

IF **E6=YES**, SKIP TO **E8.**

○ No ○ Yes
PANIC DISORDER
LIFETIME

E7 IF **E6=NO**, ARE ANY **E4** ANSWERS CODED **YES?**

THEN SKIP TO **F1.**

○ No ○ Yes
LIMITED SYMPTOM ATTACKS
LIFETIME

E8 In the past month, did you have such attacks repeatedly (2 or more), followed by persistent concern about having another attack?

IF THIS IS DENIED BY THE PATIENT - CHALLENGE BY REVIEWING THE SYMPTOMS ENDORSED IN E4

○ No ○ Yes
PANIC DISORDER
CURRENT

E9 ARE **E3** AND **E4(SUMMARY)** AND **E5b** ALL CODED **YES** AND **E5 (SUMMARY)** CODED NO?

○ No ○ Yes
Anxiety Disorder with Panic Attacks Due to a General Medical Condition
CURRENT

E10 ARE **E3** AND **E4(SUMMARY)** AND **E5a** ALL CODED **YES** AND **E5 (SUMMARY)** CODED **NO**?

○ No ○ Yes
Substance Induced Anxiety Disorder with Panic Attacks
CURRENT

E11 How old were you when you first began having symptoms of panic attacks?

Age [ ][ ]

E12 During the past year, for how many months did you have significant symptoms of panic attacks or worries about having an attack?

[ ][ ] months

F. AGORAPHOBIA

F1 Have you ever **felt anxious** or uneasy in places or situations where you might have a panic attack or panic-like symptoms where help might not be available or escape might be difficult; like being in a crowd, standing in a line (queue), when you are alone away from home or alone at home, or when crossing a bridge, traveling in a bus, train or car?

O No O Yes

IF **F1=NO**, ANSWER **NO** IN **F2** AND IN **F3**

F2 Have you ever feared these situations so much that you avoided them, or suffered through them, or needed a companion to face them?

O No O Yes
AGORAPHOBIA LIFETIME

F3 Do you **NOW** fear or avoid these places or situations?

O No O Yes
AGORAPHOBIA CURRENT

	CHECK ONLY IF **YES**	
IS AGORAPHOBIA CODED **YES?**	**F2** O lifetime	**F3** O current
IS PANIC DISORDER CODED **YES?**	**E6** O lifetime	**E8** O current

F4

a IS PANIC DISORDER, CURRENT (**E8**), CODED **YES**,

AND

IS AGORAPHOBIA, CURRENT (**F3**), CODED **NO?**

O No O Yes
Panic Disorder, Current without AGORAPHOBIA

b IS PANIC DISORDER, CURRENT (**E8**), CODED **YES**,

AND

IS AGORAPHOBIA, CURRENT(**F3**), CODED **YES?**

O No O Yes
Panic Disorder, Current with AGORAPHOBIA

c IS PANIC DISORDER, LIFETIME (**E6**), CODED **NO**,

AND

IS AGORAPHOBIA, CURRENT (**F3**), CODED **YES**?

O No O Yes
AGORAPHOBIA, CURRENT without history of Panic Disorder

d IS AGORAPHOBIA, CURRENT (**F3**) CODED **YES**,

AND IS PANIC DISORDER CURRENT (**E8**) CODED **NO**,

AND IS PANIC DISORDER, LIFETIME (**E6**) CODED **YES**?

O No O Yes
AGORAPHOBIA, CURRENT without current Panic Disorder but with a past history of Panic Disorder

e IS AGORAPHOBIA, CURRENT (**F3**) CODED **YES**,

AND LIMITED SYMPTOM ATTACKS (**E7**) CODED **NO**?

O No O Yes

AGORAPHOBIA CURRENT without history of Limited Symptom Attacks

CHRONOLOGY

F5 How old were you when you first began to fear or avoid these situations (agoraphobia)? [ ][ ] years

F6 During the past year, for how many months did you have significant fear or avoidance of these situations (agoraphobia)? [ ][ ]

G. SOCIAL PHOBIA (Social Anxiety Disorder)

=> MEANS: GO TO THE NEXT DIAGNOSTIC BOX, FILL IN NO IN ALL DIAGNOSTIC BOXES, AND MOVE TO THE NEXT MODULE

G1 In the past month, were you fearful or embarrassed about being watched, being the focus of attention, or fearful of being humiliated? This includes situations like speaking in public, eating in public or with others, writing while someone watches, or being in social situations. => O No O Yes

G2 Is this fear excessive or unreasonable? => O No O Yes

G3 Do you fear these situations so much that you avoid them or suffer through them? => O No O Yes

G4 Does this fear disrupt your normal work or social functioning or cause you significant distress?

O No O Yes

SOCIAL PHOBIA (Social Anxiety Disorder) CURRENT

SUBTYPES

Do you fear and avoid 4 or more social situations? O No O Yes
If YES --> generalized social phobia (social anxiety disorder)
If NO --> social phobia (social anxiety disorder), not generalized.

CHRONOLOGY

G5 How old were you when you first began to fear social situations? [ ][ ] years

G6 During the past year, for how many months did you have significant fear of social situations? [ ][ ]

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H. SPECIFIC PHOBIA

=> MEANS: GO TO THE NEXT DIAGNOSTIC BOX, FILL IN **NO** IN ALL DIAGNOSTIC BOXES, AND MOVE TO THE NEXT MODULE

H1 In the past month, have you been excessively afraid of things like: flying, driving, heights, storms, animals, insects, or seeing blood or needles? => O No O Yes

H2 Is this fear excessive or unreasonable? => O No O Yes

H3 Do you fear these situations so much that you avoid them or suffer through them? => O No O Yes

H4 Does this fear disrupt your normal work or social functioning or cause you significant distress? O No O Yes

SPECIFIC PHOBIA CURRENT

CHRONOLOGY

H5 How old were you when you first began to fear or avoid this situation? Age ☐☐

H6 During the past year, how many times have you had significant fear of this situation? ☐☐

I. OBSESSIVE-COMPULSIVE DISORDER

=> MEANS: GO TO THE NEXT DIAGNOSTIC BOX, FILL IN NO IN ALL DIAGNOSTIC BOXES, AND MOVE TO THE NEXT MODULE

I1 In the past month, have you been bothered by recurrent thoughts, impulses, or images that were unwanted, distasteful, inappropriate, intrusive, or distressing? (For example, the idea that you were dirty, contaminated or had germs, **or** fear of contaminating others, **or** fear of harming someone even though you didn't want to, **or** fearing you would act on some impulse, **or** fear or superstitions that you would be responsible for things going wrong, **or** obsessions with sexual thoughts, images or impulses, **or** hoarding, collecting, **or** religious obsessions). O No O Yes => to # I4

DO NOT INCLUDE SIMPLY EXCESSIVE WORRIES ABOUT REAL LIFE PROBLEMS. DO NOT INCLUDE OBSESSIONS DIRECTLY RELATED TO EATING DISORDERS, SEXUAL DEVIATIONS, PATHOLOGICAL GAMBLING, OR ALCOHOL OR DRUG ABUSE BECAUSE THE PATIENT MAY DERIVE PLEASURE FROM THE ACTIVITY AND MAY WANT TO RESIST IT ONLY BECAUSE OF ITS NEGATIVE CONSEQUENCES.

