

# GENETIC STUDIES OF SUBSTANCE DEPENDENCE

## SDGen/SSAGA-IIa

*SEMI STRUCTURED ASSESSMENT FOR THE GENETICS OF ALCOHOLISM (MODIFIED) – ver. IIa*

The SDGen/SSAGA-IIa is an instrument designed to assess physical, psychological and social manifestations of drug dependence and related disorders. It is a semi-structured interview based on prior research in psychiatric epidemiology. As such, it relies on items previously validated by other research interviews, including the DIS, CIDI, HELPER, SAM, SADS, SCID, ASI, CEQ, and (most especially) the SSAGA-II on which it is based directly.

The Genetic Studies of Substance Dependence investigators are indebted to the COGA Assessment Committee, and to the many other researchers who developed the interviews upon which, in part, the SDGen/SSAGA-IIa is based.

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RESPONDENT'S I.D.:

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Site ID Family ID Individual ID

SITE IDs: YALE: 10; MUSC: 11; UCHC: 12 McLEAN: 13

INTERVIEWER'S I.D.: \_\_\_\_

DATE OF INTERVIEW: \_\_\_\_ / \_\_\_\_ / 200 \_\_\_\_

TIME STARTED: \_\_\_\_ : \_\_\_\_ (USE 24 HOUR CLOCK)

TIME ENDED: \_\_\_\_ : \_\_\_\_ (USE 24 HOUR CLOCK)

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DATE EDITED: \_\_\_\_ / \_\_\_\_ / 200 \_\_\_\_ ( \_\_\_\_ )  
MO DAY YEAR INITIALS

DATE ENTERED: \_\_\_\_ / \_\_\_\_ / 200 \_\_\_\_ ( \_\_\_\_ )  
MO DAY YEAR INITIALS  
-----

TIME STARTED: \_\_\_\_:\_\_\_\_ (USE 24 HR CLOCK)

A1 RECORD SEX AS OBSERVED.

MALE ..... 1  
FEMALE ..... 2

A2 How tall are you?

\_\_\_\_ FT \_\_\_\_ IN

A3 How much do you weigh?

\_\_\_\_ LBS

A. What is the most you have ever weighed (when you were not pregnant)?

\_\_\_\_ LBS

B. How old were you when you first weighed (# LBS. IN A) (when you were not pregnant)?

\_\_\_\_ AGE

A4 How old are you now?

\_\_\_\_ AGE

A5 What is your birth date?

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MO DAY YEAR

A6 Were you adopted?

NO ..... 1  
YES ..... 5

A7 Are you a twin or other multiple?

NO ..... 1  
YES ..... 5

**HAND R CARD A1.**

A8 A. This card has the names of some racial groups.  
To which group do you belong?

CODE: \_\_\_\_

**IF OTHER, SPECIFY:** \_\_\_\_\_

**HAND R CARD A2.**

B. This card is a list of origins and descents. What is the origin or descent of your grandparents? Let's start with your mother's mother.

	<u>I</u>	<u>II</u>
MATERNAL GRANDMOTHER	____	____
MATERNAL GRANDFATHER	____	____
PATERNAL GRANDMOTHER	____	____
PATERNAL GRANDFATHER	____	____

**IF KNOWN, RECORD THE GRANDPARENT'S FATHER IN COL. I AND THE GRANDPARENT'S MOTHER IN COL. II.**

C. What is your religious preference?  
**IF NONE, SKIP TO A9.**

**RECORD:** \_\_\_\_\_

CODE: \_\_\_\_

1. Does your religion have rules forbidding the use of any alcohol?

NO ..... 1  
YES ..... 5

D. In the past twelve months, how many times did you attend religious services?

\_\_\_\_ TIMES

A9 Are you presently married or are you widowed, separated, divorced, or have you never been married?

**CODE RELIGIOUS ANNULMENT AS  
DIVORCED. CODE LEGAL ANNULMENT AS  
NEVER MARRIED.**

MARRIED ..... 1  
WIDOWED ... (CODE YR) . 2  
\_\_\_\_\_ YEAR  
SEPARATED ..... 3  
DIVORCED ..... 4  
NEVER MARRIED ..... 5

A10 Have you ever lived with someone (else) for at least a year as though you were married? **DO NOT COUNT INDIVIDUALS R HAS MARRIED.**

NO ..... 1  
YES ..... 5

**BOX A10 IF R NEVER MARRIED (A9=5),  
SKIP TO BOX A12.**

A11 How many times have you been legally married?

\_\_\_\_\_ TIMES

YEARS OF ALL MARRIAGES

\_\_\_\_\_ YR  
\_\_\_\_\_ YR  
\_\_\_\_\_ YR  
\_\_\_\_\_ YR

ASPFGN

A12 (So you've never been/How many times have you been) divorced? **IF NEVER, CODE 00.**

\_\_\_\_\_ TIMES

YEARS OF ALL DIVORCES

\_\_\_\_\_ YR  
\_\_\_\_\_ YR  
\_\_\_\_\_ YR  
\_\_\_\_\_ YR

**BOX A12 IF R NEVER MARRIED (A9=5) AND  
NEVER COHABITATED (A10=1), SKIP  
TO A14. OTHERS CONTINUE.**

ASPFGN

A13 (Other than when you separated just before a divorce,) have you and your partner(s) ever separated for 3 days or longer because of not getting along?

NO. .... (SKIP TO A14) .... 1  
YES ..... 5

ASPFGN

A. How many times did you separate? **COUNT ALL MARRIAGE AND LIVE-IN SITUATIONS.**

\_\_\_\_\_ TIMES

B. How old were you the last time you separated?

AGE REC: \_\_\_\_\_ / \_\_\_\_\_  
REC: 1 2 3 4 5

**BOX A14 IF R IS MALE, SKIP TO A14C.**

A14 How many times have you been pregnant? \_\_\_\_\_ TIMES  
**IF NEVER, SKIP TO A15.**

A. Are you currently pregnant? NO ..... 1  
YES ..... 5

B. How many stillbirths and miscarriages have you had? \_\_\_\_\_ NUMBER

C. How many children have you had, not counting any who are yours by adoption, who are stepchildren, or who were stillborn? \_\_\_\_\_ CHILDREN  
**RECORD SEX AND DOB.**

DATE OF BIRTH			DATE OF BIRTH		
SEX	MO	YEAR	SEX	MO	YEAR
M F	____/	____	M F	____/	____
M F	____/	____	M F	____/	____
M F	____/	____	M F	____/	____
M F	____/	____	M F	____/	____

A15 What is the highest grade in school you completed? \_\_\_\_\_ GRADE  
**CODE ACTUAL GRADE (00-17).**

TECHNICAL SCHOOL OR 1 YR COLLEGE ... 13  
 2 YRS COLLEGE ..... 14  
 3 YRS COLLEGE ..... 15  
 4 YRS COLLEGE: B.A., B.S. .... 16  
 GRADUATE: M.A., M.S., J.D., M.D., Ph.D. .... 17

**IF A15 IS 12 OR LESS, ASK A.  
 OTHERS SKIP TO C.**

A. Do you have a high school diploma? NO ..... 1  
 YES..... (SKIP TO C) ..... 5

B. Did you pass a high school equivalency test  
 (GED)? NO ..... 1  
 YES ..... 5

C. Did you graduate from the last school you  
 attended? NO ..... 1  
 YES ..... 5

D. When did you graduate from ... HIGH SCH: \_\_\_\_\_ YR  
 GED: \_\_\_\_\_ YR  
 COLLEGE: \_\_\_\_\_ YR  
 GRAD: \_\_\_\_\_ YR  
 OTHER: \_\_\_\_\_ YR

E. Are you currently in school, in a program leading  
 to a degree? NO ..... 1  
 YES ..... 5

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A16 Now I want to ask you about work for pay. In the \_\_\_\_\_ MONTHS  
 past twelve months, how many months have you been  
 employed? **COUNT SELF-EMPLOYMENT OR  
 SALARIED. IF NONE, CODE 00 AND SKIP TO  
 A17B. IF LESS THAN 1 MONTH, CODE 01.**

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A17 Are you employed now?

NO . . . . . (SKIP TO B) . . . . 1  
YES . . . . . 5

A. Do you work full-time?

NO . . . . . 1  
YES . . . . . 5

B. What is your current household gross income?

CODE: \_\_\_\_

**HAND R CARD A3.**

\$0-\$192/week . . . . .	\$0-\$833/month . . . . .	\$0-\$9,999/year . . . . . 01
\$193-\$384/week . . . . .	\$834-\$1,666/month . . . . .	\$10,000-\$19,999/year . . . . . 02
\$385-\$576/week . . . . .	\$1,667-\$2,499/month . . . . .	\$20,000-\$29,999/year . . . . . 03
\$577-\$769/week . . . . .	\$2,500-\$3,333/month . . . . .	\$30,000-\$39,999/year . . . . . 04
\$770-\$961/week . . . . .	\$3,334-\$4,166/month . . . . .	\$40,000-\$49,999/year . . . . . 05
\$962-\$1,442/week . . . . .	\$4,167-\$6,249/month . . . . .	\$50,000-\$74,999/year . . . . . 06
\$1,443-\$1,923/week . . . . .	\$6,250-\$8,333/month . . . . .	\$75,000-\$99,999/year . . . . . 07
\$1,924-\$2,884/week . . . . .	\$8,334-\$12,499/month . . . . .	\$100,000-\$149,999/year . . . . . 08
\$2,885 or more/week . . . . .	\$12,500 or more/month . . . . .	\$150,000 or more/year . . . . . 09

A18 Have you ever been on active duty in the military?  
**NATIONAL GUARD AND RESERVES ARE  
NOT CONSIDERED ACTIVE DUTY UNLESS  
OFFICIALLY ACTIVATED.**

NO . . . (SKIP TO B1, p. 6) . . . 1  
YES . . . . . 5

A. What kind of discharge did you have?  
**OTHER THAN HONORABLE INCLUDES  
WITHOUT HONOR AND  
UNDESIRABLE.**

STILL IN THE MILITARY . . . 0  
HONORABLE . . . . . 1  
GENERAL . . . . . 2  
MEDICAL . . . . . 3  
OTHER THAN HONORABLE 4  
DISHONORABLE . . . . . 6

B. What's the highest rank you achieved?

CODE: \_\_\_\_

1. RANK: \_\_\_\_\_

2. BRANCH OF MILITARY:

CODE: \_\_\_\_

A19 Are you naturally right or left handed?

RIGHT . . . . . 1  
LEFT . . . . . 2

A20 What is your eye color?

BROWN . . . . . 1  
BLUE . . . . . 2  
GREEN . . . . . 3  
GREY . . . . . 4  
BROWN CENTER . . . . . 5

B1	Now I have some questions about your physical health and medical history. First, at the present time, would you say your health is excellent, very good, good, fair, or poor?	EXCELLENT ..... 1 VERY GOOD ..... 2 GOOD ..... 3 FAIR ..... 4 POOR ..... 5
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B2	Has your health always been (ANSWER IN B1), or has it been better or worse?	NO, WORSE ..... 1 NO, BETTER ..... 2 YES, SAME .. (SKIP TO B3) .. 5 BOTH BETTER & WORSE ... 6
	A. Please explain: _____ _____	

B3	Has a doctor ever told you that you have (had):		YEAR DIAGNOSED
		NO	YES
		1	5
	1. High blood pressure? .....	1	5
	2. Migraine headaches? .....	1	5
	3. A brain injury or concussion? .....	1	5
	4. Been unconscious for longer than 5 min? .....	1	5
	5. Epilepsy or have had a seizure? .....	1	5
	6. Meningitis or encephalitis? .....	1	5
	7. A stroke? .....	1	5
	8. Heart disease? .....	1	5
	9. Liver disease? .....	1	5
	10. Thyroid disease? .....	1	5
	11. Asthma? .....	1	5
	12. Diabetes? .....	1	5
	13. Cancer? <b>SPECIFY:</b> _____	1	5
	14. HIV/AIDS? .....	1	5
	15. A sexually transmitted disease? .....	1	5
	16. Any other illness(es)? _____	1	5
	17. Other? _____	1	5

B4	A. How many times have you been in a hospital overnight (including surgery and pregnancy), <u>excluding</u> psychiatric or substance abuse treatment?	_____ TIMES
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Please tell me about your hospital stays, starting with the most recent one.

<u>YEAR</u>	<u>LENGTH OF STAY (DAYS)</u>	<u>REASON FOR HOSPITALIZATION</u>
____ _	____ _	____ _
____ _	____ _	____ _
____ _	____ _	____ _
____ _	____ _	____ _

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B4 B. How many times have you had surgery when you did not have to stay in a hospital overnight (that is, outpatient surgery)? \_\_\_\_\_ TIMES

C. How many times have you been examined or treated in the emergency room because of an accident or injury? \_\_\_\_\_ TIMES

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B5 In the last 6 months, how many visits have you made to a doctor, clinic, or emergency room for your physical health? **DO NOT COUNT CHIROPRACTORS.** \_\_\_\_\_ VISITS

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B6 A. Have you ever taken any prescription medications for two weeks or longer . . . (READ 1-7)  
**IF YES, ASK: What did you take? DO NOT COUNT OTC.**

	<u>NO</u>	<u>YES</u>	<u>MEDICATIONS</u>	<u>CODE #1</u>	<u>CODE #2</u>	<u>CODE #3</u>
1. To make you feel less nervous? . 1	5	_____	_____	_____	_____	_____
2. To help you sleep? . . . . . 1	5	_____	_____	_____	_____	_____
3. To feel less depressed? . . . . . 1	5	_____	_____	_____	_____	_____
4. For headaches? . . . . . 1	5	_____	_____	_____	_____	_____
5. To have more energy? . . . . . 1	5	_____	_____	_____	_____	_____
6. For birth control? . . . . . 1	5	_____	_____	_____	_____	_____
7. Containing steroids? . . . . . 1	5	_____	_____	_____	_____	_____

**IF ALL ARE CODED 1, SKIP TO B6B.8.**

**FOR EVERY 5 CODED IN B6A.1-7, ASK B6B.1-7, AND ASK B6B.8.**

B. In the last 30 days, have you taken any prescription medications for two weeks or longer . . .  
**IF YES, ASK: What did you take? DO NOT COUNT OTC.**

	<u>NO</u>	<u>YES</u>	<u>MEDICATIONS</u>	<u>CODE #1</u>	<u>CODE #2</u>	<u>CODE #3</u>
1. To make you feel less nervous? . 1	5	_____	_____	_____	_____	_____
2. To help you sleep? . . . . . 1	5	_____	_____	_____	_____	_____
3. To feel less depressed? . . . . . 1	5	_____	_____	_____	_____	_____
4. For headaches? . . . . . 1	5	_____	_____	_____	_____	_____
5. To have more energy? . . . . . 1	5	_____	_____	_____	_____	_____
6. For birth control? . . . . . 1	5	_____	_____	_____	_____	_____
7. Containing steroids? . . . . . 1	5	_____	_____	_____	_____	_____
8. For anything else? .(SPECIFY) . 1	5	_____	_____	_____	_____	_____

**IF YES, SPECIFY REASON(S):** \_\_\_\_\_ **B6B.8: CODE #4** \_\_\_\_\_ **CODE #5** \_\_\_\_\_

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B7 Now I would like to ask you questions about your use of alcohol or drugs during the past month and over the course of your lifetime. *First ask:* Have you ever used the following? *for each substance.* *If yes, ask:* On how many days in the past month have you used ...? *for each substance used.*

*Then ask:* For how many years in your lifetime have you used ...? *for each substance used.* *Include only those years in which the subject used the substance at least 3 times/week for a month or more.*

	<b>Past 30 Days</b>	<b>Lifetime</b>	<b>Routes of admin. (code as many as apply)</b>
	<b>#Days</b>	<b>#Yrs</b>	
A. Alcohol - Any use at all	_____	_____	
B. Alcohol - To Intoxication (Use terms "High or Drunk")	_____	_____	
C. Heroin	_____	_____	_____
D. Methadone	_____	_____	
E. Other opiates/analgesics	_____	_____	
F. Barbiturates	_____	_____	
G. Other sed/hyp/tranq.	_____	_____	
H. Cocaine	_____	_____	_____
I. Amphetamines	_____	_____	_____
J. Cannabis	_____	_____	
K. Hallucinogens	_____	_____	
L. Inhalants	_____	_____	
M. More than one substance per day (incl. Alcohol).	_____	_____	

\* *Route of Administration: 1 = Oral, 2 = Nasal, 3 = Smoking, 4 = Non IV inj., 5 = IV inj.*  
(Code up to 4 different routes of administration; use one space for each)

N. Which substance is the major problem (in subject's opinion)?

*Code as above (2-13) or 00 for "no problem" . . . . .* \_\_\_\_\_

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B8 Have you ever had any emotional problems or times that stand out as particularly troubling or upsetting during your life?

NO. . . . . (SKIP TO B9) . . . . . 1  
YES. . . . . 5

**IF YES:** Would you tell me about this?

B9 How many times have you been an inpatient in a psychiatric hospital or ward or in a chemical dependency program where you stayed overnight?

\_\_\_ \_\_ TIMES

**IF NEVER, SKIP TO B10.**

A. When was the first time you were treated as an inpatient?

\_\_\_ / \_\_\_  
MO YEAR

REASON FOR TREATMENT CODES:

1 = Psychiatric (non-alcohol or drug)  
2 = Alc/Drug Treatment  
3 = Combined Psychiatric & A/D Txmt

Please tell me about your inpatient stays, starting with the most recent one:

<u>YEAR</u>	<u>LENGTH OF STAY (DAYS)</u>	<u>REASON FOR TREATMENT</u>	<u>REASON CODE</u>
___ ___ ___	___	_____	1 2 3
___ ___ ___	___	_____	1 2 3
___ ___ ___	___	_____	1 2 3
___ ___ ___	___	_____	1 2 3

B10 Have you ever received outpatient treatment for psychiatric, emotional, or chemical dependency problems? This includes any visits to a psychiatrist, psychologist, therapist, or counselor. NO . . . (SKIP TO BOX B10) . . . . 1  
YES . . . . . 5

A. Did you speak to a ...? NO YES

1.	Psychiatrist . . . . .	1	5
2.	Psychologist . . . . .	1	5
3.	Social worker . . . . .	1	5
4.	Counselor . . . . .	1	5
5.	Other medical doctor . . . . .	1	5
6.	Nurse practitioner . . . . .	1	5
7.	Clergy . . . . .	1	5
8.	Other: _____	1	5

CODES FOR NUMBER OF VISITS:

1= 1-10 visits  
2= 11-20 visits  
3= more than 20 visits

REASON FOR TREATMENT CODES:

1= Psychiatric (non-alcohol or drug)  
2= Alc/Drug Treatment  
3= Combined Psychiatric & A/D Txmt

Please tell me about your outpatient treatment, starting with the most recent one:

<u>YEAR</u>	<u>NUMBER OF VISITS</u>	<u>REASON FOR TREATMENT</u>	<u>REASON CODE</u>
____ _	1 2 3	_____	1 2 3
____ _	1 2 3	_____	1 2 3
____ _	1 2 3	_____	1 2 3
____ _	1 2 3	_____	1 2 3

<b>BOX B10</b>	<b>A. IS R CURRENTLY IN TREATMENT?</b>	<b>NO . . . . . 1</b>
		<b>YES . . . . . 5</b>
	<b>B. DOES R VOLUNTEER MORE THAN 4 SEPARATE OUTPATIENT TREATMENT PROGRAMS?</b>	<b>NO . . . . . 1</b>
		<b>YES . . . . . 5</b>

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Now I am going to ask you some questions about problems or experiences you might have had.

**ALL QUESTIONS IN THIS SECTION ARE REPEATED IN THE INDIVIDUAL SECTIONS THAT FOLLOW. IF R ANSWERS NO TO A QUESTION HERE, REPEAT THAT QUESTION LATER IN THE RELEVANT SECTION; IF YES, START THE RELEVANT SECTION WITH:**

You've said that...

**THEN CODE THE ANSWER YES AND GO ON TO THE NEXT QUESTION**

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C1.	Have you ever had a period of time lasting at least one week when you were bothered most of the day, nearly every day, by feeling depressed, sad, blue, or irritable?	NO .....	1
		YES .....	5

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C2.	Have you ever had a period of time lasting at least one week when you lost interest or enjoyment in almost everything, even things you usually liked to do?	NO .....	1
		YES .....	5

---

Now I'm going to ask you some other questions about your mood.

C3.	Have you ever had a period of time lasting 2 days or longer when you felt extremely hyper, elated (unrealistically happy), or manic most of the time, <u>clearly different</u> from your normal self?	NO .....	1
		YES .....	5

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C4.	Did you ever have a period of time lasting 2 days or longer (other than when you were depressed/withdrawing from drugs) when you felt unusually irritable most of the time, clearly different from your normal self, so that you would shout at people or start fights or arguments?	NO .....	1
		YES .....	5

---

C5.	Now I'm going to ask you about very unusual experiences you might have had.		
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	Did you ever hear things that other people couldn't hear, such as noises, or the voices of people whispering or talking, when you were completely awake?	NO .....	1
		YES .....	5

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C6.	Did you ever see things that other people could not see or have visions when you were completely awake?	NO .....	1
		YES .....	5

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C7.	Were you a very distractable child?	NO .....	1
		YES .....	5

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NOTE. NO QUESTIONS HERE FOR SECTION I (ASP), N (SUICIDALITY), OR O (PTSD).

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- C8. Now I would like to ask you about long periods of feeling worried or anxious.

Have you ever been anxious, worried, nervous, or "on edge" more days than not for at least 6 months? For example, worrying about possible harm to a loved one who was not in danger, or worrying about finances for no good reason?

NO ..... 1  
YES ..... 5

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- C9. Have you ever had thoughts, images, or impulses that bothered you a lot and kept coming back? Ideas that are senseless -- like thinking your hands are dirty no matter how often you wash them or thinking of hurting someone you love when you're not even mad at them. Other examples are the repeated urge to curse in church or feeling sure many times that you have run over someone with your car.

NO ..... 1  
YES ..... 5

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NOTE. NO QUESTION HERE FOR SECTION R (SOCIAL PHOBIA).

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- C10. Have you ever had a spell or attack when all of a sudden you felt frightened, anxious, or panicky in situations when most people would not be afraid or anxious; that is, during times when you were not in danger, or were not making a speech, or something like that?

NO ..... 1  
YES ..... 5

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- C11. Some people have a fear of being in certain places or situations where they feel it would be difficult to leave easily. They are worried that they could not escape or get help if they suddenly became panicky. Have you ever had a period of time when you had a fear like that -- that you might become panicky and wouldn't be able to leave easily if that happened?

NO ..... 1  
YES ..... 5

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(3)	D1	A.	Have you ever tried any form of tobacco?	NO .....	1
				YES .... (SKIP TO C) .....	5
		B.	So, you never have experimented with any form of tobacco (including cigarettes) <u>even one time</u> ?	NEVER. . . (SKIP TO E1, p. 20)	1
				YES, HAS USED .....	5
		C.	Have you <u>ever</u> :	<u>NO</u>	<u>YES</u>
		1.	smoked a cigarette? .....	1	5
		2.	smoked a cigar? .....	1	5
		3.	smoked a pipe? .....	1	5
		4.	used chewing tobacco or snuff? .....	1	5
		D.	How old were you the (first/last) time you used any form of tobacco?	AGE ONS:	<u>        </u> / <u>        </u>
				ONS: 1 2 3 4 5	
				AGE REC:	<u>        </u> / <u>        </u>
				REC: 1 2 3 4 5	

(5)	D3	Over your lifetime, have you smoked a total of 100 cigarettes?	NO .. (SKIP TO E1, p. 20) . . . . 1
			YES ..... 5

(1 & 6) D4 A. When you were smoking regularly, how many days \_\_\_\_\_ DAYS  
per week did you usually smoke cigarettes?  
**IF NOT AS OFTEN AS ONCE A WEEK, CODE 0.**

ND45(=20) B. How many cigarettes did you usually smoke in a day? \_\_\_\_\_ CIGS \*  
**IF 20 OR MORE CIGS 2+ DAYS PER WEEK,  
MARK TALLY SHEET D.**

C. For about how long did you smoke this many  
cigarettes at that rate? \_\_\_\_\_ UNITS  
**CODE UNITS:**  
DAYS ..... 1  
WEEKS ..... 2  
MONTHS ..... 3  
YEARS ..... 4

D. How old were you the (first/last) time you smoked  
cigarettes at that rate? AGE ONS: \_\_\_\_\_ / \_\_\_\_\_  
ONS: 1 2 3 4 5  
AGE REC: \_\_\_\_\_ / \_\_\_\_\_  
REC: 1 2 3 4 5

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Think about the period lasting a month or more when you were smoking the most.

- (7) D5 During this period when you were smoking the most, about \_\_\_\_\_ MINUTES  
how many minutes after you woke up did you smoke your first cigarette? **IF DK, ASK A. OTHERS SKIP TO D6.**

A. **IF DK:** Was it usually (READ OPTIONS)?

WITHIN 5 MINUTES . . . . 1  
WITHIN 6-30 MINUTES . . 2  
WITHIN 31-60 MINUTES . 3  
MORE THAN ONE HOUR 4

- 
- (8) D6 During the period when you were smoking the most, did you usually smoke more frequently during the first hours after waking than during the rest of the day?
- NO . . . . . 1  
YES . . . . . 5

- 
- (9) D7 During the period when you were smoking the most, did you usually find it difficult to keep from smoking in places where it was forbidden; for example, on airplanes, in movie theaters, in "no smoking" sections of restaurants or office buildings, or perhaps in situations where someone asked you not to?
- NO . . . . . 1  
YES . . . . . 5

- 
- D8 During the period when you were smoking the most, which cigarette would you have hated most to give up: the first one in the morning, after eating, while watching television, or some other one?
- FIRST ONE IN MORNING . 5  
ANY OTHERS . . . . . 1

- 
- (10) D9 During the period when you were smoking the most, were there times you smoked even when you were so ill that you had to be in bed most of the day?
- NO . . . . . 1  
YES . . . . . 5

---

Now I'd like you to think about your cigarette smoking throughout your life as I ask you more questions about experiences people sometimes have when they smoke cigarettes. (Since you don't smoke now, I'd like to ask you about the times when you used to smoke cigarettes.)

- (11) D10 Did you ever chain smoke; that is, where you smoked several cigarettes, one right after another?
- NO . . . . . (SKIP TO D11) . . 1  
YES . . . . . 5

A. For how many hours in a row did you smoke like that? \_\_\_\_\_ HOURS  
**CODE LESS THAN 1 HOUR = 00.**

**BOX D10 IF LESS THAN 3 HOURS, SKIP TO D11.**

- ND45 B. What is the longest period of time you have chain smoked every day or nearly every day? \_\_\_\_\_ UNITS  
**CODE UNITS:**

DAYS . . . . . 1  
WEEKS . . . . . 2 \*  
MONTHS . . . . . 3 \*  
YEARS . . . . . 4 \*



(12) ND46	D11	Have you <u>often</u> given up or spent much less time in activities important to you such as work, sports, going to movies, or seeing friends or relatives because you would not be able to smoke?	NO ..... 1 YES ..... 5*
(13) ND43	D12	Have you <u>often</u> smoked a lot more than you intended or for more days in a row than you intended? For example, smoking half a pack or more when trying to limit yourself to only 1 or 2 cigarettes?	NO ..... 1 YES ..... 5*
ND43	A.	Have you <u>often</u> found that you've run out of cigarettes sooner than you intended?	NO ..... 1 YES ..... 5*
(14) ASP3RC7 ASP4A5	D13	Have you smoked in situations where it was dangerous to smoke; for example, smoking in bed, when getting gasoline, or when using paint thinners or cleaning fluids?	NO .. (SKIP TO D14) ..... 1 YES ..... 5
	A.	Did this happen a total of 3 or more times?	NO .. (SKIP TO D14) ..... 1 YES ..... 5
	B.	Did this ever happen 3 or more times in any 12-month period?	NO ..... 1 YES ..... 5
(15) ND44	D14	Have you <u>often</u> wanted to quit or cut down on smoking?	NO ..... 1 YES ..... 5*
	A.	Have you ever tried to quit smoking?	NO .. (SKIP TO D15) ..... 1 YES ..... 5
	B.	How many times did you try to quit?	_____ TIMES
	C.	Were you <u>always</u> able to stop or cut down when you tried to?	NO ... (SKIP TO D) ..... 1 YES ..... 5
	1.	Was this for at least 1 month?	NO ..... 1 YES . (SKIP TO D15) ..... 5
ND44	D.	Have you 3 or more times found that you were unable to stop or cut down on smoking (for at least 1 month)?	NO ..... 1 YES ..... 5*
(16)	D15	Since you began smoking regularly, what is the longest period of time you have gone without using any form of tobacco for any reason, like when you had an illness, or lost interest in tobacco, or intentionally quit? <b>IF NEVER, CODE 000 DAYS. IF LESS THAN ONE DAY, CODE 001 DAY.</b>	_____ UNITS <b>CODE UNITS:</b> DAYS ..... 1 WEEKS ..... 2 MONTHS ..... 3 YEARS ..... 4
<b>BOX D15 IF D15 = 000 DAYS, SKIP TO D17. OTHERS CONTINUE.</b>			

- (23)
- |    |   |                                 |
|----|---|---------------------------------|
| A. | Have you ever attended a class or group for people trying to quit or reduce their use of tobacco? | NO . . . . . 1                  |
|    |   | YES . . . . . 5                 |
| B. | Have you ever tried nicotine gum or a nicotine patch (to quit or reduce your use of tobacco)?     | NO . . . . . 1                  |
|    |   | YES . . . . . 5                 |
| C. | Have you ever tried nicotine-free cigarettes (to quit or reduce your use of tobacco)?             | NO . . . . . 1                  |
|    |   | YES . . . . . 5                 |
| D. | Have you tried any other form of treatment or medicine to quit or reduce your use of tobacco?     | NO . . . . . 1                  |
|    |   | YES . . . (SPECIFY) . . . . . 5 |

**SPECIFY:** \_\_\_\_\_  
 \_\_\_\_\_

**IF ANY 5 IS CODED IN D15A-D, CONTINUE.  
 OTHERS SKIP TO D16.**

- |    |  |                           |
|----|--|---------------------------|
| E. | How old were you the (first/last) time you tried any of these methods to quit or cut down? | AGE ONS: _____ / _____    |
|    |  | ONS:    1   2   3   4   5 |
|    |  | AGE REC: _____ / _____    |
|    |  | REC:    1   2   3   4   5 |

- (17)      **D16** I'm going to ask you about some problems that you might have had when you stopped smoking or smoked less tobacco than usual. Think about the time when you had the most problems when you went without cigarettes or had less than usual. **CODE IN COLUMN I.**

I-SX II-CLSTR III-24HRS	During that time:	(SX) COL. I		(CLSTR) COL. II		(24 HRS) COL. III	
		NO YES		NO YES		NO YES	
		NO	YES	NO	YES	NO	YES
	1. Were you irritable, angry, or frustrated? . . . . .	1	5	1	5	1	5
	2. Were you nervous or anxious? . . . . .	1	5	1	5	1	5
	3. Were you restless? . . . . .	1	5	1	5	1	5
	4. Did you have trouble concentrating? . . . . .	1	5	1	5	1	5
	5. Did your heart slow down? . . . . .	1	5	1	5	1	5
	6. Did you feel down or depressed? . . . . .	1	5	1	5	1	5
	7. Did you have such a strong desire for cigarettes that you couldn't think of anything else? . . . . .	1	5	1	5	1	5
	8. Did your appetite increase or did you gain weight? . .	1	5	1	5		
	9. Did you have trouble sleeping? . . . . .	1	5	1	5		

<b>BOX D16</b>	<b>HOW MANY 5'S CODED IN COLUMN I?</b>	<b>NONE . . . . (SKIP TO D17) 1</b>
		<b>1-3 . . . . . (SKIP TO B) . 2</b>
		<b>4 OR MORE . . . . . 3</b>

ND42A

- A. Did at least four of these (SX CODED 5 IN COL. I) occur together in the first 24 hours after you stopped or cut down?