I2 Did they keep coming back into your mind even when you tried to ignore or get rid of them? O No O Yes => to #I4

I3 Do you think that these obsessions are the product of your own mind and that they are not imposed from the outside? O No O Yes **obsessions**

I4 In the past month, did you do something repeatedly without being able to resist doing it, like washing or cleaning excessively, counting or checking things over and over, or repeating, collecting, arranging things, or other superstitious rituals? O No O Yes **compulsions**

IS **I3** OR **I4** CODED **YES?** => O No O Yes

I5 Did you recognize that either these obsessional thoughts or compulsive behaviors were excessive or unreasonable? => O No O Yes

I6 Did these obsessions or compulsions significantly interfere with your normal routine, occupational functioning, usual social activities, or relationships, or did they take more than one hour a day? ○ No ○ Yes

I7 a Were you taking any drugs or medicines just before these symptoms began? ○ No ○ Yes

b Did you have any medical illness just before these symptoms began? ○ No ○ Yes

IN THE CLINICIAN'S JUDGEMENT: IS EITHER OF THESE LIKELY TO BE DIRECT CAUSE OF THE PATIENT'S OBSESSIVE COMPULSIVE DISORDER?

I7 **(SUMMARY)**: HAS AN ORGANIC CAUSE BEEN RULED OUT? ○ No ○ Yes

ARE **I6** AND **I7** (**SUMMARY**) CODED **YES?** ○ No ○ Yes ***O.C.D. CURRENT***

I8 ARE **I6** AND **I7b** CODED **YES,** AND **I7** **(SUMMARY)** CODED **NO?** ○ No ○ Yes ***O.C.D. CURRENT Due to a General Medical Condition***

I9 ARE **I6** AND **I7a** CODED **YES,** AND **I7** **(SUMMARY)** CODED **NO?** ○ No ○ Yes ***CURRENT Substance Induced O.C.D.***

CHRONOLOGY

I10 How old were you when you first began having symptoms of O.C.D.? [ ][ ] Years

I11 During the past year, for how many months did you have significant symptoms of O.C.D.? [ ][ ] Months

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J. POSTTRAUMATIC STRESS DISORDER (optional)

=> **MEANS: GO TO THE NEXT DIAGNOSTIC BOX, FILL IN NO IN ALL DIAGNOSTIC BOXES, AND MOVE TO THE NEXT MODULE**

J1 Have you ever experienced or witnessed or had to deal with an extremely traumatic event that included actual or threatened death or serious injury to you or someone else? => O No O Yes

EXAMPLES OF TRAUMATIC EVENTS INCLUDE: SERIOUS ACCIDENTS, SEXUAL OR PHYSICAL ASSAULT, A TERRORIST ATTACK, BEING HELD HOSTAGE, KIDNAPPING, FIRE, DISCOVERING A BODY, SUDDEN DEATH OF SOMEONE CLOSE TO YOU, WAR, OR NATURAL DISASTER.

J2 Did you respond with intense fear, helplessness or horror? => O No O Yes

J3 During the past month, have you re-experienced the event in a distressing way (such as, dreams, intense recollections, flashbacks or physical reactions)? => O No O Yes

J4 **In the past month**:

a	Have you avoided thinking about the event, or have you avoided things that remind you of the event?	O No	O Yes
b	Have you had trouble recalling some important part of what happened?	O No	O Yes
c	Have you felt detached or estranged from others?	O No	O Yes
d	Have you become much less interested in hobbies or social activities?	O No	O Yes
e	Have you noticed that your feelings are numbed?	O No	O Yes
f	Have you felt that your life will be shortened or that you will die sooner than other people?	O No	O Yes
	J4 (SUMMARY): ARE **3** OR MORE **J4** ANSWERS CODED **YES?**	=> O No	O Yes

J5 **In the past month:**

a	Have you had difficulty sleeping?	O No	O Yes
b	Were you especially irritable or did you have outbursts of anger?	O No	O Yes
c	Have you had difficulty concentrating?	O No	O Yes
d	Were you nervous or constantly on your guard?	O No	O Yes
e	Were you easily startled?	O No	O Yes
	J5 (SUMMARY): ARE **2** OR MORE **J5** ANSWERS CODED **YES?**	=> O No	O Yes

J6 During the past month, have these problems significantly interfered with your work or social activities, or caused significant distress? O No O Yes

IS **J6** CODED **YES?**

O No O Yes

Posttraumatic Stress Disorder CURRENT

CHRONOLOGY

J7 How old were you when you first began having symptoms of PTSD? [ ][ ] years

J8 Since the first onset how many illness periods of PTSD did you have? [ ][ ] # of episodes

J9 During the past year, for how many months did you have significant symptoms of PTSD? [ ][ ] months

---

K. ALCOHOL ABUSE AND DEPENDENCE

=> MEANS: GO TO THE NEXT DIAGNOSTIC BOX, FILL IN NO IN ALL DIAGNOSTIC BOXES, AND MOVE TO THE NEXT MODULE

K1 **In the past 12 months**, have you had 3 or more alcoholic drinks within a 3 hour period on 3 or more occasions? => O No O Yes

K2 **In the past 12 months:**

a	Did you need to drink more in order to get the same effect that you got when you first started drinking?	O No	O Yes
b	When you cut down on drinking, did your hands shake, did you sweat or feel agitated? Did you drink to avoid these symptoms or to avoid being hungover, for example, "the shakes", sweating or agitation? If **YES** to either question, code **YES.**	O No	O Yes
c	During the times when you drank alcohol, did you end up drinking more than you planned when you started?	O No	O Yes
d	Have you tried to reduce or stop drinking alcohol but failed?	O No	O Yes
e	On the days that you drank, did you spend substantial time in obtaining alcohol, drinking, or in recovering from the effects of alcohol?	O No	O Yes
f	Did you spend less time working, enjoying hobbies, or being with others because of your drinking?	O No	O Yes
g	Have you continued to drink even though you knew that the drinking caused you health or mental problems?	O No	O Yes

ARE 3 OR MORE **K2** ANSWERS CODED **YES?**

* IF **YES,** SKIP **K3** QUESTIONS, ANSWER N/A IN ABUSE BOX MOVE TO NEXT DISORDER. DEPENDENCE PREEMPTS ABUSE

O No O Yes*

ALCOHOL DEPENDENCE CURRENT

K3 **In the past 12 months:**

a	Have you been intoxicated, high, or hungover more than once when you had other responsibilities at school, at work, or at home? Did this cause any problems? (CODE **YES** ONLY IF THIS CAUSED PROBLEMS.)	O No	O Yes
b	Were you intoxicated more than once in any situation where you were physically at risk, for example, driving a car, riding a motorbike, using machinery, boating, etc.?	O No	O Yes
c	Did you have legal problems more than once because of your drinking, for example, an arrest or disorderly conduct?	O No	O Yes
d	Did you continue to drink even though your drinking caused problems with your family or other people?	O No	O Yes

ARE 1 OR MORE **K3** ANSWERS CODED **YES?**

O No O N/A O Yes

ALCOHOL ABUSE CURRENT

K. LIFETIME ALCOHOL ABUSE AND DEPENDENCE

=> MEANS: GO TO THE NEXT DIAGNOSTIC BOX, FILL IN NO IN ALL DIAGNOSTIC BOXES, AND MOVE TO THE NEXT MODULE

K4	**Did you <u>ever</u>** have 3 or more alcoholic drinks within a 3 hour period on 3 or more occasions?	=> O No	O Yes

K5 **In your lifetime:**

a	Did you need to drink more in order to get the same effect that you did when you first started drinking?	O No	O Yes
b	When you cut down on drinking did your hands shake, did you sit or feel agitated? Did you drink to avoid these symptoms or to avoid being hungover, for example, "the shakes", seating or agitation? IF **YES** TO EITHER QUESTIONS, CODE **YES.**	O No	O Yes
c	During the times when you drank alcohol, did you end up drinking more than you planned when you started?	O No	O Yes
d	Have you tried to reduce or stop drinking alcohol but failed?	O No	O Yes
e	On the days that you drank, did you spend substantial time in obtaining alcohol, drinking, or in recovering from the effects of alcohol?	O No	O Yes
f	Did you spend less time working, enjoying hobbies, or being with others because of your drinking?	O No	O Yes
g	Have you continued to drink even though you knew that the drinking caused you health or mental problems?	O No	O Yes

ARE **3** OR MORE **K5** ANSWERS CODED **YES?**

* IF **YES**, SKIP **K6** QUESTIONS, ANSWER N/A IN ABUSE BOX MOVE TO NEXT DISORDER. DEPENDENCE PREEMPTS ABUSE

O No O Yes *

ALCOHOL DEPENDENCE **LIFETIME**

K6 **In your lifetime:**

a. Have you been intoxicated, high, or hungover more than once when you had other responsibilities at school, at work, or at home? Did this cause any problems? (CODE YES ONLY IF THIS CAUSED PROBLEMS.) — O No O Yes

b. Were you intoxicated in any situation where you were physically at risk, for example,drivng a car, driving a motorbike, using machinery, boating etc.? — O No O Yes

c. Have you had any legal problems because of your drinking, for example, an arrest or disorderly conduct? — O No O Yes

d. Have you continued to drink even though your drinking caused problems with your family or other people? — O No O Yes

ARE **1** OR MORE **K6** ANSWERS CODED **YES?**

O No O N/A O Yes
ALCOHOL ABUSE **LIFETIME**

L. NON-ALCOHOL PSYCHOACTIVE SUBSTANCE USE DISORDERS

=> MEANS: GO TO THE NEXT DIAGNOSTIC BOX, FILL IN NO IN ALL DIAGNOSTIC BOXES, AND MOVE TO THE NEXT MODULE

Now, I am going to show you/read to you a list of street drugs or medicines.

L1
a. **Have you ever taken** any of these drugs more than once to get high, to feel better, or to change your mood? — => O No O Yes

FIll IN THE CIRCLE ON THE LEFT OF EACH DRUG TAKEN:

Stimulants: O amphetamines O "speed" O crystal meth O "rush" O Dexedrine O Ritalin O diet pills

Cocaine: O snorting O IV O freebase O crack O "speedball"

Narcotics: O heroin O morphine O Dilaudid O opium O Demerol O methadone O codeine O Percodan O Darvon O OxyContin

Hallucinogens: O LSD ("acid") O mescaline O peyote O PCP ("Angel Dust", "peace pill") O psilocybin O STP O "mushrooms" O ecstasy O MDA O MDMA

Inhalants: O "glue" O ethyl chloride O nitrous oxide ("laughing gas") O amyl O butyl nitrate ("poppers")

Marijuana: O hashish ("hash") O THC O "pot" O "grass" O "weed" O "reefer"

Tranquilizer: O Quaalude O Seconal ("reds") O Valium O Xanax O Librium O Ativan O Dalmane O Halcion O Barbiturates O Miltown

Miscellaneous: O steroids O nonprescription sleep or diet pills O GHB Any others?

Specify most used drugs on the next page

Please specify any drugs if any other drugs have been taken*:

- ONLY ONE DRUG/DRUG CLASS HAS BEEN USED ○
- ONLY THE MOST USED DRUG CLASS IS INVESTIGATED ○
- EACH DRUG CLASS USED IS EXAMINED SEPARATELY ○

b SPECIFY WHICH DRUG/DRUG CLASS WILL BE EXPLORED IN THE INTERVIEW BELOW IF THERE IS CONCURRENT OR SEQUENTIAL POLYSUBSTANCE USE:

L2 Considering the (name of drug /drug class selected), in your lifetime:

a Have you found that you needed to use more (name of drug / drug class selected) to get the same effect that you did when you first started taking it? ○ No ○ Yes

b When you reduced or stopped using (name of drug /drug class selected), did you have withdrawal symptoms (aches, shaking, fever, weakness, diarrhea, nausea, sweating, heart pounding, difficulty sleeping, or feeling agitated, anxious, irritable or depressed)? Did you use any drug(s) to keep yourself from getting sick (withdrawal symptoms) or so that you would feel better? IF **YES** TO EITHER QUESTION, CODE **YES.** ○ No ○ Yes

c Have your often found that when you used (name of drug/drug class selected), you ended up taking more than you thought you would? ○ No ○ Yes

d Have you tried to reduce or stop taking (name of drug /drug class selected), but failed? ○ No ○ Yes

e On the days that you used (name of drug / drug class selected), did you spend substantial time (> 2 hours) in obtaining, using or in recovering from drug(s), or thinking about drug(s)? ○ No ○ Yes

f Did you spend less time working, enjoying hobbies, or being with family or friends because of your drug use? ○ No ○ Yes

g Have you continued to use (name of drug / drug class selected) even though it caused you health or mental problems? ○ No ○ Yes

ARE **3** OR MORE **L2** ANSWERS CODED **YES?** ○ No ○ Yes

SUBSTANCE DEPENDENCE LIFETIME

Please specify drugs:

L3

a Have you used (most used drug, any drug) in the past 12 months? => O No O Yes

b ARE **3** OR MORE **L2** ANSWERS CODED **YES** WITHIN THE PAST 12 MONTHS? O No O Yes

ARE **L3a** AND **b** CODED **YES?** O No => O Yes

SUBSTANCE DEPENDENCE CURRENT

Please specify drugs:

L4 **Considering your use of (name the drug / drug class selected), in the past 12 months:**

a Have you been intoxicated, high, or hungover from (name of drug /drug class selected) more than once, when you had other responsibilities at school, at work, or at home? Did this cause any problem? (CODE **YES** ONLY IF THIS CAUSED PROBLEMS). O No O Yes

b Have you been high or intoxicated from (name of drug /drug class selected) more than once, in any situation where you were physically at risk, (for example, driving a car, riding a motorbike, using machinery, boating, etc.)? O No O Yes

c Did you have legal problems more than once, because of your drug use, for example, an arrest or disorderly conduct? O No O Yes

d Did you continue to use (name of drug / drug class selected) even though it caused problems with your family or other poeple? O No O Yes

ARE **1** OR MORE **L4** ANSWERS CODED **YES?** O No O Yes

***SUBSTANCE ABUSE* CURRENT**

Please specify drugs:

CHRONOLOGY

L5 How old were you when you first began having problems with drug abuse? [|] years

M. PSYCHOTIC DISORDERS - PART 1

ASK FOR AN EXAMPLE OF EACH QUESTION ANSWERED POSITIVELY. CODE **YES** ONLY IF THE EXAMPLES CLEARLY SHOW A DISTORTION OF THOUGHT OR OF PERCEPTION OR IF THEY ARE NOT CULTURALLY APPROPRIATE. BEFORE CODING, INVESTIGATE WHETHER DELUSIONS QUALIFY AS "BIZARRE".