NO . . . . . (SKIP TO B) . . . 1  
YES . . . . . 5\*

1. Which ones? **CODE IN COLUMN II.**

2. How old were you the (first/last) time?

AGE ONS:            /  
ONS:    1   2   3   4   5

AGE REC:            /  
REC:    1   2   3   4   5

**FOR EACH 5 CODED IN D16.1-7 IN COL. I, ASK B.**

- B. Did (SX) last for at least 24 hours?  
**CODE IN COL. III. ONLY COUNT SYMPTOMS THAT LAST FOR MOST WAKING HOURS.**

- C. Did the problems you had after quitting or cutting down on smoking often interfere with your work, school, or household responsibilities?

NO . . . . . 1  
YES . . . . . 5

ND42B

- D. Did you start smoking again or use other sources of nicotine to avoid having the problems that quitting might cause?

NO . . . . . 1  
YES . . . . . 5\*

(18)

- D17 Has smoking ever made you nervous or jittery or caused you any other emotional or mental problem?

NO . . (SKIP TO D18) . . . . . 1  
YES . . . . . 5

- A. Did feeling nervous, jittery, or having other emotional or mental problems from smoking interfere with your functioning?

NO . . (SKIP TO D18) . . . . . 1  
YES . . (SPECIFY) . . . . . 5

**SPECIFY:** \_\_\_\_\_

ND47

- B. Did you continue to smoke after you knew it caused you problems like these?

NO . . . . . 1  
YES . . . . . 5\*

(19)

- D18 Has smoking caused you any health problem such as a problem with your heart or blood pressure, lung trouble, a cough that wouldn't go away, or any other health problem?

NO . . (SKIP TO D19) . . . . . 1  
YES . . . (SPECIFY) . . . . . 5

**SPECIFY:** \_\_\_\_\_

**CODE:** \_\_\_\_ \_\_\_\_ \_\_\_\_

ND47

- A. Did you continue to smoke after you knew it caused you (this/these) health problem(s)?

NO . . . . . 1  
YES . . . . . 5\*

(20)  
ND47

- D19 Have you continued to smoke when you had another serious illness that you knew was made worse by smoking, for example: asthma or bronchitis?

NO . . . . . 1  
YES . . (SPECIFY) . . . . . 5\*

**SPECIFY:** \_\_\_\_\_

**CODE:** \_\_\_\_ \_\_\_\_ \_\_\_\_

(21)

- D20 A. After you had been smoking regularly for some time, did you need to increase your daily use to feel comfortable?

NO . . . . . 1  
YES . . (SKIP TO C) . . . . . 5

	B.	After you had been smoking regularly, did you come to need more cigarettes each day?	NO . . . (SKIP TO D) . . . . . 1 YES . . . . . 5
ND41A	C.	Was this 50% more? So, if you used to smoke 10 cigarettes a day, you would increase to 15 a day, or go from 20 to 30?	NO . . . . . 1 YES . . (SKIP TO BOX D21) . . . . . 5*
ND41B	D.	After you had been smoking for some time, did you find that cigarettes had less effect on you than before?	NO . . . . . 1 YES . . . . . 5*

---

**BOX D21 IF 3 OR MORE BOXES MARKED ON TALLY D, CONTINUE. OTHERS SKIP TO E1, p. 20.**

---

**HAND R TOBACCO TALLY SHEET.**

(22)	D21	I'd like to review the experiences you've told me you had with smoking cigarettes. You've said that: <b>(READ SX MARKED ON TALLY SHEET D).</b>	
ND4		Did you ever have experiences from 3 or more boxes in any 12-month period? <b>IF YES:</b> Which ones? <b>CIRCLE THE SYMPTOMS THAT CLUSTER. MUST BE FROM 3 DIFFERENT BOXES.</b>	NO. . . . (SKIP TO E1, p. 20) . 1 YES . . . . . 5
	A.	How old were you the (first/last) time?	AGE ONS: ____/____ AGE REC: ____/____

---

## TOBACCO TALLY SHEET

### DSM-IV

_____ <b>D4B</b>	Smoked 20+ cigarettes in a day at least twice a week	<b>BOX 1:</b> _____
_____ <b>D10</b>	Chain smoked for 7+ days	
_____ <b>D11</b>	Gave up or greatly reduced important activities because could not smoke	<b>BOX 2:</b> _____
_____ <b>D12</b>	Often smoked a lot more than intended	<b>BOX 3:</b> _____
_____ <b>D12A</b>	Often ran out of cigarettes sooner than intended	
_____ <b>D14</b>	Often wanted to quit or cut down on smoking	<b>BOX 4:</b> _____
_____ <b>D14D</b>	Unable to stop or cut down 3+ times	
_____ <b>D16A</b>	Experienced 4 or more withdrawal symptoms in 24 hours after quitting or cutting down	<b>BOX 5:</b> _____
_____ <b>D16D</b>	Smoked or used other source of nicotine to avoid withdrawal symptoms	
_____ <b>D17B</b>	Continued to smoke knowing it caused some emotional problems	<b>BOX 6:</b> _____
_____ <b>D18A</b>	Continued to smoke knowing it caused physical health problems	
_____ <b>D19</b>	Continued to smoke despite serious physical illness	
_____ <b>D20C</b>	Needed to increase cigarette use by 50% or more	<b>BOX 7:</b> _____
_____ <b>D20D</b>	Found smoking had less effect	

- 
- (1) E1 Now I would like to ask you some questions about your use of alcoholic beverages, like beer, wine, champagne, or hard liquor like vodka, gin, or whiskey. Have you ever had a drink of alcohol? NO... (SKIP TO B) ..... 1  
YES..... 5
- A. How old were you when you took your first real drink of alcohol (not a sip; not at a religious ceremony)? **SKIP TO E2.** AGE: \_\_\_\_
- B. So, you have never had even one full drink of alcohol? NEVER. . (SKIP TO F1, p. 33) . 1  
YES, HAD A DRINK ..... 5
- 

- (7) E2 I'd like to ask you about reactions that some people have when they drink any type of alcohol.
- A. While drinking, has one or two drinks of alcohol ever caused you to . . . **CODE IN COL. A.**
- |   | COL A     |            | COL B     |            |
|---|-----------|------------|-----------|------------|
|   | <u>NO</u> | <u>YES</u> | <u>NO</u> | <u>YES</u> |
| <b>DO NOT COUNT IF ONLY ONE TYPE OF ALCOHOL CAUSED THE REACTION.</b>  |           |            |           |            |
| 1. flush or blush—that is, your face and hands felt hot and your face turned red? .....   | 1         | 5          | 1         | 5          |
| a. <b>IF E2A.1=5, ASK:</b> Did the flushing or blushing begin within the <u>first few minutes</u> after the <u>first</u> drink? ..... | 1         | 5          |           |            |
| 2. break out into hives? .....  | 1         | 5          | 1         | 5          |
| 3. feel very sleepy (when you weren't already tired)? .....   | 1         | 5          | 1         | 5          |
| 4. have nausea? .....   | 1         | 5          | 1         | 5          |
| 5. have headaches, head pounding, or throbbing? .   | 1         | 5          | 1         | 5          |
| 6. have heart palpitations, where your heart beat so hard you could feel it? .....  | 1         | 5          | 1         | 5          |
- FOR EACH 5 CODED IN COL. A, ASK B. OTHERS SKIP TO E3.**
- B. Did (SX) ever keep you from drinking any alcohol on at least one other occasion?  
**CODE IN COL. B.**

- 
- (4) E3 At what age did you begin to drink regularly; that is, drinking at least once a month for 6 months or more? AGE: \_\_\_\_  
**IF NEVER, CODE 00.**

A. How old were you the first time you got drunk, that is, your speech was slurred or you were unsteady on your feet? **IF DK, ASK A1.**  
**IF NEVER, CODE 00 AND SKIP TO E4.**  
**IF DRUNK BEFORE AGE 15, SKIP TO B.**  
**OTHERS SKIP TO E4.**

AGE: \_\_\_\_

1. Was it before you were 15 years old? NO . . . (SKIP TO E4) . . . 1  
YES . . . . . 5

B. Did you get drunk more than once before you were 15 years old? NO . . . . . 1  
YES . . . . . 5

---

(5) E4 In your lifetime, what is the largest number of drinks you have ever had in a 24-hour period (including all types of alcohol)? \_\_\_\_ DRINKS

---

**BOX E4 IF E4=3 DRINKS OR FEWER (LIFETIME), SKIP TO F1. IF E3 AND E3A BOTH CODED 00, SKIP TO F1, p. 33. OTHERS CONTINUE.**

---

(6) E5 Was there ever a time when you drank almost every day for a week or more? By “almost every day” I mean at least 4 days out of 7. NO . . . . . 1  
YES . . . . . 5

---

**BEGIN SCORING ALCOHOL TALLY SHEETS A & B.**

---

(20) E6 (After you started drinking regularly,) did you ever become tolerant to alcohol; that is, you drank a great deal more in order to get an effect, or found you could no longer get high on the amount you used to drink? **SHOW R CARD E2.** NO . . . (SKIP TO E6-D) 1  
YES . . . . . 5

A1. When you first started drinking regularly, how many drinks did it take you to get an effect? \_\_\_\_ DRINKS

A2. After you had been drinking for some years, how many drinks did you usually need to get an effect? \_\_\_\_ DRINKS  
**CODE THE TYPICAL UPPER BOUND OF TOLERANCE. DO NOT COUNT AN ISOLATED EXPERIENCE.**

**B. WAS THE INCREASE IN A2 TO 5 DRINKS (WOMEN)/ 6 DRINKS (MEN) OR MORE?** NO . . . (SKIP TO D) . . 1  
YES . . . . . 5

**C. WAS INCREASE 50% OR MORE? CHECK CARD E2.** NO . . . . . 1  
YES . . (SKIP TO E7) . . . 5 A,B

AD3RA7  
AD41A  
ADICD4

D. Did you ever find you could drink a lot more before you got drunk? NO . . . (SKIP TO E7) . . . 1  
YES . . . . . 5

E1. When you first started drinking regularly, how many drinks did it take you to get drunk? \_\_\_\_ DRINKS

E2. After you had been drinking for some years, how many drinks did it take you to get drunk? \_\_\_\_ DRINKS

**CODE THE TYPICAL UPPER BOUND OF TOLERANCE. DO NOT COUNT AN ISOLATED EXPERIENCE.**

F. **WAS THE INCREASE IN E2 TO 5 DRINKS (WOMEN)/ 6 DRINKS (MEN) OR MORE?** NO . . . (SKIP TO E7) . . . 1  
YES . . . . . 5

G. **WAS INCREASE 50% OR MORE? CHECK CARD E2.** NO . . . . . 1  
YES . . . . . 5 A,B

AD3RA7  
AD41B  
ADICD4

(9)  
AD3RA2/B  
AD44  
ADICD2

E7 Have you 3 or more times wanted to stop or cut down on drinking? NO . . . . . 1  
YES . . . . . 5 A,B  
**DO NOT COUNT DIETING OR PREGNANCY.**

A. Have you ever tried to stop or cut down on drinking? NO . . . (SKIP TO E8) . . 1  
YES . . . . . 5  
**COUNT ANY REASON.**

AD3RA2  
ALCFGNB1

B. Were you always able to stop or cut down when you tried to? NO, UNABLE . . . . . 1 A  
YES . . (SKIP TO E8) . . 5

AD44  
ADICD2

C. How many times were you unable to stop or cut down? \_\_\_\_ TIMES B  
**IF 3 OR MORE, MARK TALLY SHEET B. IF DK, ASK C1.**

AD44  
ADICD2

1. Was it 3 or more times? NO . . . . . 1  
YES . . . . . 5 B

(13)  
ALCFGNB1

E8 Have you ever started drinking at times you promised yourself that you wouldn't, or have you ever drunk more than you intended? For example, when you decided to drink 2 drinks and ended up drinking 4 or more? NO . . . . . 1  
YES . . (SKIP TO B) . . 5

A. Have you ever continued drinking for more days in a row than you intended? NO . . . (SKIP TO E9) . . 1  
YES . . . . . 5

AD3RA1/B  
AD43  
ADICD2

**IF BOTH E8 AND E8A ARE CODED 1, SKIP TO E9 OTHERWISE CONTINUE TO E8B**

B. Did this happen 3 or more times? NO . . . . . 1  
YES . . . . . 5 A,B

(14)

E9 Have you ever started drinking and become drunk when you didn't want to? NO . . (SKIP TO E10) . . 1  
YES . . . . . 5



AD3RA1/B AD43 ADICD2	A.	Did this happen 3 or more times?	NO ..... 1 YES ..... 5 A,B
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(22)	E10	Have you ever given up or greatly reduced important activities while drinking -- like sports, work, or associating with friends or relatives?	NO... (SKIP TO E11) .. 1 YES.... (SPECIFY) ... 5
		<b>SPECIFY:</b> _____ _____	

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AD3RA5/B AD46 ADICD5	A.	Did this happen 3 or more times or for a month or more?	NO ..... 1 YES ..... 5 A,B
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(15)	E11	Has there ever been a period of several days or more when you spent so much time drinking or recovering from the effects of alcohol that you had little time for anything else?	NO... (SKIP TO E12) . 1 YES ..... 5
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AD3RA3 AD45 ADICD5	A.	Did this period last for a month or more or did you have 3 or more periods like that?	NO.... ..... 1 YES ..... 5 A,B
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(12)	E12	Have you ever gone on binges or benders when you kept on drinking for 2 days or more without sobering up, except for sleeping?	NO... (SKIP TO E13) . 1 YES ..... 5
	A.	Did you neglect some of your usual responsibilities then?	NO... (SKIP TO E13) .. 1 YES ..... 5
AD3RA4/B ADICD5 ALCFGNA4	B.	Did you go on binges 3 or more times?	NO ..... 1 YES ..... 5 A
AA4A1		<b>IF FEWER THAN 3 BINGES, CODE "NO" SILENTLY.</b>	
	C.	Did this happen 3 or more times in any 12-month period?	NO ..... 1 YES ..... 5

---

(31) ALCFGNA3	E13	Have you ever had blackouts, that is when you did not pass out while drinking, but you drank enough so that the next day you could not remember things you had said or done?	NO... (SKIP TO E14) .. 1 YES ..... 5
	A.	How many blackouts have you had from drinking? <b>IF DK, ASK A1. OTHERS SKIP TO E14.</b>	_____ TIMES
	1.	Did you have 3 or more blackouts?	NO ..... 1 YES ..... 5

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(11) ADICD1	E14	In situations where you couldn't drink, did you ever have such a strong desire for it that you couldn't think of anything else?	NO... ..... 1 YES ..... 5
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(36) AD3RA4/B AA3RA2 AA4A2	E15	Have you used alcohol 3 or more times while taking medications or drugs you knew were dangerous to mix with alcohol? <b>PROBE FOR AMOUNTS OF ALC/DRUGS AND REASON THOUGHT DANGEROUS.</b>	NO . . . (SKIP TO E16) . . 1 YES . . . (SPECIFY) . . . 5 A
-------------------------------------	-----	--	---

**SPECIFY:** \_\_\_\_\_  
\_\_\_\_\_

A. What medication(s) or drug(s)?

\_\_\_\_\_  
\_\_\_\_\_

CODE: \_\_\_\_\_

CODE: \_\_\_\_\_

AA4A2	B.	Did this happen 3 or more times in any 12-month period?	NO . . . . . 1 YES . . . . . 5
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ADICD6	C.	Did you have any harmful effects from mixing alcohol and (DRUG)?	NO . . . . . 1 YES . . . . (SPECIFY) . . . 5
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**SPECIFY:** \_\_\_\_\_  
\_\_\_\_\_

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(30)	E16	When you were drunk, did you ever drive a car, motorcycle or boat; use a knife, power equipment or gun; cross against traffic; climb or swim; or put yourself in any other situation where you might have gotten hurt?	NO . . . (SKIP TO E17) . . 1 YES . . . . . 5
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AD3RA4/B AA3RA2/B ASP3RC7 ASP4A5	A.	How many times has this happened? <b>IF 3 OR MORE, MARK TALLY A AND SKIP TO B. IF FEWER THAN 3, SKIP TO E17. IF DK, ASK A1.</b>	_____ TIMES A
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AD3RA4/B AA3RA2/B ASP3RC7 ASP4A5	1.	Did this happen 3 or more times?	NO . . . (SKIP TO E17) . . 1 YES . . . . . 5 A
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AA4A2	B.	Did this happen 3 or more times in any 12-month period?	NO . . . . . 1 YES . . . . . 5
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(27) ALCFGNC2	E17	Have you ever been arrested for drunk driving?	NO . . . (SKIP TO E18). . . . 1 YES . . . . . 5
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ASP3RC7	A.	How old were you the (first/last) time?	AGE ONS: _____/_____ ONS: 1 2 3 4 5
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AGE REC: \_\_\_\_\_/\_\_\_\_\_  
REC: 1 2 3 4 5

AD3RA4/B AA3RA2/B ASP3RC7 ASP4A5	B.	How many times has this happened? <b>IF 3 OR MORE, MARK TALLY A AND SKIP TO C. IF FEWER THAN 3, SKIP TO E18. IF DK, ASK B1.</b>	___ __ TIMES A
AD3RA4/B AA3RA2/B ASP3RC7 ASP4A5	1.	Did this happen 3 or more times?	NO. . . . (SKIP TO E18) . . 1 YES . . . . . 5 A
AA4A3	C.	Did this happen 3 or more times in any 12-month period?	NO . . . . . 1 YES . . . . . 5

---

(27) ALCFGNC2	E18	Has your drinking and driving ever resulted in your damaging your car or having an accident? <b>COUNT ALL ACCIDENTS, EVEN IF NOT REPORTED TO THE POLICE.</b>	NO. . . . (SKIP TO E19) . 1 YES . . . . . 5
ASP3RC7	A.	How old were you the (first/last) time?	AGE ONS:      ___ / ___ ONS:      1   2   3   4   5  AGE REC:      ___ / ___ REC:      1   2   3   4   5
AD3RA4/B AA3RA2/B	B.	How many times has this happened? <b>IF 3 OR MORE, MARK TALLY A AND SKIP TO C. IF FEWER THAN 3, SKIP TO E19. IF DK, ASK B1.</b>	___ __ TIMES A
AD3RA4/B AA3RA2/B	1.	Did this happen 3 or more times?	NO. . . . (SKIP TO E19) . . 1 YES . . . . . 5 A
AA4A2	C.	Did this happen 3 or more times in any 12-month period?	NO . . . . . 1 YES . . . . . 5

---

(23) AD3RA4/B	E19	Has your drinking or being drunk or hung over <u>often</u> interfered with your work, school, household, or child care responsibilities?	NO. . . . (SKIP TO E20) . 1 YES. . . . (SPECIFY) . . 5 A
		<b>SPECIFY:</b> _____ _____	
AA4A1	A.	Did this happen 3 or more times in any 12-month period?	NO . . . . . 1 YES . . . . . 5

**FOR EACH 5 CODED IN E20A.1-4, ASK, "Did this happen 3 or more times?" CODE IN COL II.**

(17) ALCFGND2 ALCFGND4 AD3RA6 AA3RA1/B	E20	A1.	Did your drinking ever result in objections from or problems with your family, friends, doctors, clergy, or people at work or school?	COL I		COL II	
				<u>NO</u>	<u>YES</u>	<u>NO</u>	<u>YES</u>
				1	5	1	5 A

ALCFGND3 AD3RA6	A2.	Have you ever lost friends on account of your drinking?	1	5	1	5	A
ALCFGNC3 AD3RA6 AA3RA1/B	A3.	Did your drinking ever cause you to have problems at work or school?	1	5	1	5	A
	A4.	Did you ever get into arguments when you had been drinking?	1	5	1	5	
<b>IF ANY 5 IS CODED IN COL I, CONTINUE. OTHERS SKIP TO E21.</b>							
	B.	Did any of these experiences happen 3 or more separate times in any 12-month period?	NO . . . . .		1		
AA4A4			YES . . . . .		5		
<hr/>							
(24)	E21	Did your drinking cause serious or repeated problems in any marriage or love relationship?	NO. . . (SKIP TO E22) .		1		
			YES . . . . .		5		
AA4A4	A.	Did this happen 3 or more times in any 12-month period?	NO . . . . .		1		
			YES . . . . .		5		
AD3RA6	B.	Did you continue to drink knowing it caused these problems?	NO . . . . .		1		
			YES . . . . .		5		A
<hr/>							
(28) ALCFGNC1	E22	Have you ever been arrested or detained by the police even for a few hours because of drunk behavior (other than for drunk driving)?	NO . . . (SKIP TO E23) .		1		
			YES . . . . .		5		
AD3RA6	A.	How many times has this happened? <b>IF 3 OR MORE, MARK TALLY A AND SKIP TO B. IF FEWER THAN 3, SKIP TO E23. IF DK, ASK A1.</b>	_____		TIMES		A
AD3RA6	1.	Did this happen 3 or more times?	NO. . . (SKIP TO E23) . .		1		
			YES . . . . .		5		A
AA4A3	B.	Did this happen 3 or more times in any 12-month period?	NO . . . . .		1		
			YES . . . . .		5		
<hr/>							
(29)	E23	Have you ever accidentally injured yourself when you were drinking; that is, had a bad fall or cut yourself badly, been hurt in a traffic accident, or anything like that?	NO. . . (SKIP TO E24) . .		1		
			YES . . . . .		5		
AD3RA4/B ADICD6 AA3RA2	A.	How many times has this happened? <b>IF 3 OR MORE, MARK TALLY A, AND SKIP TO B. IF FEWER THAN 3, SKIP TO E24. IF DK, ASK A1.</b>	_____		TIMES		A
AD3RA4/B ADICD6 AA3RA2	1.	Did this happen 3 or more times?	NO. . . (SKIP TO E24) . .		1		
			YES . . . . .		5		A
AA4A2	B.	Did this happen 3 or more times in any 12-month period?	NO . . . . .		1		
			YES . . . . .		5		
<hr/>							

(35)  
ALCFGNA2

E24 There are several health problems that can result from long stretches of drinking. Did drinking ever cause you to have liver disease or yellow jaundice, stomach disease or make you vomit blood, pancreatitis, damage to your heart (cardiomyopathy), make your feet tingle or feel numb for many hours, have memory problems even when you weren't drinking (not counting blackouts), or have any other physical health problems?  
**NOTE: UNDERLINE POSITIVE ITEMS.**

NO      YES

1          5

**IF CODED 1, SKIP TO E25. OTHERS CONTINUE.**

AD3RA6  
AD47  
ADICD6  
AA3RA1

A. Did you continue to drink knowing that drinking caused you to have health problems?

NO ..... 1  
YES ..... 5 A,B

(37)

E25 Has drinking ever caused you emotional or psychological problems like: hearing, seeing, or smelling things that weren't really there or causing any of the following for more than 24 hours: feeling depressed or uninterested in things, feeling jumpy or easily startled or nervous, having trouble thinking clearly, feeling paranoid or suspicious of people.  
**NOTE: UNDERLINE POSITIVE ITEMS.**

NO      YES

1          5

**IF CODED 1, SKIP TO BOX E25. OTHERS CONTINUE.**

AD3RA6  
AD47  
ADICD6  
AA3RA1

A. Did you continue to drink after you knew it caused you any of these problems?

NO. (SKIP TO BOX E25) 1  
YES ..... 5 A,B

**BOX E25 CHECK TALLY SHEETS A & B. IF NO MARKS, SKIP TO F1, p. 33. OTHERS CONTINUE.**

**E26** People who cut down, stop, or go without drinking after drinking steadily for some time may not feel well. These feelings are more intense and can last longer than the usual hangover.

When you stopped, cut down or went without drinking, did you ever experience any of the following problems for most of the day for 2 days or longer? **REPEAT STEM OFTEN.**  
**CODE IN COL. I. (NO=1, YES=5)**

		I	II (DSM3R)	III (DSM4)
II-AD3R III-AD4 IV-AICD	1. Did you have the shakes (hands trembling)? . . . . .	1 5	1 5	1 5
	2. Were you unable to sleep? . . . . .	1 5	1 5	1 5
	3. Did you feel anxious? . . . . .	1 5	1 5	1 5
	4. Did you feel depressed or irritable? . . . . .	1 5	1 5	
	5. Did your heart beat fast or did you sweat? . . . . .	1 5	1 5	1 5
	6. Did you have nausea or vomiting? . . . . .	1 5	1 5	1 5
	7. Did you feel physically weak? . . . . .	1 5	1 5	
	8. Did you have headaches? . . . . .	1 5	1 5	
	9. Did you see or hear things that weren't there? . . . .	1 5	1 5	1 5
	10. Were you fidgety or restless? . . . . .	1 5		1 5

**BOX E26 IF NO 5'S CODED IN COLUMN I, SKIP TO E27. IF R HAD SHAKES (E26.1= 5), ASK A. IF NO SHAKES (E26.1=1), SKIP TO B.**

A. How old were you the first time you had the shakes (hands trembling)? AGE ONS: \_\_\_\_ / \_\_\_\_  
ONS: 1 2 3 4 5

AD3RB B. What was the longest time that (this/any of these) \_\_\_\_ DAYS  
problem(s) lasted?

**IF ONLY ONE SX IS CODED 5 IN E26.1-10, SKIP TO H. OTHERS CONTINUE.**

C. Was there ever a time when two or more of these problems occurred together? NO . . . (SKIP TO F) . . . 1  
YES . . . . . 5

AD3RA8  
AD42A  
ADICD3

D. Which ones? **CODE IN COL. II & III. (NO=1, YES=5)**

**IF SHAKES IN COL. II AND 1+ SX IN COL. II, MARK TALLY A.**  
**IF 2+ SX IN COL. III, MARK TALLY B.**

A  
B

E. How old were you the first time these problems occurred together? AGE ONS: \_\_\_\_ / \_\_\_\_  
ONS: 1 2 3 4 5

AD3RB F. How many times did you have problems like these \_\_\_\_ TIMES  
(occur together)? **IF DK, ASK F1. OTHERS SKIP TO G.**

AD3RB 1. Did this occur 3 or more times? NO . . . . . 1  
YES . . . . . 5

**IF NO 5'S IN COL. III, SKIP TO H.  
OTHERS CONTINUE.**

- G. You said you (**REVIEW ALL 5'S CODED IN COL. III**). Did (this/these) problem(s) interfere with your functioning at work, school, or home? NO ..... 1  
YES ..... 5
- H. Have you ever taken a drink to keep from having any of these problems (or to make them go away) (**REVIEW ALL 5'S CODED IN COL. I**)? NO. .... (SKIP TO J) .. 1  
YES ..... 5
1. How old were you the first time? AGE ONS: \_\_\_\_ / \_\_\_\_  
ONS: 1 2 3 4 5
- I. Did this happen 3 or more times? NO ..... 1  
YES ..... 5 A,B
- J. Did you ever take any medication or drug to avoid any of these problems (or to make them go away)? **DO NOT COUNT ASPIRIN, TYLENOL, ETC. DO COUNT MEDS GIVEN IN TREATMENT.** NO ..... 1  
YES. .... (SPECIFY) ... 5

**SPECIFY:** \_\_\_\_\_

CODE: \_\_\_\_ \_\_\_\_ \_\_\_\_

CODE: \_\_\_\_ \_\_\_\_ \_\_\_\_

(33)  
AD3RA8  
AD42A  
ADICD3  
ALCFGNAI

E27

When you stopped, cut down, or went without drinking, did you ever have fits, seizures, or convulsions, where you lost consciousness, fell to the floor, and had difficulty remembering what happened?

NO. ... (SKIP TO E28) . 1  
YES ..... 5 A,B

AD3RB

A. How many times did this happen? **IF DK, ASK A1. OTHERS SKIP TO B.**

\_\_\_\_ \_\_\_\_ TIMES

1. Did this occur 3 or more times?

NO ..... 1  
YES ..... 5

AD3RA9/B  
AD42B  
ADICD3

B. On 3 or more different occasions have you taken a drink to keep from having fits, seizures, or convulsions or to make them go away?

NO. .... 1  
YES ..... 5 A,B

C. Did you ever take any medication or drug to avoid having fits, seizures, or convulsions (that occurred because you went without drinking) or to make them go away?

NO ..... 1  
YES. .... (SPECIFY) ... 5

**DO NOT COUNT ASPIRIN, TYLENOL, ETC. DO COUNT MEDS GIVEN IN TREATMENT.**

**SPECIFY:** \_\_\_\_\_

CODE: \_\_\_\_ \_\_\_\_ \_\_\_\_

CODE: \_\_\_\_ \_\_\_\_ \_\_\_\_

(34)  
AD3RA8  
AD42A  
ADICD3  
ALCFGNAI

E28

When you stopped, cut down, or went without drinking, did you ever have the DT's, that is, where you were very confused, extremely shaky, felt very frightened or nervous, or saw things that weren't really there?

NO. (SKIP TO BOX E28) 1  
YES ..... 5 A,B

AD3RB

- A. How many times did this happen? **IF DK, ASK** \_\_\_\_\_ TIMES  
**A1. OTHERS SKIP TO B.**

1. Did this occur 3 or more times? NO ..... 1  
 YES ..... 5

AD3RA9/B  
AD42B  
ADICD3

- B. On 3 or more different occasions have you taken a drink to keep from having the DT's or to make them go away? NO. .... 1  
 YES ..... 5 A,B

- C. Did you ever take any medication or drug to avoid DT's or to make them go away? NO ..... 1  
 YES. ... (SPECIFY) ... 5

**DO NOT COUNT ASPIRIN, TYLENOL, ETC.**  
**DO COUNT MEDS GIVEN IN TREATMENT.**

**SPECIFY:** \_\_\_\_\_

CODE: \_\_\_\_\_

CODE: \_\_\_\_\_

DSMIIR

**BOX E28 IF 3 OR MORE BOXES MARKED ON TALLY SHEET A, CONTINUE. OTHERS SKIP TO BOX E29.**

**HAND R ALCOHOL TALLY A.**

(40)  
AD3RB

- E29 A. I have checked on this sheet the experiences with alcohol that you told me about. The experiences are grouped into boxes. You told me (**REVIEW SX**). I'd like you to tell me whether there has ever been a period lasting a month or longer when you had experiences from 3 or more boxes occurring together? **IF YES:** Please tell me the box and number for each experience. **CIRCLE SYMPTOMS THAT CLUSTER. MUST BE FROM 3 DIFFERENT BOXES. DO NOT COUNT SYMPTOMS THAT OCCURRED AS A RESULT OF AN ISOLATED INCIDENT.**

NO ..... 1  
 YES. ... (SKIP TO C) ... 5

- B. Was there ever a period lasting a month or longer when you had experiences from 2 boxes occurring together? **IF YES:** Please tell me the box and number for each experience. **CIRCLE SYMPTOMS THAT CLUSTER. MUST BE FROM 2 DIFFERENT BOXES. DO NOT COUNT SYMPTOMS THAT OCCURRED AS A RESULT OF AN ISOLATED INCIDENT.**

NO. (SKIP TO BOX E29) 1  
 YES ..... 5

- C. How old were you the (first/last) time you had experiences from 3(2) boxes occur within a period lasting a month or more?

AGE ONS: \_\_\_\_\_ / \_\_\_\_\_  
 ONS: 1 2 3 4 5

AGE REC: \_\_\_\_\_ / \_\_\_\_\_  
 REC: 1 2 3 4 5



**BOX E29 IF 3 OR MORE BOXES MARKED ON TALLY SHEET B, CONTINUE. OTHERS SKIP TO E31.**

**E30 HAND R ALCOHOL TALLY B.**

- A. I have checked the experiences with alcohol that you told me about. The experiences are grouped into boxes different from the one I just showed you. You told me **(REVIEW SX)**. I'd like you to tell me whether there has ever been a 12-month period in which you had experiences from 3 or more boxes? **IF YES:** Please tell me the box and number for each experience that occurred during the same 12-month period, even if the problems did not last the full 12 months. **CIRCLE SYMPTOMS THAT CLUSTER. MUST BE FROM 3 DIFFERENT BOXES. DO NOT COUNT SYMPTOMS THAT OCCURRED AS A RESULT OF AN ISOLATED INCIDENT.**
- NO. . . (SKIP TO E31). . . 1  
YES . . . . . 5
- B. How old were you the (first/last) time you had experiences from 3 or more boxes occur within a 12-month period?
- AGE ONS: \_\_\_\_/\_\_\_\_  
AGE REC: \_\_\_\_/\_\_\_\_

- 
- (38) E31 Have you ever brought up any problem you might have had with drinking with any professional?
- NO. . . (SKIP TO E32) . . . 1  
YES . . . . . 5
- A. Did you talk with:
- |   | <u>NO</u> | <u>YES</u> |
|---|-----------|------------|
| 1. a psychiatrist? . . . . .                                | 1         | 5          |
| 2. another medical doctor? . . . . .                        | 1         | 5          |
| 3. a psychologist? . . . . .                                | 1         | 5          |
| 4. another mental health professional? . . . . .            | 1         | 5          |
| 5. a member of the clergy? . . . . .                        | 1         | 5          |
| 6. another professional? <b>(IF YES, SPECIFY)</b> . . . . . | 1         | 5          |
- SPECIFY:** \_\_\_\_\_
- B. How old were you the first time you brought up any problem you had with drinking?
- AGE ONS: \_\_\_\_/\_\_\_\_  
ONS: 1 2 3 4 5
- C. With whom did you speak first?
- RECORD CODE (1-6)**
- CODE: \_\_\_\_
- 

- E32 Have you ever attended a self-help group (like AA) for your drinking?
- NO. . . (SKIP TO E33) . . . 1  
YES . . . . . 5

A. How old were you the first/last time you attended a self-help group meeting?

AGE ONS:        /  
ONS:     1   2   3   4   5

AGE REC:        /  
REC:     1   2   3   4   5

(39)

E33

**REFER TO B9 & B10 BEFORE ASKING**

Have you ever been in a treatment program for a drinking problem?

NO . . (SKIP TO F1, p. 33) 1  
YES . . . . . 5

A. Were you treated:

NO   YES

- |   |   |   |
|---|---|---|
| 1. at an outpatient alcohol program? . . . . .                                    | 1 | 5 |
| 2. at an outpatient program for something other than alcohol? . . . . .           | 1 | 5 |
| 3. at an inpatient alcohol program? . . . . .                                     | 1 | 5 |
| 4. when you were an inpatient for medical complications due to alcohol? . . . . . | 1 | 5 |
| 5. at any other place or program? . (IF YES, SPECIFY)                             | 1 | 5 |

**SPECIFY:** \_\_\_\_\_

B. How old were you the first/last time you were in a treatment program for a drinking problem?

AGE ONS:        /  
ONS: 1   2   3   4   5

AGE REC:        /  
REC: 1   2   3   4   5

C. Where were you first treated? **RECORD CODE (1-5)**

CODE: \_\_\_\_

(1)	F1	Have you ever used cocaine or crack?	NO. . . . (SKIP TO G1, p. 44) . . . . . 1 YES . . . . . 5
	A.	How many times in your life have you used cocaine?	_____ TIMES
	1.	<b>If DK, ASK:</b> Would you say 11 or more times ?	NO . . . . . 1 YES . . . . . 5
	B.	How old were you the last time you used cocaine? <b>IF REC CODE=5, SKIP TO D. OTHERS CONTINUE.</b>	AGE REC: _____/ REC: 1 2 3 4 5
	C.	How many times did you use cocaine in the last 12 months? <b>IF DK, ASK C1. OTHERS SKIP TO D.</b>	_____ TIMES
	1.	Did you use cocaine at least 11 times during the past 12 months?	NO . . . . . 1 YES . . . . . 5
	D.	Did you ever use cocaine at least once a week for a month or more?	NO . . . . . (SKIP TO F2) . . . . . 1 YES. . . . . 5
	1.	How old were you the (first/last) time you used cocaine at least once a week for one month or more?	AGE ONS: _____/ ONS: 1 2 3 4 5  AGE REC: _____/ REC: 1 2 3 4 5

(2)	F2	How old were you the first time you used cocaine?  <b>IF AGE ONS 15 OR LATER, SKIP TO F3. OTHERS CONTINUE.</b>	AGE ONS: _____/ ONS: 1 2 3 4 5
	A.	Did you use cocaine more than once before you were 15?	NO . . . . . 1 YES . . . . . 5

(3) DRFGNC	<b>IF F1A&lt;11 or F1A1=1, SKIP TO G1, p. 44.</b>		NO . . . . . (SKIP TO F3B) . . . . . 1 YES. . . . . 5
	F3	Did you ever use cocaine daily or almost daily?	_____ UNITS
	A.	What was the longest period of time you used cocaine almost every day? <b>IF NEVER, CODE 0000 DAYS.</b>	<b>CODE UNITS:</b> DAYS . . . . . 1 WEEKS . . . . . 2 MONTHS . . . . . 3 YEARS . . . . . 4
	B.	Please think about the period when you were using cocaine the most. During that period, how many days per month did you use cocaine?	_____ DAYS

IF R. HAS NOT USED EITHER POWDER OR CRACK,  
CODE 0's FOR THAT TYPE OF COCAINE.

- C. During that period of heaviest use, how much cocaine did you use on an average day, in dollars? **IF R CANNOT ESTIMATE DOLLARS, CODE 9999 AND GO TO C1.**

**CODE IN DOLLARS:**

\$ \_\_\_\_\_

1. During that period of heaviest use, how much cocaine did you use on an average day, in grams of powder? **IF R CANNOT ESTIMATE GRAMS OF POWDER, CODE 999 AND GO TO C2.**

**CODE IN GRAMS:**

\_\_\_\_\_g

2. During that period of heaviest use, how much cocaine did you use on an average day, in rocks of crack?

**CODE IN ROCKS:**

\_\_\_\_\_rocks

- D. How old were you when that period started?

AGE: \_\_\_\_\_

- E. How long did that period last?  
(IF <1 MONTH, CODE 001)

\_\_\_\_\_ MONTHS

- F. When you first started using cocaine, did you find that you got higher or stayed high longer than other people who would use the same amount of cocaine?

NO. .... 1  
YES ..... 5

- G. Did you ever use alcohol or any other drug to make yourself feel better when coming down from the effects of cocaine? **IF YES, WHICH ONES?**

NO. .... 1  
ALCOHOL ONLY..... 3  
YES ..... 5

1. \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_

\_\_\_\_\_ CODE  
\_\_\_\_\_ CODE  
\_\_\_\_\_ CODE

- H. Have you ever injected cocaine?  
**IF NO, SKIP TO F4.**

NO. .... 1  
YES ..... 5

1. How many times?

TIMES \_\_\_\_\_

2. How old were you the (first/last) time?

AGE ONS: \_\_\_\_\_/\_\_\_\_\_

ONS: 1 2 3 4 5

AGE REC: \_\_\_\_\_/\_\_\_\_\_

REC: 1 2 3 4 5

- I. Have you ever shared a needle?

NO. .... (SKIP TO F4) ..... 1  
YES ..... 5

1. How many times? \_\_\_\_\_ TIMES

2. How old were you the (first/last) time?

AGE ONS: \_\_\_\_\_ / \_\_\_\_\_  
 ONS: 1 2 3 4 5  
 AGE REC: \_\_\_\_\_ / \_\_\_\_\_  
 REC: 1 2 3 4 5

(4)  
DRFGNC

F4 Have you ever stayed high from cocaine for a whole day or more?

NO ... (SKIP TO F5) ..... 1  
 YES ..... 5

A. **IF YES:** Did this happen 3 or more times?

NO .... (SKIP TO F5) ..... 1  
 YES ..... 5

B. How old were you the (first/last) time you stayed high from cocaine for a whole day or more?

AGE ONS: \_\_\_\_\_ / \_\_\_\_\_  
 ONS: 1 2 3 4 5  
 AGE REC: \_\_\_\_\_ / \_\_\_\_\_  
 REC: 1 2 3 4 5

**BEGIN SCORING Cocaine TALLY SHEETS A & B**

(5)  
DDICD1

F5 Have you ever had such a strong desire for cocaine that it was hard to think of anything else?

NO ..... 1  
 YES ..... 5

A. **IF YES:** How old were you the (first/last) time?

AGE ONS: \_\_\_\_\_ / \_\_\_\_\_  
 ONS: 1 2 3 4 5  
 AGE REC: \_\_\_\_\_ / \_\_\_\_\_  
 REC: 1 2 3 4 5

(6)  
DD3RA3/B  
DD45  
DDICD5

F6 Has there ever been a period of a month or more when a great deal of your time was spent using cocaine, getting cocaine, or getting over its effects?

NO ..... 1  
 YES ..... 5 A,B

F7 Many people have paranoid experiences when high on cocaine. Some have this every time they use, others only occasionally, and some never experience it. "Paranoia" is an intense fear that you will be "caught" or harmed in some way, when you know that these things cannot happen. (For example: the idea that a noise at a fourth floor window means someone is there, a shadow behind a door means someone is crouching there, or a trusted friend is planning to steal your drugs.)

1. Have you ever had a paranoid experience?

NO. .... (SKIP TO F8) ..... 1  
 YES ..... 5

a. Have you ever had a paranoid experience when you were using cocaine?

NO ..... 1  
 YES ..... 5

b. Have you ever had a paranoid experience when you were *not* using cocaine?

NO ..... 1  
 YES ..... 5

2. Describe the most common paranoid experience(s) that you have had while using cocaine:

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(7)	F8	Because of your cocaine use, did you ever experience any of the following: <b>CODE IN COLUMN I.</b>	COL. I		COL. II		
			<u>NO</u>	<u>YES</u>	<u>NO</u>	<u>YES</u>	
		1. Feeling depressed or uninterested in things for more than 24 hours to the point that it interfered with your functioning? . . . . .	1	5	1	5	A,B
		2. Having trouble concentrating or having such trouble thinking clearly for more than 24 hours that it interfered with your functioning? . . . . .	1	5	1	5	A,B
		3. Feeling paranoid or suspicious of people for more than 24 hours to the point that it interfered with your relationships? . . . . .	1	5	1	5	A,B
		4. Hearing, seeing, feeling, or smelling things that weren't really there? . . . . .	1	5	1	5	A
		5. Feeling jumpy or easily startled or nervous for more than 24 hours to the point that it interfered with your functioning? . . . . .	1	5	1	5	
		6. Decreased contact with friends or family?	1	5	1	5	A,B

**FOR EACH 5 ("YES") CODED IN COL. I, ASK F8A.**

DD3RA6/B  
DD47  
DDICD6  
DA3RA1/B

- A. Did you continue to use cocaine after you knew it caused this? **CODE IN COLUMN II.**

**IF F8.6 IS CODED 1, SKIP TO F9. OTHERS CONTINUE.**

DA4A4

- B. Did you have decreased contact with friends or family 3 or more times in any 12-month period?
- |               |   |
|---------------|---|
| NO . . . . .  | 1 |
| YES . . . . . | 5 |

(7) DD3RA2 DD44 DDICD2	F9	Have you <u>often</u> wanted to stop or cut down on cocaine?	NO ..... 1 YES ..... 5	A,B
DD3RA2	A.	Have you ever tried to stop or cut down on cocaine but found you couldn't? <b>IF NEVER TRIED TO STOP/CUT DOWN, CODE NO.</b>	NO, COULD STOP ..... 1 YES, COULD NOT STOP ... 5	A
<b>IF NO, COULD STOP (OR NEVER TRIED), SKIP TO F10. OTHERS CONTINUE.</b>				
DD44 DDICD2	B.	Were you unable to stop or cut down 3 or more times?	NO ..... 1 YES ..... 5	B

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(8) DD3RA1/B DD43 DDICD2	F10	Have you <u>often</u> used cocaine on more days or in larger amounts than you intended to?	NO ..... 1 YES ..... 5	A,B
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(9) DD3RA7 DD41 DDICD4	F11	Did you (a) ever need larger amounts of cocaine to get an effect, or did you (b) ever find that you could no longer get high on the amount you used to use?	NO ..... 1 YES ..... 5	A,B
<b>(FOR "(a)" CODE "YES" IF R. INCREASED HIS USUAL DOSE 50% OR MORE OVER A PREVIOUS HABITUAL LEVEL OF USE)</b>				

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(10)	F12	When you stopped, cut down, or went without cocaine, did you ever experience any of these following problems <u>for most of the day for 2 days or longer</u> ? Did you.....	<b>CODE IN COLUMN I.</b>			
			<b>COL. I</b>		<b>COL. II</b>	
			<b>NO</b>	<b>YES</b>	<b>NO</b>	<b>YES</b>
	1.	feel depressed? .....	1	5	1	5
	2.	feel restless? .....	1	5	1	5
	3.	feel tired, sleepy, or weak? .....	1	5	1	5
	4.	have trouble sleeping? .....	1	5	1	5
	5.	sleep too much? .....	1	5	1	5
	6.	have a strong desire or craving for cocaine? .....	1	5	1	5
	7.	feel slowed down, like you could hardly move? .....	1	5	1	5
	8.	have an increase in appetite? .....	1	5	1	5
	9.	have nightmares? .....	1	5	1	5

**BOX F12A IF NO 5'S CODED IN F12.1-9, SKIP TO F13. OTHERS CONTINUE.**

DD3RA9/B DD42B DDICD3	A. Have you ever used cocaine to keep from having any of these problems (or to make them go away)?	NO. . . (SKIP TO BOX F12B) . . . 1 YES . . . . . 5
	B. Did this happen 3 or more times?	NO . . . . . 1 YES . . . . . 5 A,B

**BOX F12B IF ONLY ONE 5 CODED IN COL. I,  
SKIP TO F13. OTHERS CONTINUE.**

DD3RA8 DD42A DDICD3 DRFGNA	C. Did these problems ever occur together?	NO. . . . . (SKIP TO G) . . . . . 1 YES . . . . . 5 A,B
	D. Which ones? <b>CODE IN COL. II</b>	
DD3RB DA3RA	E. How many times did you have problems like that (when they occurred together)?	_____ TIMES
DD3RB	F. What was the longest time these problems occurred together?	_____ DAYS
	G. Did these problems interfere with your functioning at work, school, or home?	NO . . . . . 1 YES . . . . . 5

(11) ASP3RC7 ASP4A5	F13 Have you ever been under the effects of cocaine when it increased your chances of getting hurt, for instance, when driving a car or boat, using knives, machinery or guns, crossing against traffic, climbing or swimming?	NO . . . (SKIP TO B) . . . . . 1 YES . . . . . 5
DD3RA4/B DA3RA2/B	A. Have you been in situations like this 3 or more times?	NO. . . . . (SKIP TO B) . . . . . 1 YES . . . . . 5 A
DA4A2	1. Did this happen 3 or more times in any 12-month period?	NO . . . . . 1 YES . . . . . 5
	B. Did cocaine ever cause you to have any accidental injuries like a bad fall, cutting or burning yourself, or being hurt in a traffic accident?	NO . . . (SKIP TO F14) . . . . . 1 YES . . . . . 5
DD3RA6/B DDICD6 DA3RA1/B	C. Did this happen 3 or more times?	NO. . . (SKIP TO F14) . . . . . 1 YES . . . . . 5 A
DA4A2	1. Did this happen 3 or more times in any 12-month period?	NO . . . . . 1 YES . . . . . 5



(12)	F14	A Were there ever objections from, or problems with, your family, friends, doctor, clergy, boss, or people at work or school because of your cocaine use?	NO ..... 1
			YES ..... 5
	B.	Did you ever get into physical fights while using cocaine?	NO ..... 1
			YES ..... 5

**BOX F14 IF A AND B ARE BOTH CODED "1,"  
SKIP TO F15. OTHERS, CONTINUE.**

DA4A4	C.	Did (this/either of these experiences) happen 3 or more times in any 12-month period?	NO ..... 1
			YES ..... 5
DD3RA6 DA3RA1	D.	Did you continue to use cocaine after you realized it was causing these problems?	NO ..... 1
			YES ..... 5 A

	F15	Have you ever been arrested or had any other trouble with the police because of your cocaine use?	NO ....(SKIP TO F16) ..... 1
			YES..... 5
DD3RA6	A.	Did this happen 3 or more times ?	NO ....(SKIP TO F16) ..... 1
			YES..... 5 A
DA4A3	B.	Did this happen 3 or more times in any 12-month period?	NO ..... 1
			YES ..... 5 A

(14) DD3RA4/B	F16	Has your being high on cocaine or experiencing its after-effects <u>often</u> interfered with your work, school, household, or child care responsibilities?	NO. ....(SKIP TO F17) ..... 1
			YES ..... 5 A
DA4A1	A.	Did this happen 3 or more times in any 12-month period?	NO ..... 1
			YES ..... 5

(13)	F17	Have you given up or greatly reduced important activities like sports, work, or associating with friends or relatives while using cocaine?	NO. ....(SKIP TO F18) ..... 1
			YES ..... 5
DD3RA5/B DD46 DDICD5	A.	Has this happened 3 or more times, or did it last a month or longer?	NO ..... 1
			YES ..... 5 A,B

F18	Did using cocaine cause you to have any other problems like:	
	A. An overdose?	NO. .... (SKIP TO B) ..... 1 YES ..... 5
	1. <b>IF YES:</b> Did you require medical treatment afterwards?	NO. .... (SKIP TO F18B). ... 1 YES ..... 5
	2. <b>IF YES:</b> Did this happen 3 or more times? (Overdose that required treatment)	NO ..... 1 YES ..... 5 A,B
	B. Other serious health problems? <b>SPECIFY:</b>	NO. .... (SKIP TO F19) ..... 1 YES ..... 5
	_____	
	1. <b>IF YES:</b> Did you continue to use cocaine knowing it caused health problems?	NO ..... 1 YES ..... 5 A,B

(17)	F19	Have you ever used cocaine together with one or more other drugs, including alcohol?	NO. ... (SKIP TO BOX F19) ... 1 ALCOHOL ONLY ..... 3 YES ... (SPECIFY) ..... 5
		<b>IF YES:</b> Which ones?	
		1. _____	CODE: ____ _
		2. _____	CODE: ____ _
		3. _____	CODE: ____ _
		4. _____	CODE: ____ _

DSMIIIR

**BOX F19 IF ONE OR MORE BOXES MARKED ON TALLY SHEET A, CONTINUE. OTHERS SKIP TO BOX F21.**

(19)	F20	<b>HAND R Cocaine TALLY A.</b> I have checked on this sheet the experiences with cocaine that you have told me about. You told me <b>(REVIEW SX)</b> . When was the (first/last) time that you had any of these experiences?	AGE ONS: _____/_____ ONS: 1 2 3 4 5 AGE REC: _____/_____ REC: 1 2 3 4 5
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**BOX F20 IF 3 OR MORE BOXES MARKED ON TALLY A, CONTINUE. OTHERS SKIP TO BOX F21. NOTE: DO NOT COUNT SYMPTOMS THAT OCCURRED AS A RESULT OF AN ISOLATED INCIDENT.**

- A. Thinking about these experiences with cocaine, was there ever a period lasting a month or longer when you had experiences from 3 or more different boxes occurring together? **IF YES:** Please tell me the box and number of those experiences. **CIRCLE SYMPTOMS THAT CLUSTER. NOTE: MUST BE 3 FROM DIFFERENT BOXES.**

NO ..... 1  
YES ....(SKIP TO C) ..... 5

- B. Was there ever a period lasting a month or longer when you had experiences from 2 boxes occurring together? **IF YES:** Which ones? **CIRCLE SX. MUST BE FROM 2 DIFFERENT BOXES.**

NO ... (SKIP TO BOX F21) ... 1  
YES ..... 5

- C. How old were you the (first/last) time you had experiences from 3(2) boxes occur within a period of a month or more?

AGE ONS:      /  
ONS:    1   2   3   4   5

AGE REC:      /  
REC:    1   2   3   4   5

DSM-IV

**BOX F21 IF 3 OR MORE BOXES MARKED ON TALLY SHEET B, CONTINUE. OTHERS SKIP TO BOX F22.**

**HAND R Cocaine TALLY B.**

DD4

- F22 A. Please review this list of experiences which are grouped into boxes that are different from the last one I showed you. You told me (**REVIEW SX**). Was there ever a 12-month period in which you had experiences from 3 or more of these boxes? **IF YES:** Please tell me the box and number for each experience that occurred during the same 12-month period even if the problem didn't last the full 12 months. **CIRCLE SYMPTOMS THAT CLUSTER. MUST BE FROM 3 DIFFERENT BOXES. DO NOT COUNT SYMPTOMS THAT OCCURRED AS A RESULT OF AN ISOLATED INCIDENT.**

NO ... (SKIP TO BOX F22) ... 1  
YES ..... 5

- B. How old were you the (first/last) time you had experiences from 3 or more boxes within a 12-month period?

AGE ONS:      /  
ONS:    1   2   3   4   5

AGE REC:      /  
REC:    1   2   3   4   5

**BOX F22 IF 2+ BOXES MARKED ON TALLY A, CONTINUE. OTHERS SKIP TO F24.**

(22) F23 Since the age of (ONS), has there ever been a period of time lasting 3 months or longer when you did not use cocaine at all? NO ... (SKIP TO F24) ..... 1  
YES ..... 5

A. When did that/these occur?  
**IF R HAD MORE THAN 4 ABSTINENT PERIODS, RECORD THE 4 LONGEST.**

FROM \_\_\_\_/\_\_\_\_/\_\_\_\_ TO \_\_\_\_/\_\_\_\_/\_\_\_\_  
MO YEAR MO YEAR

FROM \_\_\_\_/\_\_\_\_/\_\_\_\_ TO \_\_\_\_/\_\_\_\_/\_\_\_\_  
MO YEAR MO YEAR

FROM \_\_\_\_/\_\_\_\_/\_\_\_\_ TO \_\_\_\_/\_\_\_\_/\_\_\_\_  
MO YEAR MO YEAR

FROM \_\_\_\_/\_\_\_\_/\_\_\_\_ TO \_\_\_\_/\_\_\_\_/\_\_\_\_  
MO YEAR MO YEAR

(18) F24 Did you ever bring up any problems you might have had with cocaine with any professional? NO ... (SKIP TO F25) ..... 1  
YES ..... 5

A. To whom did you speak first? CODE: \_\_\_\_

1. A psychiatrist
2. Another medical doctor
3. A psychologist
4. Another mental health professional
5. A member of the clergy
6. Other: **SPECIFY:** \_\_\_\_\_

B. How old were you the (first/last) time you brought up problems with cocaine with a professional?

AGE ONS: \_\_\_\_/\_\_\_\_  
ONS: 1 2 3 4 5

AGE REC: \_\_\_\_/\_\_\_\_  
REC: 1 2 3 4 5

**REFER TO B9 & B10 BEFORE ASKING**

F25 Have you ever been treated for a problem with cocaine? NO ..... (SKIP TO D) ..... 1  
YES ..... 5

A. Were you ever treated at:

	<u>NO</u>	<u>YES</u>
1. outpatient drug program? . . . . .	1	5
2. outpatient, other? . . . . .	1	5
3. inpatient drug program? . . . . .	1	5
4. inpatient for medical complications due to cocaine use? . . . . .	1	5
5. other? (IF YES, SPECIFY) . . . . .	1	5

**SPECIFY:** \_\_\_\_\_

B. How old were you the (first/last) time you were treated?

AGE ONS:          /      
ONS:    1   2   3   4   5

AGE REC:          /      
REC:    1   2   3   4   5

C. Where were you first treated? **RECORD  
CODE (1-5)**

CODE:     

D. Did you ever attend a self-help group (like AA, NA, or CA) for your cocaine use?

NO. . . (SKIP TO G1, p. 44) . . . 1  
YES . . . . . 5

1. How old were you the (first/last) time you attended a self-help group for your cocaine use?

AGE ONS:          /      
ONS:    1   2   3   4   5

AGE REC:          /      
REC:    1   2   3   4   5

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(1) G1 Have you ever used any of the following opiate drugs: NO. . . . (SKIP TO H1, p. 55 ) . . 1  
YES . . . . . 5

Heroin (903), codeine (046), Demerol (228), morphine (206), Percodan (299), Percocet (299), methadone (114), Darvon (055), opium (988), Fentanyl or P-dope (989), Dilaudid (066), Other Opiate (990)?