DELUSIONS ARE "BIZARRE" IF: CLEARLY IMPLAUSIBLE, ABSURD, NOT UNDERSTANDABLE, AND CANNOT DERIVE FROM ORDINARY LIFE EXPERIENCE.

HALLUCINATIONS ARE SCORED "BIZARRE" IF A VOICE COMMENTS ON THE PERSON'S THOUGHTS OR BEHAVIOR, OR WHEN TWO OR MORE VOICES ARE CONVERSING WITH EACH OTHER.

ALL OF THE PATIENT'S RESPONSES TO THE QUESTIONS SHOULD BE CODED IN COLUMN A. USE THE CLINICIAN JUDGMENT COLUMN (COLUMN B) ONLY IF THE CLINICIAN KNOWS FROM OTHER OUTSIDE EVIDENCE (FOR EXAMPLE, FAMILY INPUT) THAT THE SYMPTOM IS PRESENT BUT IS BEING DENIED BY THE PATIENT.

Now I am going to ask you about unusual experiences that some people have.

		COLUMN A Patient Response			COLUMN B Clinician Response (if necessary)		
		No	Yes	Yes/Bizarre	No	Yes	Yes/Bizarre
M1 a	Have you ever believed that people were spying on you, or that someone was plotting against you, or trying to hurt you?	O	O	O	O	O	O
b	If **YES:** Do you currently believe these things? **NOTE:** ASK FOR EXAMPLES, TO RULE OUT ACTUAL STALKING	O	O	O **==> M6**	O	O	O **==> M6**
M2 a	Have you ever believed that someone was reading your mind or could hear your thoughts or that you could actually read someone's mind or hear what another person was thinking?	O	O	O	O	O	O
b	If **YES:** Do you currently believe these things?	O	O	O **==> M6**	O	O	O **==> M6**
M3 a	Have you every believed that someone or some force outside of yourself put thoughts in your mind that were not your own, or made you act in a way that was not your usual self? Have you ever felt that you were possessed? CLINICIAN: ASK FOR EXAMPLES AND DISCOUNT ANY THAT ARE NOT PSYCHOTIC.	O	O	O	O	O	O
b	If **YES:** Do you currently believe these things?	O	O	O **==> M6**	O	O	O **==> M6**
M4 a	Have you ever believed that you were being sent special messages through the TV, radio, or newspaper, or that a person you did not personally know was particularly interested in you?	O	O	O	O	O	O
b	If **YES:** Do you currently believe these things?	O	O	O **==> M6**	O	O	O **==> M6**

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		COLUMN A Patient Response			COLUMN B Clinician Response		
		No	Yes	Yes/Bizarre	No	Yes	Yes/Bizarre
M5 a	Have your relatives or friends ever considered any of your beliefs strange or unusual? **INTERVIEWER:** ASK FOR EXAMPLES. CODE YES ONLY IF THE EXAMPLES ARE **CLEARLY** DELUSIONAL IDEAS (FOR EXAMPLE, SOMATIC OR RELIGIOUS DELUSIONS OR DELUSIONS OF GRANDIOSITY, JEALOUSY, GUILT, RUIN OR DESTITUTION OR OTHERS NOT EXPLORED IN **M1** TO **M4).**	O	O	O	O	O	O
b	IF **YES:** Do they currently consider your beliefs strange?	O	O	O	O	O	O
M6 a	Have you ever heard things other people couldn't hear, such as voices? HALLUCINATIONS ARE SCORED "BIZARRE" ONLY IF PATIENT ANSWERS YES TO THE FOLLOWING:	O	O		O	O	O
	IF **YES**:Did you hear a voice commenting on your thoughts or behavior, or did you hear two or more voices talking to each other?			Yes/Bizarre O			
b	IF **YES:** Have you heard these things in the past month? SCORE AS "YES/BIZARRE" IF PATIENT HEARD A VOICE COMMENTING ON HIS/HER THOUGHTS OR BEHAVIOR OR HEARD TWO OR MORE VOICES TALKING TO EACH OTHER.	O	O	O **==> M8**	O	O	O **==> M8**
M7 a	Have you ever had visions when you were awake or have you ever seen things other people couldn't see? CLINICIAN: CHECK TO SEE IF THESE ARE CULTURALLY INAPPROPRIATE.	O	O		O	O	
b	If YES: Have you seen these things in the past month?	O	O		O	O	

CLINICIAN'S JUDGMENT

M8
b Is the patient currently exhibiting incoherence, disorganized speech, or marked loosening of associations? — O No O Yes

M9
b Is the patient currently exhibiting disorganized or catatonic behavior? — O No O Yes

M10
b Are negative symptoms of schizophrenia, for example, significant affective flattening, poverty of speech (alogia) or an inability to initiate or persist in goal-directed activities (avolition) prominent during the interview? — O No O Yes

M11
a IS THERE AT LEAST ONE "**YES"** FROM **M1** TO **M10b?** — O No O Yes

M11 b

ARE THE ONLY SYMPTOMS PRESENT THOSE IDENTIFIED BY THE CLINICIAN FROM **M1** TO **M7** (COLUMN B) AND FROM **M8b** OR **M9b** OR **M10b?**

IF **YES,** SPECIFY IF THE LAST EPISODE IS CURRENT (AT LEAST ONE "b" QUESTION IS CODED "**YES"** FROM **M1** TO **M10b)** AND/OR LIFETIME (ANY QUESTION CODED YES FROM M1 TO M10b AND PASS TO THE NEXT DIAGNOSTIC SECTION.

IF **NO,** CONTINUE.

WARNING:
IF AT LEAST ONE **"b"** QUESTION IS CODED **YES,** CODE **M11c** AND **M11d.**
IF ALL **"b"** QUESTIONS ARE CODED **NO,** CODE ONLY **M11d.**

O No O Yes

PSYCHOTIC DISORDER NOT OTHERWISE SPECIFIED*

Current O

Lifetime O

* Provisional diagnosis due to insufficient information available at this time.

M11 c

FROM **M1** TO **M10b:** ARE ONE OR MORE "b" ITEMS CODED "**YES BIZARRE**"?
ARE TWO OR MORE "b" ITEMS CODED "**YES"** BUT NOT "**YES BIZARRE**"?