**CODE THREE MOST HEAVILY USED OPIATES (LEAVE #s 2 & 3 BLANK, IF NOT NEEDED)**

(IF OTHER, SPECIFY: \_\_\_\_\_)

1. \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_

A. How many times in your life have you used any of these opiate drugs? \_\_\_\_\_ TIMES

1. **IF DK, ASK:** Would you say 11 or more times ? NO . . . . . 1  
YES . . . . . 5

B. How old were you the last time you used an opiate drug? AGE REC: \_\_\_\_\_ / \_\_\_\_\_  
REC: 1 2 3 4 5  
**IF REC CODE=5, SKIP TO D. OTHERS CONTINUE.**

C. How many times did you use an opiate drug in the last 12 months? \_\_\_\_\_ TIMES  
**IF DK, ASK C1. OTHERS SKIP TO D.**

1. Did you use an opiate drug at least 11 times during the past 12 months? NO . . . . . 1  
YES . . . . . 5

D. Did you ever use an opiate drug at least once a week for a month or more? NO. . . . . (SKIP TO G3) . . . . . 1  
YES . . . . . 5

1. How old were you the (first/last) time you used an opiate drug at least once a week for one month or more? AGE ONS: \_\_\_\_\_ / \_\_\_\_\_  
ONS: 1 2 3 4 5  
AGE REC: \_\_\_\_\_ / \_\_\_\_\_  
REC: 1 2 3 4 5

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(2) G2 How old were you the first time you used an opiate drug? AGE ONS: \_\_\_\_\_ / \_\_\_\_\_  
ONS: 1 2 3 4 5

**IF AGE ONS 15 OR LATER, SKIP TO B. OTHERS CONTINUE.**

A. Did you use an opiate drug more than once before you were 15? NO . . . . . 1  
YES . . . . . 5

**IF G1A<11 or G1A1=1, SKIP TO H1, p. 55.**

G3 Did you ever use (OPIATE) daily or almost daily?

NO. . . . (SKIP TO G3B) . . . . . 1  
YES . . . . . 5

A. What was the longest period of time you used  
(OPIATE) almost every day? **IF NEVER, CODE  
0000 DAYS.**

\_\_\_\_\_ UNITS  
**CODE UNITS:**  
DAYS . . . . . 1  
WEEKS . . . . . 2  
MONTHS . . . . . 3  
YEARS . . . . . 4

B. Please think about the period when you were  
using (OPIATE) the most. During that period,  
how many days per month did you use  
(OPIATE)?

\_\_\_\_\_ DAYS

C. During that period of heaviest use, how much  
(OPIATE) did you use on an average day, in pills  
or bags (as appropriate for primary opiate of  
abuse)?

**CODE IN PILLS OR  
BAGS, AS  
APPROPRIATE (CODE  
999 FOR THE ONE  
THAT IS NOT  
APPROPRIATE)**

\_\_\_\_\_ PILLS

\_\_\_\_\_ BAGS

....and during that period of heaviest use, how  
much did you spend daily?

**CODE IN DOLLARS:**

\$ \_\_\_\_\_

D. How old were you when that period started?

AGE: \_\_\_\_\_

E. How long did that period last?  
(IF <1 MONTH, CODE 001)

\_\_\_\_\_ MONTHS

F. When you first started using (OPIATE), did you  
find that you got higher or stayed high longer  
than other people who would use the same  
amount of (OPIATE)?

NO 1  
YES 5

G. Have you ever injected an opiate drug?  
**IF NO, SKIP TO G4.**

NO . . . . . 1  
YES . . . . . 5

**IF YES, "WHICH ONE DID YOU INJECT  
MOST OFTEN?"**

CODE \_\_\_\_\_

1. How many times?

TIMES \_\_\_\_\_

2. How old were you the (first/last)  
time?

AGE ONS: \_\_\_\_\_/\_\_\_\_\_

ONS: 1 2 3 4 5

AGE REC: \_\_\_\_\_/\_\_\_\_\_

REC: 1 2 3 4 5

I. Have you ever shared a needle?	NO. .... (SKIP TO G4) .. 1
	YES ..... 5
1. How many times?	_____ TIMES
2. How old were you the (first/last) time?	AGE ONS: ONS:        1    2    3 <u>   </u> / <u>   </u> 4    5
	AGE REC: REC:        1    2    3 <u>   </u> / <u>   </u> 4    5

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(4) DRFGNC	G4	Have you ever stayed high from (OPIATE) for a whole day or more?	NO .. (SKIP TO G5) ..... 1
			YES ..... 5
	A.	<b>IF YES:</b> Did this happen 3 or more times?	NO ... (SKIP TO G5) ..... 1
			YES ..... 5
	B.	How old were you the (first/last) time you stayed high from (OPIATE) for a whole day or more?	AGE ONS: ONS:        1    2    3 <u>   </u> / <u>   </u> 4    5
			AGE REC: REC:        1    2    3 <u>   </u> / <u>   </u> 4    5

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<b>BEGIN SCORING OPIATES TALLY SHEETS A &amp; B.</b>
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(5) DDICD1	G5	Have you ever had such a strong desire for (OPIATE) that it was hard to think of anything else?	NO ..... 1
			YES ..... 5
	A.	<b>IF YES:</b> How old were you the (first/last) time?	AGE ONS: ONS:        1    2    3 <u>   </u> / <u>   </u> 4    5
			AGE REC: REC:        1    2    3 <u>   </u> / <u>   </u> 4    5

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(6) DD3RA3/B DD45 DDICD5	G6	Has there ever been a period of a month or more when a great deal of your time was spent using (OPIATE), getting (OPIATE), or getting over its effects?	NO ..... 1
			YES ..... 5    A,B

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(7)	G7	Because of your (OPIATE) use, did you ever experience any of the following: <b>CODE IN COLUMN I.</b>	COL. I <u>NO</u> <u>YES</u>		COL. II <u>NO</u> <u>YES</u>		
		1.   Feeling depressed or uninterested in things for more than 24 hours to the point that it interfered with your functioning? . . . . .	1	5	1	5	A,B
		2.   Having trouble concentrating or having such trouble thinking clearly for more than 24 hours that it interfered with your functioning? . . . . .	1	5	1	5	A,B
		3.   Feeling paranoid or suspicious of people for more than 24 hours to the point that it interfered with your relationships? . . . . .	1	5	1	5	A,B
		4.   Hearing, seeing, or smelling things that weren't really there? . . . . .	1	5	1	5	A
		5.   Feeling jumpy or easily startled or nervous for more than 24 hours to the point that it interfered with your functioning? . . . . .	1	5	1	5	
		6.   Decreased contact with friends or family? . . .	1	5	1	5	A,B
		<b>FOR EACH 5 ("YES") CODED IN COL. I, ASK G7A.</b>					
DD3RA6/B DD47 DDICD6 DA3RA1/B		A.   Did you continue to use (OPIATE) after you knew it caused this? <b>CODE IN COLUMN II.</b>					
		<b>IF G7.6 IS CODED 1, SKIP TO G8. OTHERS CONTINUE.</b>					
DA4A4		B.   Did you have decreased contact with friends or family 3 or more times in any 12-month period?	NO . . . . . 1 YES . . . . . 5				

(7) DD3RA2 DD44 DDICD2	G8	Have you <u>often</u> wanted to stop or cut down on (OPIATE)?	NO . . . . . 1 YES . . . . . 5	A,B
DD3RA2	A.	Have you ever tried to stop or cut down on (OPIATE) but found you couldn't?	NO, COULD STOP . . . . . 1 YES, COULD NOT STOP . . . . . 5	A
		<b>IF NEVER TRIED TO STOP/CUT DOWN, CODE NO. IF NO, COULD STOP (OR NEVER TRIED), SKIP TO G9. OTHERS CONTINUE.</b>		

B. Were you unable to stop or cut down 3 or more times?

NO ..... 1  
YES ..... 5 B(8)  
DD3RA1/B  
DD43  
DDICD2G9 Have you often used (OPIATE) on more days or in larger amounts than you intended to?NO ..... 1  
YES ..... 5 A,B(9)  
DD3RA7  
DD41  
DDICD4

G10 Did you ever need larger amounts of (OPIATE) to get an effect, or did you ever find that you could no longer get high on the amount you used to use?

NO ..... 1  
YES ..... 5 A,B**(CODE "YES" IF R. INCREASED HIS USUAL DOSE 50% OR MORE OVER A PREVIOUS HABITUAL LEVEL OF USE)**

(10)

G11 When you stopped, cut down, or went without (OPIATE), did you ever experience any of these following problems for most of the day for 2 days or longer? **CODE IN COLUMN I.**COL. I COL. II  
NO YES NO YES

- |  |   |   |   |   |
|--|---|---|---|---|
| 1. Did you feel depressed? .....   | 1 | 5 | 1 | 5 |
| 2. Did you have trouble sleeping? .....                                    | 1 | 5 | 1 | 5 |
| 3. Did you have a strong desire or craving for (OPIATE)?.                  | 1 | 5 | 1 | 5 |
| 4. Did you have diarrhea? .....  | 1 | 5 | 1 | 5 |
| 5. Did you have stomach aches or stomach cramps? .                         | 1 | 5 | 1 | 5 |
| 6. Did your eyes run? .....  | 1 | 5 | 1 | 5 |
| 7. Did your nose run? .....  | 1 | 5 | 1 | 5 |
| 8. Did you yawn? .....   | 1 | 5 | 1 | 5 |
| 9. Did you have muscle pains? .....  | 1 | 5 | 1 | 5 |
| 10. Were your pupils dilated or were your eyes sensitive to light? .....   | 1 | 5 | 1 | 5 |
| 11. Did you have gooseflesh, goose bumps, or did you get the chills? ..... | 1 | 5 | 1 | 5 |
| 12. Did your heart race? .....   | 1 | 5 | 1 | 5 |
| 13. Did you sweat? .....   | 1 | 5 | 1 | 5 |
| 14. Did you have a fever? .....  | 1 | 5 | 1 | 5 |
| 15. Did you have nausea, or did you vomit? .....                           | 1 | 5 | 1 | 5 |

DD3RA9/B  
DD42B  
DDICD3

- |    |  |   |     |
|----|--|---|-----|
| A. | Have you ever used (OPIATE) to keep from having any of these problems (or to make them go away)? | NO. . . (SKIP TO BOX G11B) . . . . . 1<br>YES . . . . . 5 |     |
| B. | Did this happen 3 or more times?   | NO . . . . . 1<br>YES . . . . . 5                         | A,B |

**BOX G11B IF ONLY ONE 5 CODED IN COL. I, SKIP TO G12. OTHERS CONTINUE.**

- |    |   |   |     |
|----|---|---|-----|
| C. | Did these problems ever occur together?                                       | NO . . . . . (SKIP TO G) . . . . . 1<br>YES . . . . . 5 | A,B |
| D. | Which ones? (CODE IN COL. II above)   |   |     |
| E. | How many times did you have problems like that (when they occurred together)? | _____ TIMES   |     |
| F. | What was the longest time these problems occurred together?                   | _____ DAYS  |     |
| G. | Did these problems interfere with your functioning at work, school, or home?  | NO . . . . . 1<br>YES . . . . . 5                       |     |

(11)  
ASP3RC7  
ASP4A5

**G12** Have you ever been under the effects of (OPIATE) when it increased your chances of getting hurt, for instance, when driving a car or boat, using knives, machinery or guns, crossing against traffic, climbing or swimming?

NO . . . (SKIP TO B) . . . . . 1  
YES . . . . . 5

DD3RA4/B  
DA3RA2/B

A. Have you been in situations like this 3 or more times?

NO. . . . (SKIP TO B) . . . . . 1  
YES . . . . . 5 A

DA4A2

1. Did this happen 3 or more times in any 12-month period?

NO . . . . . 1  
YES . . . . . 5

B. Did (OPIATE) ever cause you to have any accidental injuries like a bad fall, cutting or burning yourself, or being hurt in a traffic accident?

NO . . (SKIP TO G13) . . . . . 1  
YES . . . . . 5

DD3RA6/B  
DDICD6  
DA3RA1/B

C. Did this happen 3 or more times?

NO. . . (SKIP TO G13) . . . . . 1  
YES . . . . . 5 A

DA4A2

1. Did this happen 3 or more times in any 12-month period?

NO . . . . . 1  
YES . . . . . 5

(12)	G13	A. Were there ever objections from, or problems with, your family, friends, doctor, clergy, boss, or people at work or school because of your (OPIATE) use?	NO ..... 1 YES ..... 5
DA4A4 DD3RA6 DA3RA1		B. Did you ever get into physical fights while using (OPIATE)?	NO ..... 1 YES ..... 5
<div style="background-color: #e0e0e0; padding: 10px; text-align: center;"> <b>BOX G13 IF A AND B ARE BOTH CODED "1," SKIP TO G14. OTHERS, CONTINUE.</b> </div>			
DA4A4		C. Did (this/either of these experiences) happen 3 or more times in any 12-month period?	NO ..... 1 YES ..... 5
DD3RA6 DA3RA1		D. Did you continue to use (OPIATE) after you realized it was causing these problems?	NO ..... 1 YES ..... 5 A
<hr/>			
	G14	Have you ever been arrested or had any other trouble with the police because of your (OPIATE) use? <b>SPECIFY:</b> _____ _____	NO .... (SKIP TO G15) .... 1 YES..... (SPECIFY) ..... 5
DD3RA6		A. Did this happen 3 or more times?	NO .... (SKIP TO G15) .... 1 YES..... 5 A
DA4A3		1. Did this happen 3 or more times in any 12-month period?	NO ..... 1 YES ..... 5
<hr/>			
(14) DD3RA4/B	G15	Has your being high on (OPIATE) or experiencing its after-effects <u>often</u> interfered with your work, school, household, or child care responsibilities?	NO. .... (SKIP TO G16) .... 1 YES ..... 5 A
DA4A1		A. Did this happen 3 or more times in any 12-month period?	NO ..... 1 YES ..... 5
<hr/>			
(13)	G16	Have you given up or greatly reduced important activities like sports, work, or associating with friends or relatives while using (OPIATE)?	NO. ... (SKIP TO G 17) ..... 1 YES ..... 5
DD3RA5/B DD46 DDICD5		A. Has this happened 3 or more times, or did it last a month or longer?	NO ..... 1 YES ..... 5 A,B

G17	Did using (OPIATE) cause you to have any other problems like:	
	A. An overdose?	NO. . . . (SKIP TO G 17B) . . . 1 YES . . . . . 5
	1. <b>IF YES:</b> Did you require medical treatment afterwards?	NO. . . . (SKIP TO G 17B) . . . 1 YES . . . . . 5
	2. <b>IF YES:</b> Did this happen 3 or more times? (Overdose that required treatment)	NO . . . . . 1 YES . . . . . 5 A,B
	B. Other serious health problems? <b>SPECIFY:</b>	NO. . . . (SKIP TO G 18) . . . 1 YES . . . . . 5
	<hr/>	
	1. <b>IF YES:</b> Did you continue to use (OPIATE) knowing it caused health problems?	NO . . . . . 1 YES . . . . . 5 A,B

(17)	G18	Have you ever used (OPIATE) together with one or more other drugs, including alcohol?	NO. . . . (SKIP TO BOX G18) . 1 ALCOHOL ONLY . . . . . 3 YES . . (SPECIFY) . . . . . 5
		<b>IF YES:</b> Which ones?	
		1. _____	CODE: _____
		2. _____	CODE: _____
		3. _____	CODE: _____
		4. _____	CODE: _____

DSMIIIR

**BOX G18 IF ONE OR MORE BOXES MARKED ON TALLY SHEET A, CONTINUE. OTHERS SKIP TO BOX G19B.**

(19)	G19	<b>HAND R Opiates TALLY A.</b> I have checked on this sheet the experiences with (OPIATE) that you have told me about. You told me ( <b>REVIEW SX</b> ). When was the (first/last) time that you had any of these experiences?
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AGE ONS:	____/____
ONS:	1 2 3 4 5
AGE REC:	____/____
REC:	1 2 3 4 5

**BOX G19A IF 3 OR MORE BOXES MARKED ON TALLY A, CONTINUE. OTHERS SKIP TO BOX G19B. NOTE: DO NOT COUNT SYMPTOMS THAT OCCURRED AS A RESULT OF AN ISOLATED INCIDENT.**

- A. Thinking about these experiences with (OPIATE), was there ever a period lasting a month or longer when you had experiences from 3 or more different boxes occurring together? **IF YES:** Please tell me the box and number of those experiences. **CIRCLE SYMPTOMS THAT CLUSTER. NOTE: MUST BE 3 FROM DIFFERENT BOXES.**
- NO ..... 1  
YES....(SKIP TO C) ..... 5
- B. Was there ever a period lasting a month or longer when you had experiences from 2 boxes occurring together? **IF YES:** Which ones? **CIRCLE SX. MUST BE FROM 2 DIFFERENT BOXES.**
- NO. . . (SKIP TO BOX G19B). 1  
YES ..... 5
- C. How old were you the (first/last) time you had experiences from 3(2) boxes occur within a period of a month or more?
- AGE ONS: \_\_\_\_/\_\_\_\_  
ONS: 1 2 3 4 5
- AGE REC: \_\_\_\_/\_\_\_\_  
REC: 1 2 3 4 5

**BOX G19B IF 3 OR MORE BOXES MARKED ON TALLY SHEET B, CONTINUE. OTHERS SKIP TO BOX G20.**

**HAND R Opiates TALLY B.**

- G20 A. Please review this list of experiences which are grouped into boxes that are different from the last one I showed you. You told me (**REVIEW SX**). Was there ever a 12-month period in which you had experiences from 3 or more of these boxes? **IF YES:** Please tell me the box and number for each experience that occurred during the same 12-month period even if the problem didn't last the full 12 months. **CIRCLE SYMPTOMS THAT CLUSTER. MUST BE FROM 3 DIFFERENT BOXES. DO NOT COUNT SYMPTOMS THAT OCCURRED AS A RESULT OF AN ISOLATED INCIDENT.**
- NO . . . (SKIP TO BOX G20) . 1  
YES ..... 5
- B. How old were you the (first/last) time you had experiences from 3 or more boxes within a 12-month period?
- AGE ONS: \_\_\_\_/\_\_\_\_  
ONS: 1 2 3 4 5
- AGE REC: \_\_\_\_/\_\_\_\_  
REC: 1 2 3 4 5

**BOX G20 IF 2+ BOXES MARKED ON TALLY A, CONTINUE. OTHERS SKIP TO G22.**

(22) G21 Since the age of (ONS), has there ever been a period of time lasting 3 months or longer when you did not use (OPIATE) at all? NO ... (SKIP TO G22) ..... 1  
YES ..... 5

A. When did that/these occur?  
**IF R HAD MORE THAN 4 ABSTINENT PERIODS, RECORD THE 4 LONGEST.**

FROM \_\_\_\_/\_\_\_\_/\_\_\_\_ TO \_\_\_\_/\_\_\_\_/\_\_\_\_  
 MO YEAR MO YEAR

FROM \_\_\_\_/\_\_\_\_/\_\_\_\_ TO \_\_\_\_/\_\_\_\_/\_\_\_\_  
 MO YEAR MO YEAR

FROM \_\_\_\_/\_\_\_\_/\_\_\_\_ TO \_\_\_\_/\_\_\_\_/\_\_\_\_  
 MO YEAR MO YEAR

FROM \_\_\_\_/\_\_\_\_/\_\_\_\_ TO \_\_\_\_/\_\_\_\_/\_\_\_\_  
 MO YEAR MO YEAR

---

(18) G22 Did you ever bring up any problems you might have had with (OPIATE) with any professional? NO .. (SKIP TO G23) ..... 1  
YES ..... 5

A. To whom did you speak first? CODE: \_\_\_\_

1. A psychiatrist
2. Another medical doctor
3. A psychologist
4. Another mental health professional
5. A member of the clergy
6. Other: **SPECIFY:** \_\_\_\_\_

B. How old were you the (first/last) time you brought up problems with (OPIATE) with a professional?

AGE ONS: \_\_\_\_/\_\_\_\_  
 ONS: 1 2 3 4 5

AGE REC: \_\_\_\_/\_\_\_\_  
 REC: 1 2 3 4 5

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**REFER TO B9 & B10 BEFORE ASKING**

G23 Have you ever been treated for a problem with (OPIATE)? NO . . . . . (SKIP TO D) . . . 1  
YES . . . . . 5

A. Were you ever treated at:

	<u>NO</u>	<u>YES</u>
1. outpatient drug program? . . . . .	1	5
2. outpatient, other? . . . . .	1	5
3. inpatient drug program? . . . . .	1	5
4. inpatient for medical complications due to (OPIATE) use? . . . . .	1	5
5. other? (IF YES, SPECIFY) . . . . .	1	5

**SPECIFY:** \_\_\_\_\_

B. How old were you the (first/last) time you were treated?

AGE ONS:     /     /  
ONS: 1 2 3 4 5

AGE REC:     /     /  
REC: 1 2 3 4 5

C. Where were you first treated? **RECORD CODE (1-5)**

CODE: \_\_\_\_

D. Did you ever attend a self-help group (like NA) for your (OPIATE) use? NO . . . (SKIP TO H1, p. 55) . . 1  
YES . . . . . 5

1. How old were you the (first/last) time you attended a self-help group for your (OPIATE) use?

AGE ONS:     /     /  
ONS: 1 2 3 4 5

AGE REC:     /     /  
REC: 1 2 3 4 5

---



		1	2	3	4	5	6	7	8	
		<i>MJ</i>	<i>STIM</i>	<i>SED</i>	<i>PCP</i>	<i>HAL</i>	<i>SOL</i>	<i>COM</i>	<i>OTH</i>	
H1	<b>HAND R CARD H.</b>									
	Have you ever used any of these drugs to feel good or high, or to feel more active or alert? Or did you use any prescription drugs when they were not prescribed, or more than prescribed?	NO	1	1	1	1	1	1	1	1
		YES	5	5	5	5	5	5	5	5

**BOX H1 IF ALL NO, SKIP TO I1, p. 67. OTHERS CONTINUE FOR EACH DRUG CODED 5.**

		1	2	3	4	5	6	7	8
		<i>MJ</i>	<i>STIM</i>	<i>SED</i>	<i>PCP</i>	<i>HAL</i>	<i>SOL</i>	<i>COM</i>	<i>OTH</i>
A.	How many times in your life have you used (DRUG)? (IF ≥ 100, CODE 99)	TIMES	__	__	__	__	__	__	__
	1. IF DK, ASK: Would you say 11 or more times?	NO	1	1	1	1	1	1	1
		YES	5	5	5	5	5	5	5
B.	How old were you the (first/last) time you used (DRUG)?	AGE ONS	__	__	__	__	__	__	__
		ONS	__	__	__	__	__	__	__
	FOR EACH AGE ONS BEFORE 15, ASK C. OTHERS SKIP TO D.	AGE REC	__	__	__	__	__	__	__
		REC	__	__	__	__	__	__	__

		1	2	3	4	5	6	7	8
		<i>MJ</i>	<i>STIM</i>	<i>SED</i>	<i>PCP</i>	<i>HAL</i>	<i>SOL</i>	<i>COM</i>	<i>OTH</i>
C.	Did you use (DRUG) more than once before you were 15?	NO	1	1	1	1	1	1	1
		YES	5	5	5	5	5	5	5

		1	2	3	4	5	6	7	8
		<i>MJ</i>	<i>STIM</i>	<i>SED</i>	<i>PCP</i>	<i>HAL</i>	<i>SOL</i>	<i>COM</i>	<i>OTH</i>
D.	Have you ever injected any drugs?	NO	1	1				1	1
	IF YES: Which ones?	YES	5	5				5	5
	IF NO, SKIP TO F.								

1. How many times? TIMES \_\_/\_\_/\_\_/\_\_/\_\_/\_\_/\_\_/\_\_/\_\_/\_\_/\_\_

2. How old were you the (first/last) time? AGE ONS \_\_/\_\_/\_\_/\_\_/\_\_/\_\_/\_\_/\_\_/\_\_/\_\_/\_\_

ONS \_\_/\_\_/\_\_/\_\_/\_\_/\_\_/\_\_/\_\_/\_\_/\_\_/\_\_

AGE REC \_\_/\_\_/\_\_/\_\_/\_\_/\_\_/\_\_/\_\_/\_\_/\_\_/\_\_

REC \_\_/\_\_/\_\_/\_\_/\_\_/\_\_/\_\_/\_\_/\_\_/\_\_/\_\_

E. Have you ever shared a needle?

NO.....(SKIP TO F) ..... 1

YES..... 5

1. How many times? \_\_\_\_\_ TIMES

2. How old were you the (first/last) time? AGE ONS: \_\_\_\_\_/\_\_\_\_\_  
ONS: 1 2 3 4 5

AGE REC: \_\_\_\_\_/\_\_\_\_\_  
REC: 1 2 3 4 5

F. Of all the drugs you have used, which one was your favorite (including opiates, cocaine, and alcohol)? \_\_\_\_\_ (CODE)

**BOX H2**

**CHECK H1A & H1A1. IF NO DRUG USED 11 OR MORE TIMES, SKIP TO I1, p. 67.**

**IF USED MARIJUANA, STIMULANTS, SEDATIVES, OR OTHER SUBSTANCES (OTHER THAN COCAINE OR OPIATES) 11 OR MORE TIMES, CONTINUE. IF USED OTHER DRUGS 11 OR MORE TIMES, CONTINUE WITH ONE USED MOST AND CODE IN COL. 4.**

**IF "OTHER" COLUMN USED, RECORD: \_\_\_\_\_ CODE: \_ \_ \_**

		<b>ASK ONE COLUMN AT A TIME.</b>		<u><i>MJ STIM SED OTH</i></u>			
FGNDRC	H2	What is the longest period you used (DRUG) almost every day? <b>IF NEVER ALMOST EVERY DAY, CODE 0 DAYS. IF USED DAILY FOR 1 MONTH OR LONGER, CODE H2A "YES" SILENTLY.</b>	DAYS	—	—	—	—
			WEEKS	—	—	—	—
			MONTHS	—	—	—	—
			YEARS	—	—	—	—
		A. Did you ever use (DRUG) at least once a week for one month or more?	NO	1	1	1	1
			YES	5	5	5	5
		B. Think about the time when you were using (DRUG) the most. During that period, how many days per month did you use (DRUG)?	DAYS PER MO	—	—	—	—
		1. How long did that period last?	MONTHS	—	—	—	—
		2. During that period of heaviest use, how many times (i.e., separate episodes) did you use (DRUG) on an average day?	TIMES PER DAY	—	—	—	—
		3. How old were you when that period started?	AGE ONS	—	—	—	—

		<u><i>1 2 3 4</i></u> <u><i>MJ STIM SED OTH</i></u>					
(3) FGNDRC	H3	Have you ever stayed high from (DRUG) for a whole day or more?	NO	1	1	1	1
			YES	5	5	5	5
	A.	<b>IF YES:</b> Did this happen 3 or more times?	NO	1	1	1	1
			YES	5	5	5	5

**BEGIN SCORING DRUG TALLY SHEETS A & B**

(5) DDICD1	H4	Have you ever had such a strong desire for (DRUG) that it was hard to think of anything else?	NO YES	1 5	1 5	1 5	1 5
	A.	<b>IF YES:</b> How old were you the (first/last) time?	AGE ONS: ONS: AGE REC: REC:	— — — —	— — — —	— — — —	— — — —
(6) DD3RA3/B DD45 DDICD5 FAgeNDRC	H5	Was there ever a period of a month or more when a great deal of your time was spent using (DRUG), getting (DRUG), or getting over its effects?	NO YES	1 5	1 5	1 5	1 5 A,B
(7) DD3RA2 DD44 DDICD2	H6	Have you <u>often</u> wanted to stop or cut down on (DRUG)?	NO YES	1 5	1 5	1 5	1 5 A,B
DD3RA2	A.	Have you ever tried to stop or cut down on (DRUG) but found that you couldn't?	NO YES	1 5	1 5	1 5	1 5 A
		<b>IF NO (COULD STOP), SKIP TO H7. OTHERS CONTINUE.</b>					
DD44 DDICD2	B.	Were you unable to stop or cut down 3 or more times?	NO YES	1 5	1 5	1 5	1 5 B
(8) DD3RA7 DD41 DDICD4	H7	Did you ever need larger amounts of (DRUG) to get an effect or find that you could no longer get high on the amount you used to use?	NO YES	1 5	1 5	1 5	1 5 A,B
		<b>(CODE "YES" IF R. INCREASED HIS USUAL DOSE 50% OR MORE OVER A PREVIOUS HABITUAL LEVEL OF USE)</b>					

				1	2	3	4
				<i>MJ</i>	<i>STIM</i>	<i>SED</i>	<i>OTH</i>
(9)	H8	Have you ever given up or greatly reduced important activities while using (DRUG), like sports, work, or associating with friends or relatives? <b>SPECIFY:</b> _____	NO YES	1 5	1 5	1 5	1 5
DD3RA5/B DD46 DDICD5	A.	<b>IF YES:</b> Did this happen 3 or more times or for a month or more?	NO YES	1 5	1 5	1 5	1 5 A,B
(10) DD3RA1 DD43 DDICD2	H9	Have you <u>often</u> used (DRUG) more days or in larger amounts than you intended to?	NO YES	1 5	1 5	1 5	1 5 A,B
(11)	H10	People who stop, cut down, or go without drugs after using drugs steadily for some time may not feel well. These feelings are more intense and can last longer than the usual hangover. When you stopped, cut down, or went without (DRUG), did you ever experience any of the following problems <u>for most of the day for 2 days or longer?</u> (NO=1, YES=5) <b>ASK H10 A1-24 ONE COLUMN AT A TIME.</b>		1	2	3	4
<b>REPEAT STEM OFTEN.</b>				<i>MJ</i>	<i>STIM</i>	<i>SED</i>	<i>OTH</i>
A. 1. Did you feel depressed? . . . . .				—	—	—	—
2. Did you feel restless?. . . . .			—	—	—	—	—
3. Did you feel tired, sleepy, or weak? . . . . .			—	—	—	—	—
4. Did you have trouble sleeping?. . . . .			—	—	—	—	—
5. Did you sleep too much?. . . . .			—	—	—	—	—
6. Did you have a strong desire or craving for (DRUG)? . . . . .			—	—	—	—	—
7. Did you feel slowed down, like you could hardly move? . . . . .			—	—	—	—	—
8. Did you have an increase or decrease in appetite? . . . . .			—	—	—	—	—
9. Did you have nightmares? . . . . .			—	—	—	—	—
10. Did you think that people were plotting to harm you (i.e., were you paranoid?). . . . .			—	—	—	—	—
11. Did you have diarrhea?. . . . .			—	—	—	—	—
12. Did you have stomach aches or stomach cramps? . . . . .			—	—	—	—	—
13. Were your pupils dilated or were your eyes sensitive to light?			—	—	—	—	—
14. Did your heart race?. . . . .			—	—	—	—	—
15. Did you sweat? . . . . .			—	—	—	—	—
16. Did you have a fever? . . . . .			—	—	—	—	—
17. Did you have nausea, or did you vomit? . . . . .			—	—	—	—	—
18. Did you have headaches? . . . . .			—	—	—	—	—
19. Did you feel nervous, tense, or irritable? . . . . .			—	—	—	—	—
20. Did your hands shake? . . . . .			—	—	—	—	—
21. Did you tremble or twitch? . . . . .			—	—	—	—	—
22. Did you experience dizziness? . . . . .			—	—	—	—	—
23. Did you have seizures? . . . . .			—	—	—	—	—
24. Did you see, hear, or feel things that weren't really there? . . . . .			—	—	—	—	—

**CONTINUE ASKING ONE COLUMN AT A TIME.**

**FOR EACH DRUG COLUMN:**

**IF ALL CODED 1, GO TO NEXT DRUG COLUMN.**

**IF ONLY ONE CODED 5, SKIP TO E.**

**IF TWO OR MORE 5'S CODED, CONTINUE.**

DD3RA8  
DD42A  
DDICD3

- B. Was there ever a time when 2 or more of these problems occurred together because of stopping, cutting down on, or going without (DRUG)?  
**REVIEW SX AS NEEDED. IF NO, SKIP TO C.**

	1	2	3	4
<u>MJ STIM SED OTH</u>				
NO	1	1	1	1
YES	5	5	5	5 A,B

1. **IF YES:** Did these problems occur together for 2 days or longer? **IF NO, SKIP TO C.**

NO	1	1	1	1
YES	5	5	5	5

2. **IF YES:** How old were you the (first/last) time?

AGE ONS	—	—	—	—
ONS	—	—	—	—
AGE REC	—	—	—	—
REC	—	—	—	—

DD3RB

- C. Did you have any of these problems 3 or more times?

NO	1	1	1	1
YES	5	5	5	5

- D. Did these problems interfere with your functioning at work, school, or home?

NO	1	1	1	1
YES	5	5	5	5

- E. Have you ever used (DRUG) to keep from having any of these problems (or to make them go away)?  
**IF NO, SKIP TO NEXT DRUG. IF NO DRUG, SKIP TO H11.**

NO	1	1	1	1
YES	5	5	5	5

1. **IF YES:** How old were you the (first/last) time?

AGE ONS	—	—	—	—
ONS	—	—	—	—
AGE REC	—	—	—	—
REC	—	—	—	—

DD3RA9/B  
DD42B  
DDICD3

2. Did you do that 3 or more times?

NO	1	1	1	1
YES	5	5	5	5 A,B

				1	2	3	4		
				<u>MJ</u>	<u>STIM</u>	<u>SED</u>	<u>OTH</u>		
(12B-D)	H11	Did using (DRUG) cause you to have any other problems like:	NO	1	1	1	1		
		A. an overdose?	YES	5	5	5	5		
		1. IF YES: Did you require medical treatment afterwards? IF NO, SKIP TO B	NO	1	1	1	1		
			YES	5	5	5	5		
		2. IF YES: Did this happen 3 or more times? (overdose that required medical treatment)	NO	1	1	1	1		
			YES	5	5	5	5 A,B		
		B. hepatitis?	NO	1	1	1	1		
			YES	5	5	5	5		
		1. IF YES: Did you continue to use (DRUG) knowing it caused hepatitis?	NO	1	1	1	1		
			YES	5	5	5	5 A,B		
DD3RA6/B DD47 DDICD6 DA3RA1/B		C. other serious health problems? SPECIFY:	NO	1	1	1	1		
			YES	5	5	5	5		
		1. IF YES: Did you continue to use (DRUG) knowing it caused health problems?	NO	1	1	1	1		
			YES	5	5	5	5 A,B		
		(13A-C)	H12	A. Were there ever objections from or problems with your family, friends, doctor, clergy, boss or people at work or school because of your (DRUG) use?	NO	1	1	1	1
					YES	5	5	5	5
				B. Did you ever get into any physical fights while using (DRUG)?	NO	1	1	1	1
					YES	5	5	5	5
				<div>BOX H12 IF A AND B ARE BOTH CODED 1, SKIP TO H13 OTHERS CONTINUE.</div>					
DA4A4				C. Did (this/either of these experiences) happen 3 or more times in any 12-month period?	NO	1	1	1	1
					YES	5	5	5	5
				D. Did you continue to use (DRUG) after you realized it was causing you any problem?	NO	1	1	1	1
					YES	5	5	5	5 A
				(13D)	H13	Did you ever have trouble with the police because of (DRUG)? IF NO, SKIP TO H14	NO	1	1
			YES			5	5	5	5
		A. IF YES: Did this happen 3 or more times in any 12-month period?	NO			1	1	1	1
			YES			5	5	5	5
		B. Did you continue to use (DRUG) after you realized it was causing you trouble with the police?	NO			1	1	1	1
			YES			5	5	5	5 A

			1	2	3	4
			<i><u>MJ</u></i>	<i><u>STIM</u></i>	<i><u>SED</u></i>	<i><u>OTH</u></i>
(12A)	H14	Have you accidentally injured yourself when you were using (DRUG); that is had a bad fall, cut or burned yourself badly, got hurt in a traffic accident, or anything like that? <b>IF NO, SKIP TO H15.</b>	NO	1	1	1
			YES	5	5	5
DD3RA4/B DDICD6 DA3RA2/B	A.	<b>IF YES:</b> Did this happen 3 or more times? <b>IF NO, SKIP TO H15.</b>	NO	1	1	1
			YES	5	5	5 A
DA4A2	B.	<b>IF YES:</b> Did this happen 3 or more times in any 12-month period?	NO	1	1	1
			YES	5	5	5
(14) DD3RA4/B	H15	Has your being high on (DRUG) or experiencing its after-effects <u>often</u> interfered with your work, school, household, or child care responsibilities? <b>IF NO, SKIP TO H16.</b>	NO	1	1	1
			YES	5	5	5 A
DA4A1	A.	<b>IF YES, SPECIFY:</b> _____ _____ <b>IF YES:</b> Did this happen 3 or more times in any 12-month period?	NO	1	1	1
			YES	5	5	5
(16) DD3RA4/B DA3RA2/B ASP3RC7 ASP4A5	H16	Have there been 3 or more times when you have been under the influence of (DRUG) in a situation where it increased your chances of getting hurt--for instance, when driving a car or boat; using knives, machinery, or guns; crossing against traffic; climbing; or swimming? <b>IF NO, SKIP TO H17</b>	NO	1	1	1
			YES	5	5	5 A
DA4A2	A.	<b>IF YES:</b> Did this happen 3 or more times in any 12-month period?	NO	1	1	1
			YES	5	5	5

(15)	H17	Has your use of (DRUG) ever caused you emotional or psychological problems like:	<div> 1234  MJ STIM SED OTH </div>			
			1	2	3	4
		1. Feeling depressed or uninterested in things for more than 24 hours to the point that it interfered with your functioning?	NO YES	1 5	1 5	1 5
		2. Feeling paranoid or suspicious of people for more than 24 hours to the point that it interfered with your relationships?	NO YES	1 5	1 5	1 5
		3. Having trouble concentrating or thinking clearly for more than 24 hours to the point that it interfered with your functioning?	NO YES	1 5	1 5	1 5
		4. Hearing, seeing, or smelling things that weren't really there?	NO YES	1 5	1 5	1 5
		5. Feeling jumpy or easily startled or nervous for more than 24 hours to the point that it interfered with your functioning?	NO YES	1 5	1 5	1 5

**IF ALL ARE CODED 1, SKIP TO BOX H17.  
OTHERS CONTINUE.**

DD3RA6 DD47 DDICD6 DA3RA1	A.	Did you continue to use (DRUG) after you knew it caused any of these problems? <b>REVIEW SX AS NEEDED.</b>	NO	1	1	1	1
			YES	5	5	5	5 A,B

DSMIIIR

**BOX H17 IF ANY MARKS ON TALLY A, CONTINUE. OTHERS SKIP TO H21.**

(19)	H18	<b>HAND R DRUG TALLY A.</b> Please review these experiences that you told me about. <b>(REVIEW SX.)</b> When was the (first/last) time you had any of these experiences?	<div> 1234  MJ STIM SED OTH </div>			
			1	2	3	4
		AGE ONS:	—	—	—	—
		ONS:	—	—	—	—
		AGE REC:	—	—	—	—
		REC:	—	—	—	—

**BOX H18A IF 3 OR MORE BOXES MARKED ON TALLY A, CONTINUE.  
OTHERS SKIP TO BOX H18B.**



DD3RB

- A. Was there ever a period lasting a month or longer when you had experiences from 3 or more boxes occurring together?

	1	2	3	4
	<u>MJ</u>	<u>STIM</u>	<u>SED</u>	<u>OTH</u>
NO	1	1	1	1
YES	5	5	5	5

**IF YES:** Please tell me the box and number for all the experiences that occurred together.

**IF YES, CIRCLE SX THAT CLUSTER AND SKIP TO C.**

**CIRCLE SYMPTOMS THAT CLUSTER. MUST BE 3 FROM DIFFERENT BOXES. DO NOT COUNT SYMPTOMS THAT OCCURRED AS A RESULT OF AN ISOLATED INCIDENT.**

**IF NO, ASK B.**

- B. Was there ever a period lasting a month or longer when you had experiences from 2 boxes occurring together?

NO	1	1	1	1
YES	5	5	5	5

**IF YES:** Please tell me the box and number for all the experiences that occurred together.

**IF YES, CIRCLE SX THAT CLUSTER AND ASK C.**

**CIRCLE SYMPTOMS THAT CLUSTER. MUST BE FROM 2 DIFFERENT BOXES. DO NOT COUNT SYMPTOMS THAT OCCURRED AS A RESULT OF AN ISOLATED INCIDENT.**

**IF NO, SKIP TO BOX H18B.**

- C. How old were you the (first/last) time you had experiences from 3(2) boxes occur within a period lasting a month or longer?

AGE ONS:	—	—	—	—
ONS:	—	—	—	—
AGE REC:	—	—	—	—
REC:	—	—	—	—

DSM-IV

**BOX H18B IF 3 OR MORE BOXES MARKED ON TALLY B, CONTINUE. OTHERS SKIP TO BOX H19.**

DD4

H19

**HAND R DRUG TALLY B.**

A. Was there ever a 12-month period in which you had experiences from 3 or more boxes?

	1	2	3	4
	<i><u>MJ</u></i>	<i><u>STIM</u></i>	<i><u>SED</u></i>	<i><u>OTH</u></i>
NO	1	1	1	1
YES	5	5	5	5

**IF YES:** Please tell me the box and number for all the experiences that occurred during the same 12-month period even if it didn't last the full 12 months.

**IF YES, CIRCLE SX THAT CLUSTER AND ASK B.**

**IF NO, SKIP TO BOX H19.**

**CIRCLE SX THAT CLUSTER. MUST BE FROM 3 DIFFERENT BOXES. DO NOT COUNT SX RESULTING FROM AN ISOLATED INCIDENT.**

B. How old were you the (first/last) time you had experiences from 3 or more boxes occur together within a period lasting 12 months or longer?

AGE ONS:	—	—	—	—
ONS:	—	—	—	—
AGE REC:	—	—	—	—
REC:	—	—	—	—

**BOX H19 IF 2 OR MORE BOXES MARKED ON TALLY A, CONTINUE. OTHERS SKIP TO H21.**

(22) H20 Since the age of (ONS), has there ever been a period of time lasting 3 months or longer when you did not use (DRUG) at all? **FOR EACH YES, ASK A.**

		1	2	3	4
		<u>MJ</u>	<u>STIM</u>	<u>SED</u>	<u>OTH</u>
NO		1	1	1	1
YES		5	5	5	5

A. When did (that/these) occur?

	<u>MO</u>	<u>YEAR</u>		<u>MO</u>	<u>YEAR</u>		<u>MO</u>	<u>YEAR</u>		<u>MO</u>	<u>YEAR</u>
MJ	___	/	___	TO	___	/	___		___	/	___
	___	/	___	TO	___	/	___		___	/	___
STIM	___	/	___	TO	___	/	___		___	/	___
	___	/	___	TO	___	/	___		___	/	___
SED	___	/	___	TO	___	/	___		___	/	___
	___	/	___	TO	___	/	___		___	/	___
OTH	___	/	___	TO	___	/	___		___	/	___
	___	/	___	TO	___	/	___		___	/	___

(17) H21 Have you ever brought up any problem you might have had with drugs with any professional?

NO	.... (SKIP TO H22)	1
YES	.....	5

A. Did you speak with:

	<u>NO</u>	<u>YES</u>
1. A psychiatrist? .....	1	5
2. Another medical doctor? .....	1	5
3. A psychologist? .....	1	5
4. Another mental health professional? .....	1	5
5. A member of the clergy? .....	1	5
6. Anyone else? <b>SPECIFY:</b> .....	1	5

B. How old were you the (first/last) time you brought up any problem you had with drugs?

AGE ONS:					
ONS:	1	2	3	4	5
AGE REC:					
REC:	1	2	3	4	5

C. With whom did you speak first?  
**RECORD CODE (1-6).** CODE: \_\_\_

(18) H22 Have you ever been treated for a problem with drugs?

NO	.... (SKIP TO D)	1
YES	.....	5

FGNDRB  
FGNDRB

A. Were you treated:

	<u>NO</u>	<u>YES</u>
1. at an outpatient drug-free program? . . . . .	1	5
2. at an outpatient program for something other than drugs? . . . . .	1	5
3. at an inpatient drug-free program? . . . . .	1	5
4. when inpatient for medical complications due to drug use? . . . . .	1	5
5. at any other place or program? <b>IF YES, SPECIFY.</b> . . . . .	1	5

**SPECIFY:** \_\_\_\_\_

B. How old were you the (first/last) time you  
were treated for a drug problem?

AGE ONS: \_\_\_\_\_/  
ONS: 1 2 3 4 5

AGE REC: \_\_\_\_\_/  
REC: 1 2 3 4 5

C. Where were you treated first?

CODE: \_\_\_\_

**RECORD CODE (1-5)**

D. Did you ever attend a self-help group (like NA)  
because you had a problem with drugs?

NO . . . (SKIP TO 11, p. 67) . . . 1  
YES . . . . . 5

1. How old were you the (first/last) time  
you attended a self-help group for drug abuse?

AGE ONS: \_\_\_\_\_/  
ONS: 1 2 3 4 5

AGE REC: \_\_\_\_\_/  
REC: 1 2 3 4 5

		1	2	3	4	5	6	7	8
		<i>MJ</i>	<i>STIM</i>	<i>SED</i>	<i>PCP</i>	<i>HAL</i>	<i>SOL</i>	<i>COM</i>	<i>OTH</i>
H1	<b>HAND R CARD H.</b>								
	Have you ever used any of these drugs to feel good or high, or to feel more active or alert? Or did you use any prescription drugs when they were not prescribed, or more than prescribed?	NO	1	1	1	1	1	1	1
		YES	5	5	5	5	5	5	5

**BOX H1 IF ALL NO, SKIP TO I1, p. 67. OTHERS CONTINUE FOR EACH DRUG CODED 5.**

		1	2	3	4	5	6	7	8
		<i>MJ</i>	<i>STIM</i>	<i>SED</i>	<i>PCP</i>	<i>HAL</i>	<i>SOL</i>	<i>COM</i>	<i>OTH</i>
A.	How many times in your life have you used (DRUG)? (IF ≥ 100, CODE 99)	TIMES	—/—	—/—	—/—	—/—	—/—	—/—	—/—
	1. IF DK, ASK: Would you say 11 or more times?	NO	1	1	1	1	1	1	1
		YES	5	5	5	5	5	5	5
B.	How old were you the (first/last) time you used (DRUG)?	AGE ONS	—	—	—	—	—	—	—
		ONS	—	—	—	—	—	—	—
	FOR EACH AGE ONS BEFORE 15, ASK C. OTHERS SKIP TO D.	AGE REC	—	—	—	—	—	—	—
		REC	—	—	—	—	—	—	—

		1	2	3	4	5	6	7	8
		<i>MJ</i>	<i>STIM</i>	<i>SED</i>	<i>PCP</i>	<i>HAL</i>	<i>SOL</i>	<i>COM</i>	<i>OTH</i>
C.	Did you use (DRUG) more than once before you were 15?	NO	1	1	1	1	1	1	1
		YES	5	5	5	5	5	5	5

		1	2	3	4	5	6	7	8
		<i>MJ</i>	<i>STIM</i>	<i>SED</i>	<i>PCP</i>	<i>HAL</i>	<i>SOL</i>	<i>COM</i>	<i>OTH</i>
D.	Have you ever injected any drugs?	NO	1	1				1	1
	IF YES: Which ones?	YES	5	5				5	5
	IF NO, SKIP TO F.								

1. How many times? TIMES —/— —/— —/— —/—

2. How old were you the (first/last) time? AGE ONS — — — —

ONS — — — —

AGE REC — — — —

REC — — — —

E. Have you ever shared a needle? NO.....(SKIP TO F) ..... 1  
YES..... 5  
..... TIMES

1. How many times?

2. How old were you the (first/last) time?

AGE ONS: —/—  
ONS: 1 2 3 4 5

AGE REC: —/—  
REC: 1 2 3 4 5

F. Of all the drugs you have used, which one was your favorite (including opiates, cocaine, and alcohol)? \_\_\_\_\_ (CODE)

**BOX H2**

**CHECK H1A & H1A1. IF NO DRUG USED 11 OR MORE TIMES, SKIP TO I1, p. 67.**

**IF USED MARIJUANA, STIMULANTS, SEDATIVES, OR OTHER SUBSTANCES (OTHER THAN COCAINE OR OPIATES) 11 OR MORE TIMES, CONTINUE. IF USED OTHER DRUGS 11 OR MORE TIMES, CONTINUE WITH ONE USED MOST AND CODE IN COL. 4.**

**IF "OTHER" COLUMN USED, RECORD: \_\_\_\_\_ CODE: \_ \_ \_**

		<b>ASK ONE COLUMN AT A TIME.</b>		<u><i>MJ STIM SED OTH</i></u>			
FGNDRC	H2	What is the longest period you used (DRUG) almost every day? <b>IF NEVER ALMOST EVERY DAY, CODE 0 DAYS. IF USED DAILY FOR 1 MONTH OR LONGER, CODE H2A "YES" SILENTLY.</b>	DAYS	—	—	—	—
			WEEKS	—	—	—	—
			MONTHS	—	—	—	—
			YEARS	—	—	—	—
		A. Did you ever use (DRUG) at least once a week for one month or more?	NO	1	1	1	1
			YES	5	5	5	5
		B. Think about the time when you were using (DRUG) the most. During that period, how many days per month did you use (DRUG)?	DAYS PER MO	—	—	—	—
		1. How long did that period last?	MONTHS	—	—	—	—
		2. During that period of heaviest use, how many times (i.e., separate episodes) did you use (DRUG) on an average day?	TIMES PER DAY	—	—	—	—
		3. How old were you when that period started?	AGE ONS	—	—	—	—

		<u><i>1 2 3 4</i></u> <u><i>MJ STIM SED OTH</i></u>					
(3) FGNDRC	H3	Have you ever stayed high from (DRUG) for a whole day or more?	NO	1	1	1	1
			YES	5	5	5	5
	A.	<b>IF YES:</b> Did this happen 3 or more times?	NO	1	1	1	1
			YES	5	5	5	5

**BEGIN SCORING DRUG TALLY SHEETS A & B**

(5) DDICD1	H4	Have you ever had such a strong desire for (DRUG) that it was hard to think of anything else?	NO YES	1 5	1 5	1 5	1 5
	A.	<b>IF YES:</b> How old were you the (first/last) time?	AGE ONS: ONS: AGE REC: REC:	— — — —	— — — —	— — — —	— — — —

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(6) DD3RA3/B DD45 DDICD5 FAgeNDRC	H5	Was there ever a period of a month or more when a great deal of your time was spent using (DRUG), getting (DRUG), or getting over its effects?	NO YES	1 5	1 5	1 5	1 5 A,B
---	----	--	-----------	--------	--------	--------	------------

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(7) DD3RA2 DD44 DDICD2	H6	Have you <u>often</u> wanted to stop or cut down on (DRUG)?	NO YES	1 5	1 5	1 5	1 5 A,B
---------------------------------	----	--	-----------	--------	--------	--------	------------

  

DD3RA2	A.	Have you ever tried to stop or cut down on (DRUG) but found that you couldn't?	NO YES	1 5	1 5	1 5	1 5 A
--------	----	---	-----------	--------	--------	--------	----------

  

**IF NO (COULD STOP), SKIP TO H7.  
OTHERS CONTINUE.**

DD44 DDICD2	B.	Were you unable to stop or cut down 3 or more times?	NO YES	1 5	1 5	1 5	1 5 B
----------------	----	---	-----------	--------	--------	--------	----------

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(8) DD3RA7 DD41 DDICD4	H7	Did you ever need larger amounts of (DRUG) to get an effect or find that you could no longer get high on the amount you used to use?	NO YES	1 5	1 5	1 5	1 5 A,B
---------------------------------	----	--	-----------	--------	--------	--------	------------

  

**(CODE "YES" IF R. INCREASED HIS USUAL  
DOSE 50% OR MORE OVER A PREVIOUS  
HABITUAL LEVEL OF USE)**

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				1	2	3	4
				<i>MJ</i>	<i>STIM</i>	<i>SED</i>	<i>OTH</i>
(9)	H8	Have you ever given up or greatly reduced important activities while using (DRUG), like sports, work, or associating with friends or relatives? <b>SPECIFY:</b> _____	NO YES	1 5	1 5	1 5	1 5
DD3RA5/B DD46 DDICD5	A.	<b>IF YES:</b> Did this happen 3 or more times or for a month or more?	NO YES	1 5	1 5	1 5	1 5 A,B
(10) DD3RA1 DD43 DDICD2	H9	Have you <u>often</u> used (DRUG) more days or in larger amounts than you intended to?	NO YES	1 5	1 5	1 5	1 5 A,B
(11)	H10	People who stop, cut down, or go without drugs after using drugs steadily for some time may not feel well. These feelings are more intense and can last longer than the usual hangover. When you stopped, cut down, or went without (DRUG), did you ever experience any of the following problems <u>for most of the day for 2 days or longer?</u> (NO=1, YES=5) <b>ASK H10 A1-24 ONE COLUMN AT A TIME.</b>		1	2	3	4
<b>REPEAT STEM OFTEN.</b>				<i>MJ</i>	<i>STIM</i>	<i>SED</i>	<i>OTH</i>
A. 1. Did you feel depressed? . . . . .				—	—	—	—
2. Did you feel restless?. . . . .			—	—	—	—	—
3. Did you feel tired, sleepy, or weak? . . . . .			—	—	—	—	—
4. Did you have trouble sleeping?. . . . .			—	—	—	—	—
5. Did you sleep too much?. . . . .			—	—	—	—	—
6. Did you have a strong desire or craving for (DRUG)? . . . . .			—	—	—	—	—
7. Did you feel slowed down, like you could hardly move? . . . . .			—	—	—	—	—
8. Did you have an increase or decrease in appetite? . . . . .			—	—	—	—	—
9. Did you have nightmares? . . . . .			—	—	—	—	—
10. Did you think that people were plotting to harm you (i.e., were you paranoid?). . . . .			—	—	—	—	—
11. Did you have diarrhea?. . . . .			—	—	—	—	—
12. Did you have stomach aches or stomach cramps? . . . . .			—	—	—	—	—
13. Were your pupils dilated or were your eyes sensitive to light?			—	—	—	—	—
14. Did your heart race? . . . . .			—	—	—	—	—
15. Did you sweat? . . . . .			—	—	—	—	—
16. Did you have a fever? . . . . .			—	—	—	—	—
17. Did you have nausea, or did you vomit? . . . . .			—	—	—	—	—
18. Did you have headaches? . . . . .			—	—	—	—	—
19. Did you feel nervous, tense, or irritable? . . . . .			—	—	—	—	—
20. Did your hands shake? . . . . .			—	—	—	—	—
21. Did you tremble or twitch? . . . . .			—	—	—	—	—
22. Did you experience dizziness? . . . . .			—	—	—	—	—
23. Did you have seizures? . . . . .			—	—	—	—	—
24. Did you see, hear, or feel things that weren't really there? . . . . .			—	—	—	—	—



**CONTINUE ASKING ONE COLUMN AT A TIME.**

**FOR EACH DRUG COLUMN:**

**IF ALL CODED 1, GO TO NEXT DRUG COLUMN.**

**IF ONLY ONE CODED 5, SKIP TO E.**

**IF TWO OR MORE 5'S CODED, CONTINUE.**

DD3RA8  
DD42A  
DDICD3

- B. Was there ever a time when 2 or more of these problems occurred together because of stopping, cutting down on, or going without (DRUG)?  
**REVIEW SX AS NEEDED. IF NO, SKIP TO C.**

	1	2	3	4
	<i><u>MJ</u></i>	<i><u>STIM</u></i>	<i><u>SED</u></i>	<i><u>OTH</u></i>
NO	1	1	1	1
YES	5	5	5	5 A,B

1. **IF YES:** Did these problems occur together for 2 days or longer? **IF NO, SKIP TO C.**

NO	1	1	1	1
YES	5	5	5	5

2. **IF YES:** How old were you the (first/last) time?

AGE ONS	—	—	—	—
ONS	—	—	—	—
AGE REC	—	—	—	—
REC	—	—	—	—

DD3RB

- C. Did you have any of these problems 3 or more times?

NO	1	1	1	1
YES	5	5	5	5

- D. Did these problems interfere with your functioning at work, school, or home?

NO	1	1	1	1
YES	5	5	5	5

- E. Have you ever used (DRUG) to keep from having any of these problems (or to make them go away)?  
**IF NO, SKIP TO NEXT DRUG. IF NO DRUG, SKIP TO H11.**

NO	1	1	1	1
YES	5	5	5	5

1. **IF YES:** How old were you the (first/last) time?