O No

Then Criterion "A" of Schizophrenia is not currentlv met

O Yes

Then Criterion "A" of Schizophrenia is currently met

M11 d

FROM **M1** TO **M10b:** ARE ONE OR MORE "a" ITEMS CODED "**YES BIZARRE**"

OR

ARE TWO OR MORE "a" ITEMS CODED "YES" BUT NOT "**YES BIZARRE**"?
(CHECK THAT THE 2 ITEMS OCCURRED DURING THE SAME TIME PERIOD.)

O No

Then Criterion "A" of Schizophrenia is not met Lifetime

OR IS **M11c** CODED "**YES"**

O Yes

Then Criterion "A" of Schizophrenia is met Lifetime

M12

a Were you taking any drugs or medicines just before these symptoms began? ○ No ○ Yes

b Did you have any medical illness just before these symptoms began? ○ No ○ Yes

c IN THE CLINICIAN'S JUDGMENT, IS EITHER OF THESE LIKELY TO BE DIRECT CAUSE OF THE PATIENT'S PSYCHOSIS? ○ No ○ Yes

IF NECESSARY, ASK OTHER OPEN-ENDED QUESTIONS

d HAS AN ORGANIC CAUSE BEEN RULED OUT? ○ No ○ Yes ○ Uncertain

IF **M12d=NO:** SCORE **M13(a,b**) AND GO TO THE NEXT DISORDER
IF **M12d=YES:** CODE NO IN **M13(a,b)** AND GO TO **M14**
IF **M12D=UNCERTAIN:** CODE UNCERTAIN IN **M13 (a,b)** AND GO TO **M14**

M13

a IS **M12d** CODED **NO** BECAUSE OF A GENERAL MEDICAL CONDITION?

IF **YES,** SPECIFY IF THE LAST EPISODE IS

CURRENT (AT LEAST ONE "b" QUESTION IS CODED **YES** FROM **M1** TO **M10b)**
AND/OR LIFETIME ("a" OR "b") QUESTION IS CODED **YES** FROM **M1** TO **M10b.**

○ No ○ Yes

PSYCHOTIC DISORDER Due to a General Medical Condition

Current ○
Lifetime ○
Uncertain ○

M13

b IS **M12d** CODED NO BECAUSE OF A DRUG?

IF **YES,** SPECIFY IF THE LAST EPISODE IS
CURRENT (AT LEAST ONE QUESTION "b" IS CODED **YES** FROM **M1** TO **M10b**)
AND/OR LIFETIME (ANY "a" OR "b" QUESTION CODED **YES** FROM **M1** TO **M10b**).

○ No ○ Yes

Substance Induced
PSYCHOTIC DISORDER

Current ○
Lifetime ○
Uncertain ○

M14

How long (days) was the longest period during which you had those beliefs or experiences?
IF <1 DAY, GO TO THE NEXT SECTION

| | | | | Days

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M15

a During or after a period when you had these beliefs or experiences, did you have difficulty working, or difficulty in your relationship with others, or in taking care of yourself?

O No O Yes

b IF **YES,** how long (weeks) did these difficulties last?
IF>=6 MONTHS, GO TO **M16**

[ ][ ][ ] Weeks

c Have you been treated with medications or were you hospitalized because of these beliefs or experiences, or the difficulties caused by these problems?

O No O Yes

d IF **YES,** what was the longest time you were treated with medication or were hospitalized for these problems?

[ ][ ][ ] Weeks

M16

a THE PATIENT REPORTED DISABILITY **(M15a CODED YES)** OR WAS TREATED OR HOSPITALIZED FOR PSYCHOSIS (**M15c=YES**)

O No O Yes

b CLINICIAN'S JUDGMENT: CONSIDERING YOUR EXPERIENCE, RATE THE PATIENT'S **LIFETIME** DISABILITY CAUSED BY THE PSYCHOSIS.

1 O absent
2 O mild
3 O moderate
4 O severe

M17

WHAT WAS THE DURATION OF THE PSYCHOSIS, TAKING INTO ACCOUNT THE ACTIVE PHASE (**M14)** AND THE ASSOCIATED DIFFICULTIES (**M15b)** AND PSYCHIATRIC TREATMENT (**M15d)**

1 O >=1 day to <1 month
2 O >=1 month to <6 months
3 O >=6 months

CHRONOLOGY

M18

a How old were you when you first began having these unusual beliefs or experiences?

[ ][ ] Years

b Since the first onset how many distinct times did you have significant episodes of these unusual beliefs or experiences?

[ ][ ] Number of Episodes

PSYCHOTIC DISORDERS - PART 2

DIFFERENTIAL DIAGNOSIS BETWEEN PSYCHOTIC AND MOOD DISORDERS

CODE THE QUESTIONS **M19** TO **M23** ONLY IF THE PATIENT DESCRIBED AT LEAST 1 PSYCHOTIC SYMPTOM (**M11a=**YES AND **M11b=**NO), NOT EXPLAINED BY AN ORGANIC CAUSE (**M12d=YES** OR **UNCERTAIN**).

M19

a DOES THE PATIENT CODE POSITIVE FOR CURRENT AND/OR PAST MAJOR DEPRESSIVE EPISODE (QUESTION **A8** CODED **YES**)? — O No O Yes

b IF **YES:** IS **A1** (DEPRESSED MOOD) CODED **YES**? — O No O Yes

c DOES THE PATIENT CODE POSITIVE FOR CURRENT AND/OR PAST MANIC EPISODE (QUESTION **D7** IS CODED **YES**)? — O No O Yes

d IS **M19a** OR **M19c** CODED **YES?** — O No O Yes

No → **STOP! Skip to M24**

NOTE: VERIFY THAT THE RESPONSES TO THE QUESTIONS **M20** TO **M23** REFER TO THE PSYCHOTIC, DEPRESSIVE (**A8**) AND MANIC EPISODES (**D7**), ALREADY IDENTIFIED IN **M11c** AND **M11d, A8** AND **D7.** IN CASE OF DISCREPANCIES, REEXPLORE THE SEQUENCE OF DISORDERS, TAKING INTO ACCOUNT IMPORTANT LIFE ANCHOR POINTS/MILESTONES AND CODE **M20** TO **M23** ACCORDINGLY.

M20 When you were having the beliefs and experiences you just described (GIVE EXAMPLES TO PATIENT), were you also feeling depressed/high/irritable at the same time? — O No O Yes

No → **STOP! Skip to M24**

M21 Were the beliefs or experiences you just described (GIVE EXAMPLES TO PATIENT) restricted exclusively to times you were feeling depressed/high/irritable? — O No O Yes

Yes → **STOP! Skip to M24**

M22 Have you ever had a period of two weeks or more of having these beliefs or experiences when you were not feeling depressed/high/irritable? — O No O Yes

No → **STOP! Skip to M24**

M23 Which lasted longer: these beliefs or experiences or the periods of feeling depressed/high/irritable?

1 O mood
2 O beliefs, experiences
3 O same

M24

AT THE END OF THE INTERVIEW, GO TO THE DIAGNOSTIC ALGORITHMS FOR PSYCHOTIC DISORDERS.

CONSULT ITEMS **M11a** AND **M11b:**

IF THE CRITERION "A" OF SCHIZOPHRENIA IS MET (**M11c** AND/OR **M11d=YES**) GO TO DIAGNOSTIC ALGORITHMS I

IF THE CRITERION "A" OF SCHIZOPHRENIA IS NOT MET (**M11c** AND/OR **M11d=NO**) GO TO DIAGNOSTIC ALGORITHMS II

FOR MOOD DISORDERS GO TO DIAGNOSTIC ALGORITHM III

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N. ANOREXIA NERVOSA

=> MEANS: GO TO THE NEXT DIAGNOSTIC BOX, FILL IN NO IN ALL DIAGNOSTIC BOXES, AND MOVE TO THE NEXT MODULE

N1

a How tall are you? ft ☐☐ in ☐☐ OR cm ☐☐☐

b What was your lowest weight in the past 3 months? lbs ☐☐☐ OR kgs. ☐☐☐

IS PATIENT'S WEIGHT LOWER THAN THE THRESHOLD CORRESPONDING TO HIS/HER HIEGHT? (SEE TABLE BELLOW) => No Yes

TABLE HEIGHT/WEIGHT THRESHOLD (height-without shoes; weight-without clothing)

Female Height/Weight

ft/in.	4'9	4'10	4'11	5'0	5'1	5'2	5'3	5'4	5'5	5'6	5'7	5'8	5'9	5'10
lbs.	84	85	86	87	89	92	94	97	99	102	104	107	110	112
cms.	145	147	150	152	155	158	160	163	165	168	170	173	175	178
kgs.	38	39	39	40	41	42	43	44	45	46	47	49	50	51

Male Height/Weight

ft/in.	5'1	5'2	5'3	5'4	5'5	5'6	5'7	5'8	5'9	5'10	5'11	6'0	6'1	6'2	6'3
lbs.	105	106	108	110	111	113	115	116	118	120	122	125	127	130	133
cms.	155	156	160	163	165	168	170	173	175	178	180	183	185	188	191
kgs.	47	48	49	50	51	51	52	53	54	55	56	57	58	59	61

The weight thresholds above are calculated as a 15% reduction below the normal range for the patient's height and gender as required by DSM-IV. This table reflects weights that are 15% lower than the low end of the normal distribution range in the Metropolitan Life Insurance Table of Weights.

In the past 3 months:

N2 In spite of this low weight, have you tried not to gain weight? => No Yes

N3 Have you feared gaining weight or becoming fat? => No Yes

N4

a Have you considered yourself fat or that part of your body was too fat? No Yes

b Has your body weight or shape greatly influenced how you felt about yourself? No Yes

c Have you thought that your current low body weight was normal or excessive? No Yes

N5 ARE 1 OR MORE ITEMS FROM **N4** CODED **YES?** => No Yes

N6 **FOR WOMEN ONLY:** During the last 3 months, did you miss all your menstrual periods when they were expected to occur (when you were not pregnant)? => No Yes

FOR WOMEN: ARE **N5** AND **N6** CODED **YES?**

FOR MEN: IS **N5** CODED **YES?**

=>
O No O Yes
ANOREXIA NERVOSA
CURRENT

CHRONOLOGY

N7 How old were you when you first began having symptoms of anorexia? ☐☐ Years

N8 Since the first onset how many distinct illness periods of anorexia did you have? ☐☐☐ Number of Episodes

N9 During the past year, for how many months did you have significant symptoms of anorexia? ☐☐☐ Months

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O. BULIMIA NERVOSA

=> MEANS: GO TO THE NEXT DIAGNOSTIC BOX, FILL IN NO IN ALL DIAGNOSTIC BOXES, AND MOVE TO THE NEXT

O1 In the past three months, did you have eating binges or times when you ate a very large amount of food within a 2-hour period? => O No O Yes

O2 In the last 3 months, did you have eating binges as often as twice a week? => O No O Yes

O3 During these binges, did you feel that your eating was out of control? => O No O Yes

O4 Did you do anything to compensate for, or to prevent a weight gain from these binges, like vomiting, fasting, exercising or taking laxatives, enemas, diuretics (fluid pills), or other medications? => O No O Yes

O5 Does your body weight or shape greatly influence how you feel about yourself? => O No O Yes

O6 DO THE PATIENT'S SYMPTOMS MEET CRITERIA FOR ANOREXIA NERVOSA? O No O Yes

Skip to O8

O7 Do these binges occur only when you are under(__________lbs/kgs)? O No O Yes
INTERVIEWER: WRITE IN THE ABOVE PARENTHESIS THE THRESHOLD WEIGHT FOR THIS PATIENT'S HEIGHT FROM THE HEIGHT/WEIGHT TABLE IN THE ANOREXIA NERVOSE MODULE (PAGE 29)

O8 IS **O5** CODED **YES** AND **O7** CODED NO OR SKIPPED?

O No O Yes

BULIMIA NERVOSA
CURRENT

CHRONOLOGY

O9 How old were you when you first began having symptoms of bulimia? [ ][ ] Age

O10 Since the first onset how many illness periods of bulimia did you have? [ ][ ][ ] Number of Episodes

O11 During the past year, for how many months did you have significant symptoms of bulimia? [ ][ ][ ] Months

SUBTYPES OF BULIMIA NERVOSA

Do you regularly engage in self induced vomiting, misuse of laxatives, diuretics or enemas?

IN THE NON-PURGING TYPE, HAS THE PATIENT USED OTHER COMPENSATORY BEHAVIORS SUCH AS FASTING OR EXCESSIVE EXERCISE, BUT NOT PURGING?

O No — Non-Purging Type
O Yes — Purging Type

BULIMIA NERVOSA

SUBTYPES OF ANOREXIA NERVOSA

Binge-Eating/Purging Type

IS **O7** CODED **YES?**

O No O Yes

ANOREXIA NERVOSA
Binge Eating/Purging Type
CURRENT

Restricting Type

Do you lose weight without purging?

O No O Yes

ANOREXIA NERVOSA
Restricting Type
CURRENT

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P. GENERALIZED ANXIETY DISORDER

=> MEANS: GO TO THE NEXT DIAGNOSTIC BOX, FILL IN NO IN ALL DIAGNOSTIC BOXES, AND MOVE TO THE NEXT MODULE

P1

a Have you worried excessively or been anxious about several things over the past 6 months? — => O No O Yes

b Are these worries present most days? — => O No O Yes

IS THE PATIENT'S ANXIETY RESTRICTED EXCLUSIVELY TO , OR BETTER EXPLAINED BY, ANY DISORDER PRIOR TO THIS POINT? — O No => O Yes

P2 Do you find it difficult to control the worries or do they interfere with your ability to focus on what you are doing? — => O No O Yes

P3

FOR THE FOLLOWING, CODE **NO,** IF THE SYMPTOMS ARE CONFINED TO FEATURES OF ANY DISORDER EXPLORED PRIOR TO THIS POINT.