AGE ONS	—	—	—	—
ONS	—	—	—	—
AGE REC	—	—	—	—
REC	—	—	—	—

DD3RA9/B  
DD42B  
DDICD3

2. Did you do that 3 or more times?

NO	1	1	1	1
YES	5	5	5	5 A,B

				1	2	3	4
				<i><u>MJ</u></i>	<i><u>STIM</u></i>	<i><u>SED</u></i>	<i><u>OTH</u></i>
(12B-D)	H11	Did using (DRUG) cause you to have any other problems like:	NO	1	1	1	1
		A. an overdose?	YES	5	5	5	5
		1. <b>IF YES:</b> Did you require medical treatment afterwards? <b>IF NO, SKIP TO B</b>	NO	1	1	1	1
			YES	5	5	5	5
		2. <b>IF YES:</b> Did this happen 3 or more times? (overdose that required medical treatment)	NO	1	1	1	1
			YES	5	5	5	5 A,B
		B. hepatitis?	NO	1	1	1	1
			YES	5	5	5	5
		1. <b>IF YES:</b> Did you continue to use (DRUG) knowing it caused hepatitis?	NO	1	1	1	1
			YES	5	5	5	5 A,B
DD3RA6/B DD47 DDICD6 DA3RA1/B		C. other serious health problems? <b>SPECIFY:</b>	NO	1	1	1	1
			YES	5	5	5	5
		1. <b>IF YES:</b> Did you continue to use (DRUG) knowing it caused health problems?	NO	1	1	1	1
			YES	5	5	5	5 A,B
(13A-C)	H12	A. Were there ever objections from or problems with your family, friends, doctor, clergy, boss or people at work or school because of your (DRUG) use?	NO	1	1	1	1
			YES	5	5	5	5
		B. Did you ever get into any physical fights while using (DRUG)?	NO	1	1	1	1
			YES	5	5	5	5
		<b>BOX H12 IF A AND B ARE BOTH CODED 1, SKIP TO H13 OTHERS CONTINUE.</b>					
DA4A4  DD3RA6 DA3RA1		C. Did (this/either of these experiences) happen 3 or more times in any 12-month period?	NO	1	1	1	1
			YES	5	5	5	5
		D. Did you continue to use (DRUG) after you realized it was causing you any problem?	NO	1	1	1	1
			YES	5	5	5	5 A
(13D)	H13	Did you ever have trouble with the police because of (DRUG)? <b>IF NO, SKIP TO H14</b>	NO	1	1	1	1
			YES	5	5	5	5
		A. <b>IF YES:</b> Did this happen 3 or more times in any 12-month period?	NO	1	1	1	1
			YES	5	5	5	5
		B. Did you continue to use (DRUG) after you realized it was causing you trouble with the police?	NO	1	1	1	1
			YES	5	5	5	5 A

			1	2	3	4
			<i><u>MJ</u></i>	<i><u>STIM</u></i>	<i><u>SED</u></i>	<i><u>OTH</u></i>
(12A)	H14	Have you accidentally injured yourself when you were using (DRUG); that is had a bad fall, cut or burned yourself badly, got hurt in a traffic accident, or anything like that? <b>IF NO, SKIP TO H15.</b>	NO	1	1	1
			YES	5	5	5
	A.	<b>IF YES:</b> Did this happen 3 or more times? <b>IF NO, SKIP TO H15.</b>	NO	1	1	1
DD3RA4/B			YES	5	5	5 A
DDICD6	B.	<b>IF YES:</b> Did this happen 3 or more times in any 12-month period?	NO	1	1	1
DA3RA2/B			YES	5	5	5
DA4A2			NO	1	1	1
			YES	5	5	5
(14) DD3RA4/B	H15	Has your being high on (DRUG) or experiencing its after-effects <u>often</u> interfered with your work, school, household, or child care responsibilities? <b>IF NO, SKIP TO H16.</b>	NO	1	1	1
			YES	5	5	5 A
		<b>IF YES, SPECIFY:</b> _____ _____				
DA4A1	A.	<b>IF YES:</b> Did this happen 3 or more times in any 12-month period?	NO	1	1	1
			YES	5	5	5
(16) DD3RA4/B DA3RA2/B ASP3RC7 ASP4A5	H16	Have there been 3 or more times when you have been under the influence of (DRUG) in a situation where it increased your chances of getting hurt--for instance, when driving a car or boat; using knives, machinery, or guns; crossing against traffic; climbing; or swimming? <b>IF NO, SKIP TO H17</b>	NO	1	1	1
			YES	5	5	5 A
DA4A2	A.	<b>IF YES:</b> Did this happen 3 or more times in any 12-month period?	NO	1	1	1
			YES	5	5	5

(15)	H17	Has your use of (DRUG) ever caused you emotional or psychological problems like:	<div> 1234  MJ STIM SED OTH </div>			
			1	2	3	4
		1. Feeling depressed or uninterested in things for more than 24 hours to the point that it interfered with your functioning?	NO YES	1 5	1 5	1 5
		2. Feeling paranoid or suspicious of people for more than 24 hours to the point that it interfered with your relationships?	NO YES	1 5	1 5	1 5
		3. Having trouble concentrating or thinking clearly for more than 24 hours to the point that it interfered with your functioning?	NO YES	1 5	1 5	1 5
		4. Hearing, seeing, or smelling things that weren't really there?	NO YES	1 5	1 5	1 5
		5. Feeling jumpy or easily startled or nervous for more than 24 hours to the point that it interfered with your functioning?	NO YES	1 5	1 5	1 5

**IF ALL ARE CODED 1, SKIP TO BOX H17.  
OTHERS CONTINUE.**

DD3RA6 DD47 DDICD6 DA3RA1	A.	Did you continue to use (DRUG) after you knew it caused any of these problems? <b>REVIEW SX AS NEEDED.</b>	NO	1	1	1	1
			YES	5	5	5	5 A,B

DSMIIIR

**BOX H17 IF ANY MARKS ON TALLY A, CONTINUE. OTHERS SKIP TO H21.**

(19)	H18	<b>HAND R DRUG TALLY A.</b> Please review these experiences that you told me about. <b>(REVIEW SX.)</b> When was the (first/last) time you had any of these experiences?	<div> 1234  MJ STIM SED OTH </div>			
			1	2	3	4
		AGE ONS:	—	—	—	—
		ONS:	—	—	—	—
		AGE REC:	—	—	—	—
		REC:	—	—	—	—

**BOX H18A IF 3 OR MORE BOXES MARKED ON TALLY A, CONTINUE.  
OTHERS SKIP TO BOX H18B.**

DD3RB

- A. Was there ever a period lasting a month or longer when you had experiences from 3 or more boxes occurring together?

	1	2	3	4
	<u>MJ</u>	<u>STIM</u>	<u>SED</u>	<u>OTH</u>
NO	1	1	1	1
YES	5	5	5	5

**IF YES:** Please tell me the box and number for all the experiences that occurred together.

**IF YES, CIRCLE SX THAT CLUSTER AND SKIP TO C.**

**CIRCLE SYMPTOMS THAT CLUSTER. MUST BE 3 FROM DIFFERENT BOXES. DO NOT COUNT SYMPTOMS THAT OCCURRED AS A RESULT OF AN ISOLATED INCIDENT.**

**IF NO, ASK B.**

- B. Was there ever a period lasting a month or longer when you had experiences from 2 boxes occurring together?

NO	1	1	1	1
YES	5	5	5	5

**IF YES:** Please tell me the box and number for all the experiences that occurred together.

**IF YES, CIRCLE SX THAT CLUSTER AND ASK C.**

**CIRCLE SYMPTOMS THAT CLUSTER. MUST BE FROM 2 DIFFERENT BOXES. DO NOT COUNT SYMPTOMS THAT OCCURRED AS A RESULT OF AN ISOLATED INCIDENT.**

**IF NO, SKIP TO BOX H18B.**

- C. How old were you the (first/last) time you had experiences from 3(2) boxes occur within a period lasting a month or longer?

AGE ONS:	—	—	—	—
ONS:	—	—	—	—
AGE REC:	—	—	—	—
REC:	—	—	—	—

DSM-IV

**BOX H18B IF 3 OR MORE BOXES MARKED ON TALLY B, CONTINUE. OTHERS SKIP TO BOX H19.**

DD4

H19

**HAND R DRUG TALLY B.**

A. Was there ever a 12-month period in which you had experiences from 3 or more boxes?

	1	2	3	4
	<i><u>MJ</u></i>	<i><u>STIM</u></i>	<i><u>SED</u></i>	<i><u>OTH</u></i>
NO	1	1	1	1
YES	5	5	5	5

**IF YES:** Please tell me the box and number for all the experiences that occurred during the same 12-month period even if it didn't last the full 12 months.

**IF YES, CIRCLE SX THAT CLUSTER AND ASK B.**

**IF NO, SKIP TO BOX H19.**

**CIRCLE SX THAT CLUSTER. MUST BE FROM 3 DIFFERENT BOXES. DO NOT COUNT SX RESULTING FROM AN ISOLATED INCIDENT.**

B. How old were you the (first/last) time you had experiences from 3 or more boxes occur together within a period lasting 12 months or longer?

AGE ONS:	—	—	—	—
ONS:	—	—	—	—
AGE REC:	—	—	—	—
REC:	—	—	—	—

**BOX H19 IF 2 OR MORE BOXES MARKED ON TALLY A, CONTINUE. OTHERS SKIP TO H21.**

(22) H20 Since the age of (ONS), has there ever been a period of time lasting 3 months or longer when you did not use (DRUG) at all? **FOR EACH YES, ASK A.**

		1	2	3	4
		<u>MJ</u>	<u>STIM</u>	<u>SED</u>	<u>OTH</u>
NO		1	1	1	1
YES		5	5	5	5

A. When did (that/these) occur?

	<u>MO</u>	<u>YEAR</u>	<u>MO</u>	<u>YEAR</u>	<u>MO</u>	<u>YEAR</u>	<u>MO</u>	<u>YEAR</u>
MJ	___/___	___	TO	___/___	___	___/___	TO	___/___
	___/___	___	TO	___/___	___	___/___	TO	___/___
STIM	___/___	___	TO	___/___	___	___/___	TO	___/___
	___/___	___	TO	___/___	___	___/___	TO	___/___
SED	___/___	___	TO	___/___	___	___/___	TO	___/___
	___/___	___	TO	___/___	___	___/___	TO	___/___
OTH	___/___	___	TO	___/___	___	___/___	TO	___/___
	___/___	___	TO	___/___	___	___/___	TO	___/___

(17) H21 Have you ever brought up any problem you might have had with drugs with any professional?

NO	.... (SKIP TO H22)	1
YES	.....	5

A. Did you speak with:

	<u>NO</u>	<u>YES</u>
1. A psychiatrist? .....	1	5
2. Another medical doctor? .....	1	5
3. A psychologist? .....	1	5
4. Another mental health professional? .....	1	5
5. A member of the clergy? .....	1	5
6. Anyone else? <b>SPECIFY:</b> .....	1	5

B. How old were you the (first/last) time you brought up any problem you had with drugs?

AGE ONS:	1	2	3	4	5
ONS:					
AGE REC:					
REC:	1	2	3	4	5

C. With whom did you speak first?

**RECORD CODE (1-6).**

CODE: \_\_\_\_

(18) H22 Have you ever been treated for a problem with drugs?

NO	.... (SKIP TO D)	1
YES	.....	5

FGNDRB  
FGNDRB

A. Were you treated:

	<u>NO</u>	<u>YES</u>
1. at an outpatient drug-free program? . . . . .	1	5
2. at an outpatient program for something other than drugs? . . . . .	1	5
3. at an inpatient drug-free program? . . . . .	1	5
4. when inpatient for medical complications due to drug use? . . . . .	1	5
5. at any other place or program? <b>IF YES, SPECIFY.</b> . . . . .	1	5

**SPECIFY:** \_\_\_\_\_

B. How old were you the (first/last) time you were treated for a drug problem?

AGE ONS: \_\_\_\_\_/\_\_\_\_\_  
ONS: 1 2 3 4 5

AGE REC: \_\_\_\_\_/\_\_\_\_\_  
REC: 1 2 3 4 5

C. Where were you treated first?

CODE: \_\_\_\_

**RECORD CODE (1-5)**

D. Did you ever attend a self-help group (like NA) because you had a problem with drugs?

NO . . . (SKIP TO 11, p. 67) . . . 1  
YES . . . . . 5

1. How old were you the (first/last) time you attended a self-help group for drug abuse?

AGE ONS: \_\_\_\_\_/\_\_\_\_\_  
ONS: 1 2 3 4 5

AGE REC: \_\_\_\_\_/\_\_\_\_\_  
REC: 1 2 3 4 5



**BEGIN SCORING TALLY SHEET FOR SECTION I.**

**FOR ANY AGE ONS THAT R SAYS "DK", ASK: Do you think it was before your 13th birthday or was it later than that?**

**A/D PROBE: Did this ever happen when you were under the influence of alcohol (or drugs)?**

**[IF YES:] Did this only happen when you were under the influence of alcohol (or drugs)?**

**UNDER 13 ..... RECORD -1**  
**13-14 ..... RECORD -2**  
**15-17 ..... RECORD -3**  
**18 OR OLDER .... RECORD -4**

**ONLY ALC/DRUGS = 3**  
**NEVER ALC/DRUGS = 5**  
**BOTH = 6**

Now I'd like to ask you some questions about when you were younger.

I1 Except for your senior year in high school, did you ever play hooky from school for an entire day? NO .... (SKIP TO I2) .... 1  
 YES ..... 5

A. Did this ever happen twice in 1 year? NO .... (SKIP TO I2) .... 1  
 YES ..... 5

ASP3RB1  
 CD3RA5  
 CD4A15  
 CDICD18  
 FGNASPA

B. How old were you the first time you played hooky twice in one year? **MARK TALLY IF AGE ONSET BEFORE 13.** AGE ONS: \_\_\_\_/\_\_\_\_ A

I2 Were you ever suspended or expelled from school? NO .... (SKIP TO I3) .... 1  
 YES ..... 5

FGNASPA

A. How old were you the first time? AGE ONS: \_\_\_\_/\_\_\_\_

FGNASPB

I3 Did you ever run away from home overnight? NO .... (SKIP TO I4) .... 1  
 YES ..... 5

A. Why did you run away?  
 \_\_\_\_\_  
**CODE SILENTLY:**  
 AVOID PHYSICAL ABUSE .. 2  
 AVOID SEXUAL ABUSE .... 3  
 OTHER ..... 4

ASP3RB2  
 CD3RA2  
 CD4A14  
 CDICD19

B. Did you run away overnight more than once? NO. .... (SKIP TO C) .... 1  
 YES ..... 5 A

1. How old were you the (first/last) time you ran away from home overnight? AGE ONS: \_\_\_\_/\_\_\_\_  
 AGE REC: \_\_\_\_/\_\_\_\_

**CODE AGES AND THEN SKIP TO I4.**

ASP3RB2  
 CD3RA2

C. After you ran away, did you return home? NO. .... (SKIP TO 2) .... 1 A  
 YES ..... 5

CD4A14  
 CDICD19

1. When you ran away, how long did you stay away from home? **CHECK TALLY IF AWAY FOR 7 OR MORE DAYS.** \_\_\_\_\_ DAYS A

2. How old were you? AGE ONS: \_\_\_\_/\_\_\_\_

CD4A13 CDICD12	I4	Did you ever stay out late at night without permission, either for 2 or more hours after the curfew your parents set or all night without permission?	NO .... (SKIP TO I5) ..... 1 YES ..... 5
	A. Did this happen 3 or more times?	NO. ....(SKIP TO I5) ..... 1 YES ..... 5	
B. How old were you the first time? <b>MARK TALLY IF AGE ONS LESS THAN 13.</b>	AGE ONS:      ___/___ A		
CD4A13 CDICD12	I5	Did you ever sneak out of the house at night after your parents thought you had gone to bed?	NO. .... (SKIP TO I6) ..... 1 YES ..... 5
	A. Did this happen 3 or more times?	NO. .... (SKIP TO I6) ..... 1 YES ..... 5	
B. How old were you the first time? <b>MARK TALLY IF AGE ONS LESS THAN 13.</b>	AGE ONS:      ___/___ A		
(7) CD3RA11 CD4A2	I6	Did you 3 or more times start physical fights <u>with</u> your brothers or sisters?	NO .... (SKIP TO B) ..... 1 ALC/DRUGS ONLY ..... 3 YES, CLEAN ..... 5 A,B BOTH A/D & CLEAN .... 6 A,B
	A. At what age did you (first/last) start fights with siblings?	AGE ONS:      ___/___	
ASP3RB3 FGNASPF	A1. UNRELATED TO ALC/DRUGS.	AGE ONS A/D:      ___/___	
	A2. IN CONTEXT OF ALC/DRUGS.	AGE REC:      ___/___	
	A3. RECENCY.	NO .... (SKIP TO D) ..... 1 ALC/DRUGS ONLY ..... 3 YES, CLEAN ..... 5 A,B BOTH A/D & CLEAN .... 6 A,B	
CD3RA11 CD4A2 CDICD10	B. Did you 3 or more times start physical fights with persons <u>other than</u> your brothers and sisters?		
	C. At what age did you (first/last) start fights with persons other than siblings?		
ASP3RB3 FGNASPF	C1. UNRELATED TO ALC/DRUGS.	AGE ONS A/D:      ___/___	
	C2. IN CONTEXT OF ALC/DRUGS.	AGE REC:      ___/___	
	C3. RECENCY.	NO ....(SKIP TO I7) ..... 1 ALC/DRUGS ONLY ..... 3 YES, CLEAN ..... 5 B BOTH A/D & CLEAN .... 6 B	
ASP3RC3 ASP4A4 FGNASPF DSICDB4	D. (Even though you didn't start fights,) since your 15th birthday, have you been in 3 or more physical fights (other than in combat or as part of your job)? <b>DO NOT COUNT FIGHTS WITH SIBLINGS UNLESS SOMEONE WAS HURT.</b>		
	E. How old were you the (first/last) time?		
	E1. UNRELATED TO ALC/DRUGS.	AGE ONS A/D:      ___/___	
E2. IN CONTEXT OF ALC/DRUGS.	AGE REC:      ___/___		
E3. RECENCY.			

(12) CDICD3	I7	When you were younger did you <u>often</u> challenge your parents, teachers, or other adults by refusing to do things they asked you to do, just because you didn't want to? For example, refusing to do things like chores or running errands, refusing to participate in class, or not behaving well?	NO . . . . (SKIP TO I8) . . . . 1 YES . . . . . 5
		A. How old were you the first time?	AGE ONS: ____/____
(13) CDICD1 FGNASPF	I8	As a child, when things did not go your way, did you <u>often</u> throw temper tantrums, that is, you would throw things or lie on the ground and scream?	NO . . . . (SKIP TO I9) . . . . 1 YES . . . . . 5
		A. How old were you the first time?	AGE ONS: ____/____
(14) CD4A1 CDICD22	I9	Did people complain that you were <u>often</u> a bully, deliberately hurting, threatening, or being mean to other children?	NO . . . . (SKIP TO I10) . . . . 1 YES . . . . . 5 A,B
		A. How old were you the (first/last) time?	AGE ONS: ____/____ AGE REC: ____/____
(15) CD3RA8 CD4A5 CDICD14	I10	Did you ever hurt or injure a pet or any other animal on purpose? <b>SPECIFY:</b> _____	NO . . . . (SKIP TO I11) . . . . 1 YES . . . . (SPECIFY) . . . . 5 A,B
		A. How many times?	____ TIMES
ASP3RB6		B. How old were you the (first/last) time?	AGE ONS: ____/____ AGE REC: ____/____

(4) CD3RA3	I11 Throughout your life have you told <u>a lot</u> of lies?	NO ..... 1 ALC/DRUGS ONLY ..... 3 YES, CLEAN ..... 5 A BOTH A/D & CLEAN .... 6 A
CD3RA3 CD4A11 CDICD9	A. Did you <u>often</u> lie to get your own way, or to get out of trouble?	NO ..... 1 ALC/DRUGS ONLY ..... 3 YES, CLEAN ..... 5 A BOTH A/D & CLEAN .... 6 A
	B. Have you ever used an alias or a false name? <b>EXCLUDE MINORS USING FALSE ID TO BUY ALCOHOL OR ENTER A BAR.</b>	NO . (SKIP TO BOX I11) .. 1 ALC/DRUGS ONLY ..... 3 YES, CLEAN ..... 5 BOTH A/D & CLEAN .... 6
CD3RA3 CD4A11 CDICD9	B1. Did you ever do this to take advantage of a person or a situation?	NO ..... 1 YES ..... 5 A
<b>BOX I11 IF I11, I11A, AND I11B.1 ARE ALL CODED 1, SKIP TO I12. OTHERS CONTINUE.</b>		
ASP3RB10 ASP3RC6 ASP4A2	C. How old were you when you (first/last) (told a lot of lies / used an alias to take advantage of someone)? C1. UNRELATED TO ALC/DRUGS. C2. IN CONTEXT OF ALC/DRUGS. C3. RECENCY.	AGE ONS: ____/____ AGE ONS A/D: ____/____ AGE REC: ____/____
CDICD5 DSICDB6	I12 When something went wrong that was your fault, did you <u>usually</u> try to get out of it by blaming others?	NO .... (SKIP TO I13) .... 1 ALC/DRUGS ONLY ..... 3 YES, CLEAN ..... 5 BOTH A/D & CLEAN .... 6
	A. How old were you the (first/last) time? A1. UNRELATED TO ALC/DRUGS. A2. IN CONTEXT OF ALC/DRUGS. A3. RECENCY.	AGE ONS: ____/____ AGE ONS A/D: ____/____ AGE REC: ____/____
CD3RA3 CD4A11 CDICD9	I13 Did you <u>often</u> cheat on schoolwork, on exams, in games or anything like that?	NO ..... 1 YES ..... 5 A
CD3RA3 CD4A11 CDICD9	A. Have you often cheated on things as an adult? Examples include cheating at work or on taxes. <b>IF I13 AND I13A ARE BOTH CODED 1, SKIP TO I14. OTHERS CONTINUE.</b>	NO ..... 1 ALC/DRUGS ONLY ..... 3 YES, CLEAN ..... 5 A BOTH A/D & CLEAN .... 6 A
ASP3RB10 ASP3RC6 ASP4A2	B. How old were you the (first/last) time? B1. UNRELATED TO ALC/DRUGS. B2. IN CONTEXT OF ALC/DRUGS. B3. RECENCY.	AGE ONS: ____/____ AGE ONS A/D: ____/____ AGE REC: ____/____

(5) CD3RA1 CD4A12 CDICD17 DSICDB2	I14	Did you <u>more than once</u> steal money or things from your family, friends, or relatives? <b>COUNT ONLY IF MORE THAN A FEW DOLLARS.</b>	NO . . . . (SKIP TO B) . . . . 1 ALC/DRUGS ONLY . . . . 3 YES, CLEAN . . . . . 5 A,B BOTH A/D & CLEAN . . . . 6 A,B
ASP3RB11	A.	How old were you the (first/last) time? A1. UNRELATED TO ALC/DRUGS. A2. IN CONTEXT OF ALC/DRUGS. A3. RECENCY.	AGE ONS:     ___/___ AGE ONS A/D:     ___/___ AGE REC:     ___/___
CD3RA1 CD4A12 CDICD17 DSICDB2	B.	Did you <u>more than once</u> steal or shoplift from stores or from other people? (NO CONFRONTATION)	NO . . . . (SKIP TO D) . . . . 1 ALC/DRUGS ONLY . . . . 3 YES, CLEAN . . . . . 5 A,B BOTH A/D & CLEAN . . . . 6 A,B
ASP3RB11	C.	How old were you the (first/last) time? C1. UNRELATED TO ALC/DRUGS. C2. IN CONTEXT OF ALC/DRUGS. C3. RECENCY.	AGE ONS:     ___/___ AGE ONS A/D:     ___/___ AGE REC:     ___/___
CD3RA1 CD4A12 CDICD17 DSICDB2	D.	Did you <u>more than once</u> forge anyone's signature on a check or credit card without permission?	NO . . (SKIP TO BOX I14) . . 1 ALC/DRUGS ONLY . . . . 3 YES, CLEAN . . . . . 5 A,B BOTH A/D & CLEAN . . . . 6 A,B
ASP3RB11	E.	How old were you the (first/last) time? E1. UNRELATED TO ALC/DRUGS. E2. IN CONTEXT OF ALC/DRUGS. E3. RECENCY.	AGE ONS:     ___/___ AGE ONS A/D:     ___/___ AGE REC:     ___/___
<b>BOX I14 IF I14, I14B, AND I14D ARE ALL CODED 1, SKIP TO I15. OTHERS CONTINUE.</b>			
ASP3RC2 ASP4A1	F.	Since your 15th birthday, have you stolen things (or forged a signature without permission) 3 or more times?	NO . . . . . 1 YES . . . . . 5

---

(18) CD3RA6 CD4A10 CDICD23 DSICDB2	I15	Did you ever break into someone else's home, car, or building ( <u>not</u> because you were locked out)?	NO . . . . (SKIP TO I16) . . . . 1 ALC/DRUGS ONLY . . . . 3 YES, CLEAN . . . . . 5 A,B BOTH A/D & CLEAN . . . . 6 A,B
	A.	How old were you the (first/last) time? A1. UNRELATED TO ALC/DRUGS. A2. IN CONTEXT OF ALC/DRUGS. A3. RECENCY.	AGE ONS:     ___/___ AGE ONS A/D:     ___/___ AGE REC:     ___/___
ASP3RC2 ASP4A1	B.	Has this happened 3 or more times since you were 15?	NO . . . . . 1 YES . . . . . 5

(19) CD3RA12 CD4A6 CDICD20 DSICDB2	<b>I16</b> Have you ever taken money or property from someone else by threatening them or using force, like snatching a purse or robbing them?	NO .... (SKIP TO I17) .... 1 ALC/DRUGS ONLY ..... 3 YES, CLEAN ..... 5 A,B BOTH A/D & CLEAN .... 6 A,B
ASP3RB12	<b>A.</b> How old were you the (first/last) time?	
	A1. UNRELATED TO ALC/DRUGS.	AGE ONS:     ___/___
	A2. IN CONTEXT OF ALC/DRUGS.	AGE ONS A/D:     ___/___
	A3. RECENCY.	AGE REC:     ___/___
ASP3RC2 ASP4A1	<b>B.</b> Has this happened 3 or more times since you were 15?	NO ..... 1 YES ..... 5

---

(16) CD3RA4 DSICDB2	<b>I17</b> Did you ever deliberately set fires you were not supposed to?	NO .... (SKIP TO I18) .... 1 ALC/DRUGS ONLY ..... 3 YES, CLEAN ..... 5 BOTH A/D & CLEAN .... 6
CD4A8 CDICD16	<b>A.</b> Did you do this with the intention to damage property?	NO ..... 1 YES ..... 5 A,B
ASP3RB9 ASP3RC2 ASP4A1 DSICDB2	<b>B.</b> How old were you the (first/last) time?	
	B1. UNRELATED TO ALC/DRUGS.	AGE ONS:     ___/___
	B2. IN CONTEXT OF ALC/DRUGS.	AGE ONS A/D:     ___/___
	B3. RECENCY.	AGE REC:     ___/___
ASP3RC2	<b>C.</b> Has this happened 3 or more times since you were 15?	NO ..... 1 YES ..... 5

---

(6) CD3RA7 CD4A9 CDICD15 DSICDB2	<b>I18</b> Have you ever damaged someone's property on purpose (other than by fire setting)?  <b>SPECIFY:</b> _____ _____	NO .... (SKIP TO I19) .... 1 ALC/DRUGS ONLY ..... 3 YES, CLEAN ..... 5 A,B BOTH A/D & CLEAN .... 6 A,B
ASP3RB8	<b>A.</b> How old were you the (first/last) time?	
	A1. UNRELATED TO ALC/DRUGS.	AGE ONS:     ___/___
	A2. IN CONTEXT OF ALC/DRUGS.	AGE ONS A/D:     ___/___
	A3. RECENCY.	AGE REC:     ___/___
	<b>IF AGE ONS IS LESS THAN 15, ASK B.          OTHERS SKIP TO D.</b>	
	<b>B.</b> Did you more than once damage someone's property before you turned 15?	NO ..... 1 YES ..... 5
	<b>C.</b> Since your 15th birthday, have you damaged someone else's property on purpose?	NO .... (SKIP TO I19) .... 1 YES ..... 5

ASP3RC2  
ASP4A1

D. Have you done this 3 or more times since your  
15th birthday?

NO ..... 1  
YES ..... 5

(9)  
CD3RA13  
CD4A4  
CDICD13

I19 (Outside of fighting) have you ever physically injured  
anyone on purpose?

NO .... (SKIP TO I20) .... 1  
ALC/DRUG ONLY ..... 3  
YES, CLEAN ..... 5 A,B  
BOTH A/D & CLEAN .... 6 A,B

**SPECIFY:** \_\_\_\_\_  
\_\_\_\_\_

ASP3RB7  
ASP3RC3  
ASP4A4  
FGNASPF  
DSICDB4

A. How old were you the (first/last) time?

A1. UNRELATED TO ALC/DRUGS.

AGE ONS: \_\_\_\_/\_\_\_\_

A2. IN CONTEXT OF ALC/DRUGS.

AGE ONS A/D: \_\_\_\_/\_\_\_\_

A3. RECENCY.

AGE REC: \_\_\_\_/\_\_\_\_

(8)  
CD3RA10  
CD4A3  
CDICD11  
DSICDB4  
FGNASPF

I20 Did you ever use a weapon like a stick, gun, or a knife  
to injure someone (other than in combat or as part of  
your job)?

NO .... (SKIP TO I21) .... 1  
ALC/DRUG ONLY ..... 3  
YES, CLEAN ..... 5 A,B  
BOTH A/D & CLEAN .... 6 A,B

A. How old were you the (first/last) time?

A1. UNRELATED TO ALC/DRUGS.

AGE ONS: \_\_\_\_/\_\_\_\_

A2. IN CONTEXT OF ALC/DRUGS.

AGE ONS A/D: \_\_\_\_/\_\_\_\_

A3. RECENCY.

AGE REC: \_\_\_\_/\_\_\_\_

(26)  
CD3RA9  
CD4A7  
CDICD21  
DSICDB4

I21 Have you ever forced anyone into any sexual activity?

NO . (SKIP TO BOX I22) .. 1  
ALC/DRUG ONLY ..... 3  
YES, CLEAN ..... 5 A,B  
BOTH A/D & CLEAN .... 6 A,B

A. How old were you the (first/last) time?

A1. UNRELATED TO ALC/DRUGS.

AGE ONS: \_\_\_\_/\_\_\_\_

A2. IN CONTEXT OF ALC/DRUGS.