When you were anxious over the past 6 months, most of the time did you:

a Feel restless, keyed up or on edge? — O No O Yes

b Feel tense? — O No O Yes

c Feel tired, weak or exhausted easily? — O No O Yes

d Have difficulty concentrating or find your mind going blank? — O No O Yes

e Feel irritable? — O No O Yes

f Have difficulty sleeping (difficulty falling asleep, waking up in the middle of the night, early morning wakening) or sleeping excessively? — O No O Yes

SUMMARY OF P3: ARE 3 OR MORE **P3** ANSWERS CODED **YES?** — => O No O Yes

P4 Did these symptoms of anxiety cause you significant distress or impair your ability to function at work, socially, or in some other important way? — => O No O Yes

P5

a Were you taking any drugs or medicines just before these symptoms began? — O No O Yes

b Did you have any medical illness just before these symptoms began? — O No O Yes

IN THE CLINICIAN'S JUDGMENT: IS EITHER OF THESE LIKELY TO BE DIRECT CAUSE OF THE PATIENT'S GENERALIZED ANXIETY DISORDER?

P5 (SUMMARY): HAS AN ORGANIC CAUSE BEEN RULED OUT? — O No O Yes

IS **P5 (SUMMARY)** CODED **YES?** — O No O Yes

GENERALIZED ANXIETY DISORDER CURRENT

P6 IS **P5 (SUMMARY)** CODED **NO** AND **P5b** CODED **YES?**

○ No ○ Yes

CURRENT
GENERALIZED ANXIETY DISORDER
Due to a General
Medical Condition

P7 IS **P5 (SUMMARY)** CODED **NO** AND **P5a** CODED **YES?**

○ No ○ Yes

CURRENT
Substance Induced
Generalized Anxiety Disorder

CHRONOLOGY

P8 How old were you when you first began having symptoms of generalized anxiety?

[ ][ ] Age

P9 During the past year, for how many months did you have significant symptoms of generalized anxiety?

[ ][ ][ ] Months

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Q. ANTISOCIAL PERSONALITY DISORDER (optional)

=> MEANS: GO TO THE NEXT DIAGNOSTIC BOX, FILL IN NO IN ALL DIAGNOSTIC BOXES, AND MOVE TO THE NEXT MODULE

Q1 Before you were 15 years old, did you:

a	repeatedly skip school or run away from home overnight?	O No	O Yes
b	repeatedly lie, cheat, "con" others, or steal?	O No	O Yes
c	start fights or bully, threaten, or intimidate others?	O No	O Yes
d	deliberately destroy things or start fires?	O No	O Yes
e	deliberately hurt animals or people?	O No	O Yes
f	force someone to have sex with you?	O No	O Yes
	ARE **2** OR MORE **Q1** ANSWERS CODED **YES?**	=> O No	O Yes

DO NOT CODE **YES** TO THE BEHAVIORS BELOW IF THEY ARE EXCLUSIVELY POLITICALLY OR RELIGIOUSLY MOTIVATED

Q2 Since you were 15 years old, have you:

a	repeatedly behaved in a way that others would consider irresponsible, like failing to pay for things you owed, deliberately being impulsive or deliberately not working to support yourself?	O No	O Yes
b	done things that are illegal even if you didn't get caught (for example, destroying property, shoplifting, stealing, selling drugs, or committing a felony?)	O No	O Yes
c	been in physical fights repeatedly (including physical fights with your spouse or children)?	O No	O Yes
d	often lied or "conned" other people to get money or pleasure, or lied just for fun?	O No	O Yes
e	exposed others to danger without caring?	O No	O Yes
f	felt no guilt after hurting, mistreating, lying to, or stealing from others, or after damaging property?	O No	O Yes

ARE **3** OR MORE **Q2** QUESTIONS CODED **YES?**

O No O Yes

ANTISOCIAL PERSONALITY DISORDER LIFETIME

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R. SOMATIZATION DISORDER (optional)

=> MEANS: GO TO THE NEXT DIAGNOSTIC BOX, FILL IN NO IN ALL DIAGNOSTIC BOXES, AND MOVE TO THE NEXT MODULE

R1

		=>	
a	Have you had **many** physical complaints not clearly related to a specific disease beginning before age 30?	O No =>	O Yes
b	Did these physical complaints occur over several years?	O No =>	O Yes
c	Did these complaints lead you to seek treatment?	O No =>	O Yes
d	Did these complaints cause significant problems at school, at work, socially, or in other important areas?	O No =>	O Yes

R2 Did you have pain in your:

head	O No	O Yes
abdomen	O No	O Yes
back	O No	O Yes
joints, extremities, chest, rectum	O No	O Yes
during menstruation	O No	O Yes
during sexual intercourse	O No	O Yes
during urination	O No	O Yes
ARE **2** OR MORE **R2** ANSWERS CODED **YES?**	O No =>	O Yes

R3 Did you have any of the following abdominal symptoms:

nausea	O No	O Yes
bloating	O No	O Yes
vomiting	O No	O Yes
diarrhea	O No	O Yes
intolerance of several different foods	O No	O Yes
ARE **2** OR MORE **R3** ANSWERS CODED **YES?**	O No =>	O Yes

R4 Did you have any of the following sexual symptoms:

loss of sexual interest	O No	O Yes
erection or ejaculation problems	O No	O Yes
irregular menstrual bleeding	O No	O Yes
excessive menstrual bleeding	O No	O Yes
vomiting throughout pregnancy	O No	O Yes
ARE **2** OR MORE **R4** ANSWERS CODED **YES?**	O No =>	O Yes

R5 Did you have any of the following symptoms:

paralysis or weakness in parts of your body	O No	O Yes
impaired coordination or imbalance	O No	O Yes
difficulty swallowing or lump in throat	O No	O Yes
difficulty speaking	O No	O Yes
difficulty emptying your bladder	O No	O Yes
loss of touch or pain sensation	O No	O Yes
double vision or blindness	O No	O Yes
deafness, seizure, loss of consciousness	O No	O Yes
significant episodes of forgetfulness	O No	O Yes
unexplained sensations in your body	O No	O Yes

CLINICIAN: PLEASE EVALUATE IF THESE ARE SOMATIC HALLUCINATIONS

ARE **2** OR MORE **R5** ANSWERS CODED **YES?**	O No =>	O Yes

R6 Were the symptoms investigated by your physician? ○ No ○ Yes

R7 Was any medical illness found, or were you using any drug or medication that could explain these symptoms? ○ No ○ Yes

R6 AND R7 (SUMMARY): CLINICIAN: HAS AN ORGANIC CAUSE BEEN RULED OUT? ○ No ○ Yes

R8 Were the complaints or disability out of proportion to the patient's physical illness? ○ No ○ Yes

IS **R7 (SUMMARY)** OR **R8** CODED **YES?** => ○ No ○ Yes

R9 Were the symptoms a pretense or intentionally produced (as in factitious disorder)? ○ No => ○ Yes

IS **R9** CODED **NO**

○ No ○ Yes
SOMATIZATION DISORDER LIFETIME

R10 Are you currently suffering from these symptoms?

○ No ○ Yes
SOMATIZATION DISORDER CURRENT

S. HYPOCHONDRIASIS

=> **MEANS: GO TO THE NEXT DIAGNOSTIC BOX, FILL IN NO IN ALL DIAGNOSTIC BOXES, AND MOVE TO THE NEXT MODULE**

S1 In the past six months, have you worried a lot about having a serious physical illness? => ○ No ○ Yes

DO NOT CODE YES IF ANY PHYSICAL DISORDER CAN ACCOUNT FOR THE PHYSICAL SENSATIONS OR SIGNS THE PATIENT DESCRIBES.

S2 Have you had this worry for 6 months or more? => ○ No ○ Yes

S3 Have you ever been examined by a doctor for these symtpoms? => ○ No ○ Yes

S4 Have your illness fears persisted in spite of the doctor's reassurance? => ○ No ○ Yes

S5 Does this worry cause you significant distress, or does it interfere with your ability to function at work, socially, or in other important ways? ○ No ○ Yes

S6 IS **S5** CODED **YES?**

○ No ○ Yes
HYPOCHONDRIASIS CURRENT

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U. PAIN DISORDER

=> MEANS: GO TO THE NEXT DIAGNOSTIC BOX, FILL IN NO IN ALL DIAGNOSTIC BOXES, AND MOVE TO THE NEXT MODULE

U1	Currently, is pain your main problem?	=> O No	O Yes
U2	Currently, is the pain severe enough to need medical attention?	=> O No	O Yes
U3	Currently, is the pain causing you significant distress, or interfering significantly with your ability to function at work, socially, or in some other important way?	=> O No	O Yes
U4	Did psychological factors or stress have an important role in the onset of the pain, or did they make it worse, or keep it going?	=> O No	O Yes
U5	Observed Rating: Is the pain a pretense or intentionally produced or feigned? (As in factitious disorder)?	O No	=> O Yes
U6	Did a medical condition have an important role in the onset of the pain, or did the medical condition make it worse, or keep it going?	O No	O Yes
U7	Has the pain been present for more than 6 months?	O No ↓ Acute	O Yes ↓ Chronic

U8 IS **U6** CODED **NO?**

O No O Yes

PAIN DISORDER associated with psychological factors CURRENT

U9 IS **U6** CODED **YES?**

O No O Yes

PAIN DISORDER associated with psychological factors and general medical conditions CURRENT

IF **U8** OR **U9** ARE CODED **YES**
AND **U7=NO**, ACUTE DIAGNOSIS IS AUTOMATICALLY REPORTED
AND **U7=YES**, CHRONIC DIAGNOSIS IS AUTOMATICALLY REPORTED.

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ATTENTION DEFICIT/HYPERACTIVITY DISORDER

(Adult)

=> MEANS: GO TO THE NEXT DIAGNOSTIC BOX, FILL IN NO IN ALL DIAGNOSTIC BOXES, AND MOVE TO THE NEXT MODULE

W5 As a child:

a	Were you active, fidgety, restless, always on the go?	O No	O Yes
b	Were you inattentive and easily distractible?	O No	O Yes
c	Were you unable to concentrate at school or while doing your homework?	O No	O Yes
d	Did you fail to finish things, such as school work, projects, etc.?	O No	O Yes
e	Were you short tempered, irritable, or did you have a "short fuse", or tend to explode.	O No	O Yes
f	Did things have to be repeated to you many times before you did them?	O No	O Yes
g	Did you tend to be impulsive without thinking of the consequences?	O No	O Yes
h	Did you have difficulty waiting for your turn, frequently needing to be first?	O No	O Yes
i	Did you get into fights and/or bother other children?	O No	O Yes
j	Did your school complain about your behavior?	O No	O Yes
	W5 (SUMMARY):ARE **6** OR MORE **W5** ANSWERS CODED **YES?**	=> O No	O Yes

W6 Did you have some of these hpyeractive-impulsive or inattentive symptoms before you were 7 years old? => O No O Yes

W7 As an adult:

a	Are you still distractible?	O No	O Yes
b	Are you intrusive, or do you butt in, or say things that you later regret either to friends, at work, or home?	O No	O Yes
c	Are you impulsive, even if you have better control than when you were a child?	O No	O Yes
d	Are you still fidgety, restless, always on the go, even if you have better control than when you were a child?	O No	O Yes
e	Are you still irritable and get angrier than you need to?	O No	O Yes
f	Are you still impulsive? For example, do you tend to spend more money than you really should?	O No	O Yes
g	Do you have difficulty getting work organized?	O No	O Yes
h	Do you have difficulty getting organized even outside of work?	O No	O Yes
i	Are you under-employed or do you work below your capacity?	O No	O Yes
j	Are you not achieving according to people's expectations of your ability?	O No	O Yes
k	Have you changed jobs or have been asked to leave jobs more frequently than other people?	O No	O Yes
l	Does your spouse complain about your inattentiveness or lack of interest in him/her and/or the family?	O No	O Yes
m	Have you gone through two or more divorces, or changed partners more than others?	O No	O Yes
n	Do you sometimes feel like you are in a fog, like a snowy television or out of focus?	O No	O Yes
	W7 (SUMMARY):ARE **9** OR MORE **W7** ANSWERS CODED **YES?**	=> O No	O Yes

W8 Have some of these symptoms caused significant problems in two or more of the following situations: at school, at work, at home, or with family or friends? => O No O Yes

IS **W8** CODED **YES?**

O No O Yes
ADULT ATTENTION DEFICIT / HYPERACTIVITY DISORDER

Y. PREMENSTRUAL DYSPHORIC DISORDER

=> MEANS: GO TO THE NEXT DIAGNOSTIC BOX, FILL IN NO IN ALL DIAGNOSTIC BOXES, AND MOVE TO THE NEXT MODULE

Y1 During the past year, were most of your menstrual periods preceded by a period lasting about one week when your mood changed significantly? => O No O Yes

Y2 During these periods, do you have difficulty in your usual activities or relationships with others, are you less efficient at work, or do you avoid other people? => O No O Yes

Y3 During these premenstrual episodes (but not in the week after your period ends) do you have the following problems most of the time.

a	Do you feel sad, low, depressed, hopeless, or self-critical	O No	O Yes
b	Do you feel particularly anxious, tense, keyed up or on edge?	O No	O Yes
c	Do you often feel suddenly sad or tearful, or are you particulary sensitive to others' comments?	O No	O Yes
d	Do you feel irritable, angry or argumentative?	O No	O Yes
	ARE **1** OR MORE **Y3** ANSWERS CODED **YES?**	=> O No	O Yes
e	Are you less interested in your usual activities, such as work, hobbies or meeting with friends?	O No	O Yes
f	Do you have difficulty concentrating?	O No	O Yes
g	Do you feel exhausted, tire easily, or lack energy?	O No	O Yes
h	Does your appetite change, or do you overeat or have specific food cravings?	O No	O Yes
i	Do you have difficulty sleeping or do you sleep excessively?	O No	O Yes
j	Do you feel you are overwhelmed or out of control?	O No	O Yes
k	Do you have physical symptoms such as breast tenderness or swelling, headache, joint or muscle pain, a sensation of bloating, or weight gain?	O No	O Yes

ARE **5** OR MORE **Y3** ANSWERS CODED **YES?**

IF **YES,** DIAGNOSIS MUST BE CONFIRMED BY PROSPECTIVE DAILY RATINGS DURING AT LEAST 2 CONSECUTIVE CYCLES.

O No O Yes
Premenstrual Dysphoric Disorder Probable
CURRENT

Please do not write here.

Error Report

Please do not write here.