AGE ONS A/D: \_\_\_\_/\_\_\_\_

A3. RECENCY.

AGE REC: \_\_\_\_/\_\_\_\_

**BOX I22 IF 3 OR MORE MARKS IN PART A OF  
TALLY I, CONTINUE. OTHERS SKIP TO  
I23.**

(20)  
CD3R  
CD4A  
CDICD

I22 You mentioned that you (**LIST SX IN PART A OF TALLY I**). Did 3 or more of these ever happen within a 12-month period? **IF YES:** Which ones?  
**CIRCLE SX THAT CLUSTER.**

NO. . . . (SKIP TO I23) . . . . 1  
YES . . . . . 5

A. How old were you the (first/last) time?

AGE ONS: \_\_\_\_/\_\_\_\_

AGE REC: \_\_\_\_/\_\_\_\_

REC: 1 2 3 4 5

(21)

I23 Since your 15th birthday, have you ever...

<u>NO</u>	<u>ALC/ DRUGS ONLY</u>	<u>YES CLEAN</u>	<u>BOTH A/D &amp; CLEAN</u>
-----------	--------------------------------	----------------------	-------------------------------------

ASP3RC2  
ASP4A1  
DSICDB2

1. Deliberately written bad checks?

1	3	5	6
---	---	---	---

ASP3RC2  
ASP4A1  
DSICDB2

2. Received, sold, or bought stolen goods (fenced), sold drugs, or "run numbers" (illegally gambled)?

1	3	5	6
---	---	---	---

ASP3RC2  
ASP4A1  
DSICDB2  
FGNASPG

3. Been paid for having sex with someone?

1	3	5	6
---	---	---	---

a. **IF YES (3, 5, OR 6):** Were you paid with drugs?

NO . . . . . 1  
YES . . . . . 5

ASP3RC2  
ASP4A1  
DSICDB2  
FGNASPG

4. Found customers for male or female prostitutes or "call girls"?

1	3	5	6
---	---	---	---

**IF ALL CODED 1, CONTINUE.  
OTHERS SKIP TO B.**

ASP3RC2  
ASP4A1

A. Since your 15th birthday, have you ever done anything else that you could have been arrested for, even if you weren't (other than using drugs or underage drinking)?

NO . . . . (SKIP TO I24) . . . . 1  
ALC/DRUGS ONLY . . . . . 3  
YES, CLEAN . . . . . 5  
BOTH A/D & CLEAN . . . . 6

**SPECIFY:** \_\_\_\_\_  
\_\_\_\_\_

B. Did this happen 3 or more times?

NO . . . . . 1  
YES . . . . . 5

C. How old were you the (first/last) time?

C1. UNRELATED TO ALC/DRUGS.

AGE ONS: \_\_\_\_/\_\_\_\_

C2. IN CONTEXT OF ALC/DRUGS.

AGE ONS A/D: \_\_\_\_/\_\_\_\_

C3. RECENCY.

AGE REC: \_\_\_\_/\_\_\_\_



(33)  
ASP3RC4  
ASP4A6  
DSICDB2

I24 Since your 15th birthday, have you often failed to pay debts that you owed? Have you often had things you bought taken back, or often failed to take care of other financial responsibilities? (Examples: defaulting on credit card charges, loans from family or friends, car or house loans.)

NO . . . . (SKIP TO I25) . . . . 1  
ALC/DRUG ONLY . . . . . 3  
YES, CLEAN . . . . . 5  
BOTH A/D & CLEAN . . . . 6

- A. How old were you the (first/last) time?  
A1. UNRELATED TO ALC/DRUGS.  
A2. IN CONTEXT OF ALC/DRUGS.  
A3. RECENCY.

AGE ONS: \_\_\_\_/\_\_\_\_  
AGE ONS A/D: \_\_\_\_/\_\_\_\_  
AGE REC: \_\_\_\_/\_\_\_\_

Now I have a few questions about being responsible for a child.

I25 Before I ask, let me check, have you ever been responsible for a child for one year or longer?

NO. . . . (SKIP TO I26) . . . . . 1  
YES . . . . . 5

(34)  
ASP3RC4  
ASP4A6  
DSICDB2

A. Have you often not provided financial support for your family when you were supposed to? . . . . .

<u>NO</u>	<u>ALC/ DRUGS ONLY</u>	<u>YES CLEAN</u>	<u>BOTH A/D &amp; CLEAN</u>
1	3	5 B	6 B

ASP3RC8E  
ASP4A5  
DSICDB2

B. Have you often left young children under 6 at home alone while you were out shopping or doing anything else? . . . . .

1	3	5 B	6 B
---	---	-----	-----

ASP3RC8D  
ASP4A6  
DSICDB2

C. Has a neighbor fed or taken care of a child of yours because no one was taking care of the child at home? . . . . .

1	3	5 B	6 B
---	---	-----	-----

ASP3RC8A  
ASP3RC8B  
ASP3RC8C  
ASP4A6  
DSICDB2

D. Has a nurse, social worker or teacher said that your child wasn't getting enough to eat, wasn't being kept clean, or wasn't getting needed medical attention? . . . . .

1	3	5 B	6 B
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ASP3RC8F  
ASP4A3  
DSICDB2

E. Have you more than once run out of money for food for your family because you had spent the food money on yourself or on going out? . . . . .

1	3	5 B	6 B
---	---	-----	-----

**IF ALL CODED 1, SKIP TO I26.  
OTHERS CONTINUE.**

F. How old were you the (first/last) time this happened?

F1. UNRELATED TO ALC/DRUGS.

AGE ONS: \_\_\_\_/\_\_\_\_

F2. IN CONTEXT TO ALC/DRUGS.

AGE ONS A/D: \_\_\_\_/\_\_\_\_

F3. RECENCY.

AGE REC: \_\_\_\_/\_\_\_\_

(27)  
ASP3RC3  
ASP4A4  
DSICDB4  
FGNASPE

I26 Have you ever been accused of child abuse or been the subject of a complaint on the child abuse hotline?

NO . . . . (SKIP TO I27) . . . . 1  
ALC/DRUG ONLY . . . . . 3  
YES, CLEAN . . . . . 5  
BOTH A/D & CLEAN . . . . 6

A. How old were you the (first/last) time?

A1. UNRELATED TO ALC/DRUGS.

AGE ONS: \_\_\_\_/\_\_\_\_

A2. IN CONTEXT OF ALC/DRUGS.

AGE ONS A/D: \_\_\_\_/\_\_\_\_

A3. RECENCY.

AGE REC: \_\_\_\_/\_\_\_\_

(28)  
ASP3RC3  
ASP4A4  
DSICDB4  
FGNASPF

I27 Since you were 15, have you often hit, physically attacked, or thrown things at anyone (including your wife/husband/partner/children)?

NO . . . . (SKIP TO I28) . . . . 1  
ALC/DRUG ONLY . . . . . 3  
YES, CLEAN . . . . . 5 B  
BOTH A/D & CLEAN . . . . 6 B

A. How old were you the (first/last) time?

A1. UNRELATED TO ALC/DRUGS.

AGE ONS: \_\_\_\_/\_\_\_\_

A2. IN CONTEXT OF ALC/DRUGS.

AGE ONS A/D: \_\_\_\_/\_\_\_\_

A3. RECENCY.

AGE REC: \_\_\_\_/\_\_\_\_

(10)  
ASP3RC7  
ASP4A5

I28 Have you ever had a traffic ticket for a moving violation (things like speeding, running a red light, or causing an accident)?

NO . . . . (SKIP TO I29) . . . . 1  
ALC/DRUG ONLY . . . . . 3  
YES, CLEAN . . . . . 5  
BOTH A/D & CLEAN . . . . 6

FGNASPC  
DSICDB2

A. How many tickets have you received in your life?  
**IF DK, ASK A1. OTHERS SKIP TO B.**

\_\_\_\_ TICKETS

FGNASPC  
DSICDB2

A1. Was it at least 4?

NO . . . . . 1  
YES . . . . . 5

B. How old were you the (first/last) time?

B1. UNRELATED TO ALC/DRUGS.

AGE ONS: \_\_\_\_/\_\_\_\_

B2. IN CONTEXT OF ALC/DRUGS.

AGE ONS A/D: \_\_\_\_/\_\_\_\_

B3. RECENCY.

AGE REC: \_\_\_\_/\_\_\_\_

(11)  
ASP3RC2  
ASP4A1  
DSICDB2

I29 Have you ever been arrested for anything other than moving violations? **IF YES, SPECIFY. DO NOT COUNT DRUNK & DISORDERLY CONDUCT OR PUBLIC INTOXICATION.**  
REASON(S): \_\_\_\_\_

NO . . . . (SKIP TO I30) . . . . 1  
ALC/DRUG ONLY . . . . . 3  
YES, CLEAN . . . . . 5  
BOTH A/D & CLEAN . . . . 6

	A. How old were you the (first/last) time you were arrested?	
	A1. UNRELATED TO ALC/DRUGS.	AGE ONS: ____/____
	A2. IN CONTEXT OF ALC/DRUGS.	AGE ONS A/D: ____/____
	A3. RECENCY.	AGE REC: ____/____
FGNASPC	B. How many times have you been arrested (other than for moving violations)?	____ TIMES
FGNASPC	C. Have you ever been convicted of a felony? <b>SPECIFY:</b> _____	NO ..... 1 YES.....(SPECIFY) ..... 5
	D. Have you ever spent time in jail for something other than <u>using</u> drugs or alcohol? <b>SPECIFY:</b> _____	NO .... (SKIP TO I30) .... 1 YES.....(SPECIFY) ..... 5
DSICDB5	E. Since you got out of jail have you ever been arrested for things other than <u>using</u> drugs or alcohol? <b>SPECIFY:</b> _____	NO ..... 1 YES..... (SPECIFY) ..... 5

---

(29) ASP3RC1C ASP4A3 DSICDB2 FGNASPD	I30	Since you were 15, have you quit 3 or more jobs before having another job lined up?	NO ..... 1 ALC/DRUG ONLY ..... 3 YES, CLEAN ..... 5 BOTH A/D & CLEAN .... 6
		<b>IF 5 OR 6, SKIP TO I31. OTHERS CONTINUE.</b>	
ASP3RC1C ASP4A3 DSICDB2 FGNASPD		A. Since you were 15, have you dropped out of 3 or more academic programs? <b>INCLUDE GED AND TECHNICAL TRAINING PROGRAMS.</b>	NO ..... 1 ALC/DRUG ONLY ..... 3 YES, CLEAN ..... 5 BOTH A/D & CLEAN .... 6

---

(30) ASP3RC1B ASP4A6 DSICDB2	I31	On <u>any</u> job you have had since you were 15, have you frequently been late or absent?	NO. .... (SKIP TO I32) .... 1 ALC/DRUG ONLY ..... 3 YES, CLEAN ..... 5 BOTH A/D & CLEAN .... 6
		A. What were some reasons? _____ _____	
		B. How old were you the (first/last) time?	
		B1. UNRELATED TO ALC/DRUGS.	AGE ONS: ____/____
		B2. IN CONTEXT OF ALC/DRUGS.	AGE ONS A/D: ____/____
		B3. RECENCY.	AGE REC: ____/____
		C. Were you reprimanded 3 or more times or ever fired because you were frequently late or absent?	NO ..... 1 YES ..... 5

---

(31)	I32	In the last 5 years, have you been without a job for 6 months or more?	NO .... (SKIP TO I33) .... 1 YES ..... 5
ASP3RC1A ASP4A6 DSICDB2 FGNASPD		A. Was this when you were in school, laid off, sick, on strike, a full-time homemaker, retired, or in jail?	NO, ANOTHER REASON ... 1 YES.... (SKIP TO I33) .... 5
		B. Were you having problems with alcohol or drugs at that time?	NO ..... 1 YES ..... 5

---

(32) ASP3RC5 ASP4A3 DSICDB2 FGNASPH	I33	Since your 15th birthday, have you ever traveled around without any arrangements or had no regular place to live for a month or more? <b>DO NOT COUNT VACATIONS.</b>	NO .... (SKIP TO I34) .... 1 YES ..... 5
		A. How old were you the (first/last) time?	AGE ONS:    ___/___ AGE REC:    ___/___
		B. Were you having problems with alcohol or drugs at that time?	NO ..... 1 YES ..... 5

---

Now I'm going to ask you a few more questions about your relationships and your sexual experiences.

(22) DSICDB3	I34	Since you were 18, have you ever had a close personal friendship or love relationship that lasted continuously for more than 1 year?	NO ..... 1 YES ..... 5 N/A ... (CURRENTLY 18) ... 9
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(23)	I35	How old were you when you first had sexual intercourse (voluntarily)?	AGE ONS:    ___/___
		<div style="border: 1px solid black; padding: 5px; background-color: #f0f0f0;"> <b>BOX I35    IF NEVER, CODE 00 AND SKIP TO I38.</b> </div>	
FGNASPG		A. How many sexual partners have you had in your life?	_____ NUMBER
		<b>IF 1, SKIP TO I37. IF 2-9, SKIP TO I36. OTHERS CONTINUE.</b>	
FGNASPG		B. Have you ever had sex with 10 different people within a single year?	NO ..... 1 YES ..... 5

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(24)	I36	Have you ever been unfaithful to any person in a romantic or love relationship; that is, when you had an affair or one-night stand?	NO .... (SKIP TO I37) .... 1 ALC/DRUG ONLY ..... 3 YES, CLEAN ..... 5 BOTH, A/D & CLEAN .... 6
(25) DSICDB3 FGNASPE		A. Did this happen 3 or more times?	NO ..... 1 YES ..... 5
ASP3RC9 DSICDB3		B. Have you ever been faithful to 1 person for more than 1 year (that is, when you did not have any other sexual relationships)? <b>IF NEVER HAD A 1-YEAR RELATIONSHIP, CODE 9.</b>	NO, NEVER FAITHFUL .. 1 B YES, WAS FAITHFUL .... 5 N/A ..... 9

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ASP3RC7 ASP4A5	I37	Have you more than once had unprotected sex (without a condom) with someone you believed could give you a disease, or when you had a disease that could be spread that way?	NO ..... 1 ALC/DRUG ONLY ..... 3 YES, CLEAN ..... 5 BOTH A/D & CLEAN .... 6
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ASP3RC7 ASP4A5	I38	Have you <u>often</u> taken chances where you or someone else might get physically hurt? For example, playing with fireworks or guns in a reckless manner?	NO ..... 1 ALC/DRUG ONLY ..... 3 YES, CLEAN ..... 5 BOTH A/D & CLEAN .... 6
		<b>SPECIFY:</b> _____	
ASP3RC7 ASP4A5	A.	Have you <u>often</u> taken chances when driving--like racing a train to a crossing, or drag racing?	NO ..... 1 ALC/DRUG ONLY ..... 3 YES, CLEAN ..... 5 BOTH A/D & CLEAN .... 6
		<b>SPECIFY:</b> _____	

**BOX I38 IF I38 AND I38A ARE BOTH CODED 1, SKIP TO I39. OTHERS CONTINUE.**

	B.	How old were you the (first/last) time?	
	B1.	UNRELATED TO ALC/DRUGS.	AGE ONS: ____/____
	B2.	IN CONTEXT OF ALC/DRUGS.	AGE ONS A/D: ____/____
	B3.	RECENCY.	AGE REC: ____/____

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(17)	I39	Was there ever a time when you really enjoyed conning people to the point that you would <u>often</u> go out of your way to put something over on them?	NO .... (SKIP TO I40) .... 1 ALC/DRUG ONLY ..... 3 YES, CLEAN ..... 5 BOTH A/D & CLEAN .... 6
	A.	How old were you the (first/last) time?	
	A1.	UNRELATED TO ALC/DRUGS.	AGE ONS: ____/____
	A2.	IN CONTEXT OF ALC/DRUGS.	AGE ONS A/D: ____/____
	A3.	RECENCY.	AGE REC: ____/____
ASP3RC6 ASP4A2	B.	Did this happen 3 or more times since your 15th birthday?	NO ..... 1 YES ..... 5

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(35) ASP3RC10 ASP4A7 DSICDB1	I40	Have you <u>often</u> ignored the feelings of others in order to do what <u>you</u> wanted?	NO ..... 1 ALC/DRUG ONLY ..... 3 YES, CLEAN ..... 5 BOTH A/D & CLEAN .... 6
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(35) ASP3RC3 CDICD6/7 DSICDB6	I41	Have you <u>often</u> felt irritable, angry, or resentful (that is, you <u>frequently</u> lost your temper, or it was easy to annoy you or make you mad)?	NO ..... 1 ALC/DRUG ONLY ..... 3 YES, CLEAN ..... 5 BOTH A/D & CLEAN .... 6
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(37)  
CDICD5  
DSICDB6

I42 Have you often felt that others were to blame for your troubles or your mistakes?

NO ..... 1  
ALC/DRUG ONLY ..... 3  
YES, CLEAN ..... 5  
BOTH A/D & CLEAN .... 6

**BOX I43 REVIEW PART B OF TALLY SHEET I.  
IF 2 OR MORE ITEMS MARKED,  
CONTINUE. OTHERS SKIP TO I44.**

(38)

I43 Now I'd like to review some of these behaviors that you told me about. You said that since the age of 15 you **(LIST SX IN PART B)**. How old were you the last time you were in any of these situations?

AGE REC:        /  
REC:    1   2   3   4   5

DSICDB5  
ASP3RC10  
ASP4A7

A. When you were involved in any of the situations checked on this list, did you more often than not feel bad or guilty afterwards?

NO ..... 1  
YES .. (SKIP TO I44) ..... 5

DSICDB6

B. Was that because you felt the person(s) (or animals) involved deserved it more times than not?

NO ..... 1  
YES ..... 5

Now I would like to review some specific legal problems that you may have had. Have you ever been arrested or charged with any crime, other than a motor vehicle infraction?

NO. . . . .(SKIP TO C). . . . . 1  
YES . . . . (CONTINUE). . . . . 5

A. How many times in your life have you been arrested and charged with the following:

- A1. shoplifting/vandalism. . . . . \_\_\_/\_\_\_
- A2. parole/probation violations. . . . . \_\_\_/\_\_\_
- A3. drug charges. . . . . \_\_\_/\_\_\_
- A4. forgery. . . . . \_\_\_/\_\_\_
- A5. weapons offense. . . . . \_\_\_/\_\_\_
- A6. burglar, larceny, B & E . . . . . \_\_\_/\_\_\_
- A7. robbery . . . . . \_\_\_/\_\_\_
- A8. assault . . . . . \_\_\_/\_\_\_
- A9. arson . . . . . \_\_\_/\_\_\_
- A10. rape . . . . . \_\_\_/\_\_\_
- A11. homicide, manslaughter . . . . . \_\_\_/\_\_\_
- A12. prostitution . . . . . \_\_\_/\_\_\_
- A13. contempt of court . . . . . \_\_\_/\_\_\_
- A14. other . . . . . \_\_\_/\_\_\_

B. How many of these charges resulted in conviction?.. . . . \_\_\_/\_\_\_

C. How many times in your life have you been charged with the following:

- C1. Disorderly conduct, vagrancy, or public intoxication. . . . . \_\_\_/\_\_\_
- C2. Driving while intoxicated . . . . . \_\_\_/\_\_\_
- C3. Major driving violations (reckless driving, speeding, no license, etc.) . . . . . \_\_\_/\_\_\_

D. How many months have you been incarcerated in your life?.. . . . \_\_\_/\_\_\_

---

Now I'm going to ask you some questions about your mood.

DEPRDCA J1 Have you ever had a period of time lasting at least one week when you were bothered most of the day, nearly every day, by feeling depressed, sad, blue, or irritable? NO ..... 1  
YES ..... 5

---

J2 Have you ever had a period of time lasting at least one week when you lost interest or enjoyment in almost everything, even things you usually liked to do? NO ..... 1  
YES ..... 5

---

**BOX J2 IF J1 AND J2 BOTH CODED 1, SKIP TO K1, p. 101. OTHERS CONTINUE.**

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J3 During the past 30 days, have you been feeling depressed, uninterested in things, or unable to enjoy almost everything most of the day, nearly everyday, for at least one week? NO .... (SKIP TO J4) ..... 1  
YES ..... 5

A. For how long have you felt this way? \_\_\_\_\_ WEEKS

**BOX J3 SKIP TO J5.**

---

J4 Please tell me about the time in your life that stands out as the most severe period of feeling depressed, uninterested in things or irritable most of the day, nearly everyday. When did it begin? \_\_\_\_\_ / \_\_\_\_\_  
MO YEAR

DESCRIPTION: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

A. So you were \_\_\_\_\_ years old? AGE: \_\_\_\_\_

B. How long did that episode last? \_\_\_\_\_ WEEKS

**BOX J4**

A. DOES A CURRENT EPISODE EXIST (J3=5)? NO .. (SKIP TO J5) .. 1  
YES ..... 5

B. IS THE EPISODE IN J4 THE CURRENT EPISODE? NO .. (SKIP TO J5) .. 1  
YES ..... 5

C. IS THIS EPISODE CLEAN (BOX J13A=5)? NO .. (GO TO J5) ... 1  
YES . (SKIP TO J34) . 5

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Sometimes people have episodes of depression that follow the death of a loved one, heavy drinking or drug use, a change in medication, or a serious illness (or childbirth).

		CURRENT EPISODE (PAST MONTH)	MOST SEVERE EPISODE
(31)	J5 During the 6 weeks before <u>this</u> episode of feeling (depressed/uninterested/irritable) began, how many days a week did you <u>typically</u> drink alcohol?	DAYS: _____	DAYS: _____
	A. On the days you drank, how many drinks would you <u>typically</u> have in a day?	DRINKS: _____	DRINKS: _____
DEP3RB1 DEP4D	<b>CODE SILENTLY:</b> B. TYPICALLY 3+ (WOMAN) OR 5+ (MAN) DRINKS FOR 4+ DAYS/WEEK?	NO ..... 1 YES... (SKIP TO J6) .. 5*	NO ..... 1 YES ... (SKIP TO E) ... 5
	C. During the 6 weeks before this episode began, what was the <u>largest</u> number of drinks you had in one day?	DRINKS: _____	DRINKS: _____
DEP3RB1 DEP4D	D. Did you drink at least 5 drinks 2 or more times a week during the 6 weeks before this episode began?	NO ..... 1 YES ..... 5*	NO... (SKIP TO J6) .... 1 YES ..... 5
	E. <b>MOST SEVERE ONLY:</b> Did you have <u>another</u> episode of feeling (depressed/uninterested/irritable) for at least one week that <u>did not follow</u> a time when you had been drinking daily or almost daily (or heavily)?		NO. .... (SKIP TO J11) . 1* YES ..... 5
	F. When did this episode begin?		____ / ____ MO YEAR
	1. How old were you?		AGE: _____

REMIND R WHICH EPISODE AS NEEDED.	CURRENT EPISODE (PAST MONTH)	MOST SEVERE EPISODE
<p><b>IF NEVER USED DRUGS (F1=1, G1=1, &amp; H1=1), SKIP TO J7.</b></p> <p><b>HAND R CARD J.</b></p> <p>(30) DEP3RB1 DEP4D</p> <p>J6 During the 6 weeks before <u>this</u> episode of feeling (depressed/uninterested/irritable) began, did you use any of these street drugs or abuse any prescription drugs? <b>IF YES:</b> Which ones? <b>CIRCLE ON CARD J. CODE THE THREE USED MOST.</b></p> <p>A. Did you take any of these drugs for a high or intoxication <u>daily or almost daily</u>? <b>IF YES:</b> Which ones?</p> <p>B. During that time, on average, how many days per week did you take (DRUG) daily or almost daily?</p> <p>C. What is the <u>average</u> number of times you used (DRUG) on those days you used?</p> <p>D. During the 6 weeks before this episode began, what was the <u>largest</u> number of times you used (DRUG) in one day?</p> <p>E. On how many days during that 6-week period did you use (DRUG) that much (# IN D) in a day?</p> <p>F. <b>MOST SEVERE ONLY:</b> Did you have <u>another</u> episode of feeling (depressed/uninterested/irritable) for at least one week when it was <u>not</u> after a time when you had been drinking or using drugs daily or almost daily?</p> <p>G. When did this episode begin?</p>	<p>NO. . . . (SKIP TO J7) . . . 1 YES. . . . (SPECIFY) . . . . 5</p> <p>1: _____ _ _ _ _ 2: _____ _ _ _ _ 3: _____ _ _ _ _</p> <p>NO. . . . (SKIP TO D) . . . 1 YES. . . . (SPECIFY) . . . . 5*</p> <p>CIRCLE DRUG: 1 2 3</p> <p>DRUG 1: _____ DAYS DRUG 2: _____ DAYS DRUG 3: _____ DAYS</p> <p>DRUG 1: _____ AVG DRUG 2: _____ AVG DRUG 3: _____ AVG</p> <p>DRUG 1: _____ MAX DRUG 2: _____ MAX DRUG 3: _____ MAX</p> <p>DRUG 1: _____ DAYS DRUG 2: _____ DAYS DRUG 3: _____ DAYS</p> <p><b>SKIP TO J7.</b></p>	<p>NO. . . . (SKIP TO J7) . . . . 1 YES. . . . (SPECIFY) . . . . . 5</p> <p>1: _____ _ _ _ _ 2: _____ _ _ _ _ 3: _____ _ _ _ _</p> <p>NO. . . . (SKIP TO D) . . . . 1 YES . . . . (SPECIFY) . . . . . 5</p> <p>CIRCLE DRUG: 1 2 3</p> <p>DRUG 1: _____ DAYS DRUG 2: _____ DAYS DRUG 3: _____ DAYS</p> <p>DRUG 1: _____ AVG DRUG 2: _____ AVG DRUG 3: _____ AVG</p> <p>DRUG 1: _____ MAX DRUG 2: _____ MAX DRUG 3: _____ MAX</p> <p>DRUG 1: _____ DAYS DRUG 2: _____ DAYS DRUG 3: _____ DAYS</p> <p><b>IF J6A=1, SKIP TO J7. OTHERS CONTINUE.</b></p> <p>NO. . . . (SKIP TO J11) . . . 1* YES . . . . . 5</p> <p>_____/_____ MO YEAR</p>

REMIND R WHICH EPISODE AS NEEDED.	CURRENT EPISODE (PAST MONTH)	MOST SEVERE EPISODE
<div> <div>(29)</div> <div>DEP3RB1</div> <div>DEP4D</div> </div> <div> <div>J7</div> <div>           Did <u>this</u> episode of feeling            (depressed/uninterested/irritable            ) begin within 6 weeks of            starting or changing the dose of            prescription medication, such as            tranquilizers, pills for high            blood pressure, heart medicines,            or steroids?         </div> </div> <div> <div>A.</div> <div> <b>MOST SEVERE ONLY:</b>            Did you have <u>another</u>            episode of feeling            (depressed/            uninterested/irritable) for at            least one week that was <u>not</u>            after a time when you had a            change in prescription            medicines and was <u>not</u> after            a time when you had been            drinking or using drugs            daily or almost daily?         </div> </div> <div> <div>B.</div> <div>           When did this episode            begin?         </div> </div> <div> <div>1.</div> <div>How old were you?</div> </div>	<div>           NO. . . . (SKIP TO J8) . . . 1            YES. . . . (SPECIFY) . . . . 5*         </div> <div> <div>1.</div> <div>_____</div> <div>_____</div> </div> <div> <div>2.</div> <div>_____</div> <div>_____</div> </div> <div> <div>SKIP TO J8.</div> </div>	<div>           NO. . . . (SKIP TO J8) . . . . 1            YES. . . . (SPECIFY) . . . . 5         </div> <div> <div>1.</div> <div>_____</div> <div>_____</div> </div> <div> <div>2.</div> <div>_____</div> <div>_____</div> </div> <div> <div>NO. . . . (SKIP TO J11) . . . 1*</div> <div>YES . . . . . 5</div> </div> <div> <div>____/____</div> <div>MO YEAR</div> </div> <div> <div>AGE: ____</div> </div>

REMIND R WHICH EPISODE AS NEEDED.	CURRENT EPISODE (PAST MONTH)	MOST SEVERE EPISODE
<div> <div>(28)</div> <div>DEP3RB2</div> <div>DEP4E</div> </div> <div> <div>J8</div> <div> <div>A.</div> <div>Did this episode of feeling (depressed/uninterested/irritable) begin within 6 months of learning about the death of someone close to you?</div> </div> </div> <div> <div>B. MOST SEVERE ONLY:</div> <div>Did you have <u>another</u> episode of feeling (depressed/uninterested/irritable) for at least one week that <u>did not follow</u> the death of someone close to you, was <u>not</u> after a time when you had a change in prescription medicines, and was <u>not</u> after a time when you had been drinking or using drugs daily or almost daily?</div> </div> <div> <div>C.</div> <div>When did this episode begin?</div> </div> <div> <div>1.</div> <div>How old were you?</div> </div>	<div> <div>NO. . . . (SKIP TO J9) . . . 1</div> <div>YES. . . (SPECIFY) . . . . 5*</div> </div> <div> <div>RELATIONSHIP:</div> <div>_____</div> </div> <div> <div>DATE OF DEATH:</div> <div>____/____/____</div> <div>MO                  YEAR</div> </div> <div> <div>SKIP TO J9.</div> </div>	<div> <div>NO. . . . (SKIP TO J9) . . . . 1</div> <div>YES. . . (SPECIFY) . . . . . 5</div> </div> <div> <div>RELATIONSHIP:</div> <div>_____</div> </div> <div> <div>DATE OF DEATH:</div> <div>____/____/____</div> <div>MO                  YEAR</div> </div> <div> <div>NO. . . . (SKIP TO J11) . . . 1*</div> <div>YES . . . . . 5</div> </div> <div> <div>____/____/____</div> <div>MO                  YEAR</div> </div> <div> <div>AGE:    ____</div> </div>



**BOX J10** IF R IS MALE OR HAS NEVER BEEN PREGNANT, SKIP TO J12. OTHERS CONTINUE.

REMINDE R WHICH EPISODE AS NEEDED.		CURRENT EPISODE (PAST MONTH)	MOST SEVERE EPISODE
(27)	<p>J10 Did this episode of feeling (depressed/uninterested/irritable ) begin around the time of a childbirth, miscarriage, or abortion?</p> <p>A. Did it begin between the 2 weeks before to 6 weeks after the (birth/miscarriage/abortion)?</p> <p>B. <b>MOST SEVERE ONLY:</b> Did you have <u>another</u> episode of feeling (depressed/uninterested/irritable) for at least one week that was <u>not</u> around the time of childbirth, miscarriage, or abortion; was <u>not</u> after a time when you had a serious physical illness; was <u>not</u> after the death of someone close to you; was <u>not</u> after a change in medication; and was <u>not</u> after a time when you had been drinking or using drugs daily or almost daily?</p> <p>C. When did this episode begin?</p> <p>1. How old were you?</p>	<p>NO. . . (SKIP TO J12) . . . . 1 YES . . . . . 5</p> <p>NO . . . . . 1 YES . . . . . 5*</p> <p><b>SKIP TO J12.</b></p>	<p>NO. . . . (SKIP TO J12) . . . . 1 YES . . . . . 5</p> <p>NO. . . . (SKIP TO J11) . . . 1* YES . . . . . 5</p> <p>____ / ____ MO YEAR</p> <p>AGE: ____</p> <p><b>SKIP TO J12.</b></p>

**J11 IF NO CLEAN EPISODE EXISTS, CONTINUE THE SECTION ASKING ABOUT THE MOST SEVERE EPISODE CODED IN J4. REMIND R WHICH EPISODE TO FOCUS ON AS FREQUENTLY AS NEEDED.**

I'd like to (return to/focus on) the most severe episode of feeling (depressed/uninterested/irritable) when you were \_\_\_\_ years old (**CHECK J4A**).



Now I would like to ask you about other experiences you may have had during this episode of feeling (depressed/uninterested/irritable).

During this current episode . . . During this most severe episode when you were _____ years old . . .	CURRENT EPISODE (PAST MONTH)	MOST SEVERE EPISODE
(5) J14 A. Did you have a change in DEP3RA3 appetite (that was not due to DEP4A3 pregnancy, a physical DEPICDC7 condition, or dieting)? RDCB1	NO .. (SKIP TO B) ... 1 YES ..... 5+	NO ... (SKIP TO B) .... 1 YES ..... 5+
FGNB1 1. Increase or decrease?	INCREASE ..... 2 DECREASE ..... 3 BOTH ..... 4	INCREASE ..... 2 DECREASE ..... 3 BOTH ..... 4
DEP3RA3 B. Did you gain or lose weight DEP4A3 when you were not trying to DEPICDC7 (that was not due to RDCB1 pregnancy, a physical condition, or dieting)?	NO .. (SKIP TO J15) ... 1 YES ..... 5+	NO .. (SKIP TO J15) .... 1 YES ..... 5+
FGNB1 1. Gained or lost weight?	GAINED ..... 2 LOST ..... 3 BOTH ..... 4	GAINED ..... 2 LOST ..... 3 BOTH ..... 4
DEP3RA3 C. What was your weight before DEP4A3 the (gain/loss)? <b>IF BOTH,</b> RDCB1 <b>CODE THE MORE</b> <b>SIGNIFICANT CHANGE.</b>	_____ LBS	_____ LBS
DEP3RA3 D. What was your weight after DEP4A3 the (gain/loss)? RDCB1	_____ LBS	_____ LBS
DEP3RA3 E. Over what period of time did DEP4A3 you (gain/lose) this amount of RDCB1 weight?	_____ WEEKS	_____ WEEKS



During this current episode . . . During this most severe episode when you were _____ years old . . .			<b>CURRENT EPISODE (PAST MONTH)</b>	<b>MOST SEVERE EPISODE</b>
(6) DEPICDD6 RDCB2 FGNB2	J15	Did you have more trouble sleeping than usual?	NO . . . . (SKIP TO F) . . . 1 YES . . . . . 5	NO . . . . (SKIP TO F) . . . . 1 YES . . . . . 5
		A. Were you unable to fall asleep?	NO . . . . (SKIP TO C) . . . 1 YES . . . . . 5	NO . . . . (SKIP TO C) . . . . 1 YES . . . . . 5
		B. Was this for at least one hour?	NO . . . . . 1 YES . . . . . 5+	NO . . . . . 1 YES . . . . . 5+
		C. Did you wake up in the middle of the night and have trouble going back to sleep?	NO . . . . . 1 YES . . . . . 5+	NO . . . . . 1 YES . . . . . 5+
		D. Did you wake up too early in the morning?	NO . . . . (SKIP TO F) . . . 1 YES . . . . . 5	NO . . . . (SKIP TO F) . . . . 1 YES . . . . . 5
		E. Was this at least one hour earlier than usual?	NO . . . . . 1 YES . . . . . 5+	NO . . . . . 1 YES . . . . . 5+
DEP3RA4 DEP4A4		F. Did you sleep much more than usual?	NO . . . . . 1 YES . . . . . 5+	NO . . . . . 1 YES . . . . . 5+
(7) DEP3RA5 DEP4A5 DEPICDC5 RDCB4 FGNB4	J16	Were you so fidgety or restless that other people could have noticed?	NO . . . . . 1 YES . . . . . 5+	NO . . . . . 1 YES . . . . . 5+
(8) DEP3RA5 DEP4A5 DEPICDC5 RDCB4 FGNB4	J17	Were you moving or speaking so slowly that other people could have noticed?	NO . . . . . 1 YES . . . . . 5+	NO . . . . . 1 YES . . . . . 5+
(9) DEP3RA2 DEP4A2 FGNB5 RDCB5	J18	Were you much less interested in things or less able to enjoy sex or other pleasurable activities?	NO . . . . . 1 YES . . . . . 5+	NO . . . . . 1 YES . . . . . 5+
(10) DEP3RA6 DEP4A6 DEPICDB3 RDCB3 FGNB3	J19	Were you feeling a loss of energy or were you more tired than usual?	NO . . . . . 1 YES . . . . . 5+	NO . . . . . 1 YES . . . . . 5+
(11) DEP3RA7 DEP4A7 DEPICDC2 RDCB6 FGNB6	J20	Were you feeling excessively guilty or that you were a bad person?	NO . . . . . 1 YES . . . . . 5+	NO . . . . . 1 YES . . . . . 5+

During this current episode... During this most severe episode when you were ____ years old...		<b>CURRENT EPISODE (PAST MONTH)</b>	<b>MOST SEVERE EPISODE</b>
(12) DEP3RA7 DEP4A7 DEPICDC1 RDCB6 FGNB6	J21 Were you feeling that you were a failure or worthless?	NO ..... 1 YES ..... 5+	NO ..... 1 YES ..... 5+
(13) DEP3RA8 DEP4A8 DEPICDC4 RDCB7 FGNB7	J22 Were you having more difficulty than usual thinking, concentrating, or making decisions?	NO ..... 1 YES ..... 5+	NO ..... 1 YES ..... 5+
(14) DEP3RA9 DEP4A9 DEPICDC3 RDCB8 FGNB8	J23 Did you have thoughts of dying, or taking your life, or wishing you were dead? <b>DO NOT COUNT THINKING ABOUT THE DEATH OF A RECENTLY DECEASED OR DYING LOVED ONE.</b>	NO ..... 1 YES ..... 5+	NO ..... 1 YES ..... 5+
DEP3RA9 DEP4A9 DEPICDC3	A. Did you make a plan for committing suicide?	NO ..... 1 YES ..... 5+	NO ..... 1 YES ..... 5+
DEP3RA9 DEP4A9 DEPICDC3	B. Did you try to kill yourself?	NO ..... 1 YES ..... 5+	NO ..... 1 YES ..... 5+

**BOX J24 COUNT THE BOXES  
MARKED ON TALLY  
SHEET I**

**# OF BOXES: \_\_\_\_\_**

**IF FEWER THAN 4  
BOXES: GO BACK TO J4  
AND ASK ABOUT THE  
MOST SEVERE  
EPISODE.**

**IF ONLY 4 BOXES:  
SKIP TO J26.**

**IF 5 OR MORE BOXES:  
CONTINUE TO BOX J25.**

**# OF BOXES: \_\_\_\_\_**

**IF FEWER THAN 4  
BOXES: CHECK # OF  
BOXES IN CURRENT  
EPISODE. IF ALSO  
FEWER THAN 4 IN  
CURRENT, SKIP TO J34.  
IF 4 OR MORE IN  
CURRENT, RECONCILE  
WITH SUBJECT AND  
RECODE BOX J13 AS  
NECESSARY.**

**IF ONLY 4 BOXES:  
SKIP TO J26.**

**IF 5 OR MORE BOXES:  
CONTINUE TO BOX J25.**

	CURRENT EPISODE (PAST MONTH)	MOST SEVERE EPISODE
<b>BOX J25 IF R DENIES LOW MOOD, LOSS OF INTEREST, AND IRRITABILITY (BOX J13B=1), SKIP TO J25B. OTHERS CONTINUE.</b>		
<b>HAND R TALLY I.</b>		
(16) ENDORSES MOOD	J25 A. You told me you experienced the following <b>(REVIEW HEADINGS OF BOXES ENDORSED)</b> . Did you feel (depressed/uninterested/irritable) and have experiences from 4 or more other groups of problems nearly every day, for at least 2 weeks?  NO .. (SKIP TO J26) ... 1 YES ..... 5  <b>IF YES: Which ones?</b>  <b>CIRCLE MOOD AND SX THAT CLUSTER.</b> <b>NOTE: BOX A OR BOX B MUST BE INCLUDED.</b>  <b>SKIP TO D.</b>	NO .. (SKIP TO J26) ... 1 YES ..... 5  <b>IF YES: Which ones?</b>  <b>CIRCLE MOOD AND SX THAT CLUSTER.</b> <b>NOTE: BOX A OR BOX B MUST BE INCLUDED.</b>  <b>SKIP TO D.</b>
DENIES MOOD	B. You told me that during this episode you experienced <b>(REVIEW HEADINGS OF BOXES ENDORSED)</b> . During this episode, did you have experiences from 4 or more of these groups of problems nearly every day, for at least two weeks?  NO .. (SKIP TO J26) ... 1 YES ..... 5  <b>IF YES: Which ones?</b>  <b>CIRCLE SX THAT CLUSTER.</b>	NO .. (SKIP TO J26) ... 1 YES ..... 5  <b>IF YES: Which ones?</b>  <b>CIRCLE SX THAT CLUSTER.</b>
	C. During this period, did you also feel depressed or uninterested, (or irritable) in most things most of the day, nearly every day for at least 2 weeks?  NO .. (SKIP TO J26) ... 1 YES ..... 5	NO .. (SKIP TO J26) ... 1 YES ..... 5
	D. When did this episode begin (when you had these experiences nearly every day)?  ____ / ____ MO                      YEAR	____ / ____ MO                      YEAR
DEP3RA DEP4A DEPICDA RDCC FGNC	E. For how long did you feel (depressed/uninterested/irritable) and have experiences from at least 4 other groups of problems nearly every day?  ____ WEEKS	____ WEEKS

		CURRENT EPISODE (PAST MONTH)	MOST SEVERE EPISODE
(17) DEP4E RDCD	J26 During this episode, did you see or hear things that other people could not see or hear, that is, did you have hallucinations?	<div>CODE: 1 2 3 4 5</div> SPECIFY: _____  WHOM SAW: _____ WHAT TOLD: _____	<div>CODE: 1 2 3 4 5</div> SPECIFY: _____  WHOM SAW: _____ WHAT TOLD: _____
DEP4E RDCD	A. During this episode, did you have beliefs or ideas that you later found out were <u>not</u> true?	<div>CODE: 1 2 3 4 5</div> SPECIFY: _____  WHOM SAW: _____ WHAT TOLD: _____	<div>CODE: 1 2 3 4 5</div> SPECIFY: _____  WHOM SAW: _____ WHAT TOLD: _____
<p align="center"><b>IF ANY 5 IN J26 OR J26A CONTINUE. OTHERS SKIP TO J27.</b></p>			
	B. Did these (beliefs/ideas/hallucinations) occur before your (depressed mood/loss of interest/irritability)?	NO .. (SKIP TO D) .... 1 YES ..... 5	NO ... (SKIP TO D) ..... 1 YES ..... 5
	C. How long before your (depressed mood/loss of interest/irritability) began did you have these (beliefs/ideas/hallucinations)?	____ _ DAYS	____ _ DAYS
	D. Did you keep having these (beliefs/ideas/hallucinations) after your mood came back to normal?	NO (SKIP TO BOX J26) .. 1 YES ..... 5 EPISODE ONGOING ... 6  <b>IF ONGOING, SKIP TO BOX J26.</b>	NO (SKIP TO BOX J26) .. 1 YES ..... 5 EPISODE ONGOING .... 6  <b>IF ONGOING, SKIP TO BOX J26.</b>
DEP3RC RDCD4	E. How long did they last after your mood came back to normal?	____ _ DAYS	____ _ DAYS
<b>BOX J26 DID EXAMPLES IN J26 AND J26A HAVE CONTENT THAT WAS ENTIRELY CONSISTENT WITH THEMES OF PERSONAL INADEQUACY, GUILT, POVERTY, PUNISHMENT, ILLNESS, OR CATASTROPHE?</b>		NO ..... 1 YES ..... 5	NO ..... 1 YES ..... 5

		CURRENT EPISODE (PAST MONTH)	MOST SEVERE EPISODE
(19)	J27 During this episode, were you seen by a doctor, or other professional?	NO .. (SKIP TO J31) .... 1 YES .. (SPECIFY) ..... 5  _____ _____	NO .. (SKIP TO J31) ..... 1 YES .. (SPECIFY) ..... 5  _____ _____
(20)	J28 During this episode, were you prescribed medicine for depression (or were you already taking medicine for depression)?	NO ..... 1 YES .. (SPECIFY) ..... 5  1. _____ 2. _____	NO ..... 1 YES .. (SPECIFY) ..... 5  1. _____ 2. _____
(21)	J29 During this episode, did you receive ECT (shock treatments)?	NO ..... 1 YES ..... 5	NO ..... 1 YES ..... 5
(22) RDCC	J30 During this episode, were you hospitalized for depression?  A. For how long?	NO .. (SKIP TO J31) .... 1 YES ..... 5  _____ DAYS	NO .. (SKIP TO J31) ..... 1 YES ..... 5  _____ DAYS
(23)	J31 During this episode, were you (working/going to school) full-time?  A. What was your major responsibility during this episode?	NO ..... 1 YES . (SKIP TO J32) .... 5  PART-TIME JOB ..... 1 HOME ..... 2 PART-TIME SCHOOL .. 3 OTHER: _____ 4	NO ..... 1 YES . (SKIP TO J32) ..... 5  PART-TIME JOB ..... 1 HOME ..... 2 PART-TIME SCHOOL ... 3 OTHER: _____ 4
(24) DEP4C	J32 Did you have trouble functioning in this role?  A. Did something happen as a result of poor functioning?	NO .. (SKIP TO D) .... 1 YES ..... 5  NO ..... 1 YES .. (SPECIFY) ..... 5  _____ _____	NO ... (SKIP TO D) ..... 1 YES ..... 5  NO ..... 1 YES .. (SPECIFY) ..... 5  _____ _____
RDCE	B. Did anyone notice you had trouble functioning? (If no one was around, could someone have noticed this?)	NO ..... 1 YES ..... 5	NO ..... 1 YES ..... 5
DEP4C RDCE	C. Were you completely unable to function in this role for at least 2 days in a row?	NO ..... 1 YES ..... 5	NO ..... 1 YES ..... 5

D. Was your functioning in any other area of your life affected? (MINOR ROLE DYSFUNCTION)	NO ..... 1 YES .. (SPECIFY) ..... 5 _____ _____	NO ..... 1 YES .. (SPECIFY) ..... 5 _____ _____
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(25) **BOX J33 RATE FUNCTIONING:**

<b><u>INCAPACITATED</u> --</b> <b>(J32C=5) COMPLETELY UNABLE TO</b> <b>FUNCTION IN PRINCIPAL ROLE FOR</b> <b>2+ DAYS , OR</b> <b>(J30A=2+) HOSPITALIZED 2+ DAYS , OR</b> <b>(J29=5) ECT , OR</b> <b>(J26 OR J26A=5) PSYCHOTIC SYMPTOMS.</b>	<b>INCAPACITATED .... 5</b> <b>IMPAIRED ..... 4</b> <b>NEITHER ..... 1</b>	<b>INCAPACITATED .... 5</b> <b>IMPAIRED ..... 4</b> <b>NEITHER ..... 1</b>
<b><u>IMPAIRED</u> --</b> <b>(J32B=5 AND J32C=1) A DECREASE,</b> <b>NOTICEABLE TO OTHERS, IN</b> <b>QUALITY OF THE MOST IMPORTANT</b> <b>ROLE PERFORMANCE. THIS</b> <b>USUALLY REQUIRES A DECREASE IN</b> <b>THE AMOUNT OF PERFORMANCE.</b>	<b>GO BACK TO J4 AND</b> <b>ASK ABOUT MOST</b> <b>SEVERE EPISODE.</b>	

J34 Have you had at least one other severe episode when you were (depressed/uninterested in things/irritable) for at least one week that did not follow the death of a loved one, did not follow daily or (almost daily) use of alcohol or drugs, did not follow a serious physical illness, and did not follow a change in prescription medicines (**IF FEMALE:** and was not around the time of childbirth, miscarriage, or abortion)? **IF MORE THAN ONE ADDITIONAL CLEAN EPISODE, HAVE R PICK THE MOST SEVERE ONE.**

NO... (SKIP TO J35) .. 1  
YES ..... 5

A. How old were you then?

AGE: \_\_\_\_

B. During this episode:

**COUNT ONLY IF MORE THAN USUAL:**

	<u>NO</u>	<u>YES</u>
1. Were you depressed ( <b>IF AGE IN A&lt;18:</b> or irritable)? .....	1	5
2. Did you lose interest in pleasurable activities? .....	1	5
3. Did you have an increase or decrease in your appetite or weight? .....	1	5
4. Did you have any sleep difficulty or did you sleep too much? .....	1	5
5. Were you either more restless or more slowed down than usual? .....	1	5
6. Did you have a loss of energy or were you more tired than usual? .....	1	5
7. Did you feel excessively guilty or bad about yourself? .....	1	5
8. Did you have difficulty thinking or concentrating? .....	1	5
9. Did you have thoughts of dying or committing suicide, or did you make a suicide plan, or did you attempt suicide? .....	1	5

**IF FIVE OR MORE CODED 5 IN B.1-9 (INCLUDING B.1 AND/OR B.2), CONTINUE. OTHERS SKIP TO E.**

C. For how long were at least 5 of these problems present nearly every day, including feeling (depressed/uninterested in things/irritable)? **IF LESS THAN 2 WEEKS, SKIP TO E.**

\_\_\_\_ WEEKS

D. When did this episode begin (when you had these experiences together nearly every day)?

\_\_\_\_ / \_\_\_\_  
MO YEAR

E. Did you have trouble managing your work, school, or household responsibilities?

NO ..... 1  
YES... (SPECIFY)... 5

**SPECIFY:** \_\_\_\_\_

F. Did you seek help, receive any treatment (such as medications or ECT), or were you hospitalized during this episode?

NO... (SKIP TO J35) .. 1  
YES... (SPECIFY) ... 5

**SPECIFY:**

	<u>NO</u>	<u>YES</u>
1. Received professional help .....	1	5
2. Medications: _____ .....	1	5
		CODE: ____
		CODE: ____
3. ECT (shock treatment) .....	1	5
4. Hospitalized .....	1	5

J35 Have you had at least one other severe episode when you were (depressed/uninterested in things/irritable) for at least one week that may have followed the death of a loved one, daily (or almost daily) use of alcohol or drugs, a serious physical illness, or a change in prescription medicines (**IF FEMALE:** or childbirth, miscarriage, or abortion)? **IF MORE THAN ONE ADDITIONAL DIRTY EPISODE, HAVE R PICK THE MOST SEVERE ONE.**

NO... (SKIP TO J36) ... 1  
YES ..... 5

A. How old were you then?

AGE: \_\_\_\_

B. During this episode:

**COUNT ONLY IF MORE THAN USUAL:**

	NO	YES
1. Were you depressed ( <b>IF AGE IN A&lt;18:</b> or irritable)?	1	5
2. Did you lose interest in usually pleasurable activities?	1	5
3. Did you have an increase or decrease in your appetite or weight?	1	5
4. Did you have any sleep difficulty or did you sleep too much?	1	5
5. Were you either more restless or more slowed down than usual?	1	5
6. Did you have a loss of energy or were you more tired than usual?	1	5
7. Did you feel excessively guilty or bad about yourself?	1	5
8. Did you have difficulty thinking or concentrating?	1	5
9. Did you have thoughts of dying or committing suicide, or did you make a suicide plan, or did you attempt suicide?	1	5

**IF FIVE OR MORE CODED 5 IN B.1-9 (INCLUDING B.1 AND/OR B.2), CONTINUE. OTHERS SKIP TO E.**

C. For how long were at least 5 of these problems present nearly every day, including feeling (depressed/uninterested in things/irritable)? **IF LESS THAN 2 WEEKS, SKIP TO E.**

\_\_\_\_ WEEKS

D. When did this episode begin (when you had these experiences together nearly every day)?

\_\_\_\_ / \_\_\_\_  
MO YEAR

E. Did you have trouble managing your work, school, or household responsibilities?

NO ..... 1  
YES... (SPECIFY) ... 5

**SPECIFY:** \_\_\_\_\_

F. Did you seek help, receive any treatment (such as medications or ECT), or were you hospitalized during this episode?

NO... (SKIP TO J36) ... 1  
YES .. (SPECIFY) ... 5

**SPECIFY:**

	NO	YES
1. Received professional help	1	5
2. Medications: _____	1	5
		CODE: ____
		CODE: ____
3. ECT (shock treatment)	1	5
4. Hospitalized	1	5



(32F/33F)	J36	How many episodes of depression lasting a week or longer (such as the one(s) we have been talking about) have you had over your lifetime, <u>including</u> the one(s) we already talked about?	____ NUMBER
			AGE ONS:      ____/____
			ONS:          1 2 3 4 5
(34)	A.	How old were you the (first/last) time you had an episode of depression lasting a week or longer?	AGE REC:      ____/____
			REC:          1 2 3 4 5

**IF ANY 5 CODED IN J28, J29, J34F.2/3, OR J35F.2/3, CODE J37 "YES" SILENTLY:**

(35)	J37	Were you <u>ever</u> treated for depression with medication or ECT (shock treatment)?	NO. (SKIP TO BOX J38) 1 YES ..... 5
	A.	Did you ever feel high or were you overactive following treatment for depression with medication or ECT?	NO ..... 1 YES ..... 5

com.

**BOX J38 IF R HAD 1+ BOX MARKED ON ALCOHOL/COCAINE/OPIATE/OTHER DRUG TALLY SHEET A, CONTINUE. OTHERS SKIP TO K1, p. 101.**

**J38 FOR EACH EPISODE OF DEPRESSION, ASK A.**

A. You said you had an episode of feeling (depressed/sad/down/blue/irritable) that started at (AGE).

**IF 3R CLUSTERING ENDORSED ON ALCOHOL/COCAINE/OPIATE/OTHER DRUG TALLY SHEET A, HAND TALLY(IES) TO R AND ASK 1. OTHERS SKIP TO 2.**

CLUSTERING  
PER EPISODE

1. Around the time this episode of feeling (depressed/sad/down/blue/irritable) began, were you having experiences from 3 or more boxes found on this (ALCOHOL/COCAINE/OPIATE/OTHER DRUG) sheet?  
**IF NO, CONTINUE TO 2.**

**IF YES, RETURN TO J38A FOR NEXT EPISODE OF DEPRESSION. IF NO OTHER EPISODES, SKIP TO J38B.**

HEAVY USE  
PER EPISODE  
WHEN NOT  
CLUSTERING

2. Around the time this episode of feeling (depressed/sad/down/blue/irritable) began, were you (drinking heavily/using DRUGS) daily or almost daily?

**RETURN TO J38A FOR NEXT EPISODE OF DEPRESSION. IF NO OTHERS, SKIP TO J38B.**

B. So, according to the information that you have provided,

CLUSTERING  
FOR ALL  
EPISODES

- |  |   |
|--|---|
| 1. . . . your episodes of feeling (depressed/sad/down/blue/<br>irritable) (NEVER / SOMETIMES / ALWAYS) started<br>around a time when you were experiencing some problems<br>with alcohol,or drugs? | NEVER ..... 1<br>SOMETIMES ..... 3<br>ALWAYS (SKIP TO K1, p.101). 5 |
|--|---|

HEAVY USE  
FOR THE  
EPISODES  
WHEN NOT  
CLUSTERING

- |   |  |
|---|--|
| 2. . . . your episodes (that did <u>not</u> start when you were having<br>problems with alcohol or drugs) (NEVER / SOMETIMES<br>/ ALWAYS) started around a time when you were<br>drinking heavily or using drugs daily (or almost daily)? | NEVER ..... 1<br>SOMETIMES ..... 3<br>ALWAYS ..... 5 |
|---|--|
-

Now I'm going to ask you some other questions about your mood.

(1)  
MAN3RA1  
MAN4A  
MANICDA  
MANFGNA  
MANRDCA

K1 A. Have you ever had a period of time lasting 2 days or longer when you felt extremely hyper, elated (unrealistically happy), or manic most of the time, clearly different from your normal self? **DO NOT COUNT RECOVERY FROM DEPRESSION BACK TO NORMAL MOOD.**

NO .....	1
ALC/DRUGS ONLY ..	3
YES .....	5

MAN3RA2  
MAN4A  
MANICDA  
MANFGNA  
MANRDCA

B. Did you ever have a period of time lasting 2 days or longer (other than when you were depressed/withdrawing from drugs) when you felt unusually irritable most of the time, clearly different from your normal self, so that you would shout at people or start fights or arguments?

NO .....	1
ALC/DRUGS ONLY ..	3
YES .....	5

<b>BOX K1</b>	<b>DOES R ENDORSE MOOD? (A OR B CODED 5)</b>	<b>DENIES MOOD .....</b>	<b>(READ a)</b>	<b>1</b>
		<b>ENDORSES MOOD ..</b>	<b>(READ b)</b>	<b>5</b>

C. [a] Did you ever have a period of time lasting 2 days or longer, when you were not under the influence of alcohol or drugs, when you were...(READ 1-7)

**AFTER THE FIRST YES, ASK:** During this period were you also:

[b] You said you had a period of time of feeling (hyper, elated, irritable). I'm going to ask you about several other problems you might have had during this period. During this period were you also.... (READ 1-7).

	<u>NO</u>	<u>YES</u>
1. much more active than usual? .....	1	5
2. much more talkative than usual? .....	1	5
3. talking unusually fast or were your thoughts racing? .....	1	5
4. feeling very special, gifted with special powers? .....	1	5
5. <u>needing</u> much less sleep than usual? .....	1	5
6. more easily distracted than usual? .....	1	5
7. doing reckless or foolish things (spending sprees, reckless driving, affairs)? .....	1	5

**DO NOT COUNT RECOVERY FROM DEPRESSION BACK TO NORMAL MOOD. CODE SX ONLY IF MORE THAN USUAL AND ONLY IF LASTED FOR 2 OR MORE DAYS.**

**BOX K1A IF 2 OR MORE 5'S ARE CODED IN K1D.1-7, CONTINUE TO BOX K1B. OTHERS SKIP TO K31, p. 113.**

**BOX K1B IF R ENDORSES MOOD (BOX K1=5), SKIP TO K3. OTHERS CONTINUE.**

(12)  
MAN3RA1  
MAN4A  
MANICDA  
MANFGNA  
MANRDCA

D. You told me you experienced the following problems (**LIST  
SX IN K1C.1-7**). At the time you were having these  
problems, were you also feeling extremely good, elated, hyper,  
manic, irritable, or angry, clearly different from your normal  
self?

NO. (SKIP TO K31, p. 113) 1  
YES ..... 5

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(3) K2 Think about your most severe episode of feeling extremely hyper,  
elated, or irritable that lasted 2 days or longer.

A. When did it begin?

\_\_\_\_ / \_\_\_\_  
MO YEAR

B. So you were \_\_\_\_ years old?

AGE: \_\_\_\_

C. How long did that episode last?

\_\_\_\_ DAYS

---

K3 Before I ask more questions about this episode of feeling (hyper/elated/irritable), I need to know  
more about some other experiences you might have had at about the same time.

---

REMIND R WHICH EPISODE AS NEEDED.		MOST SEVERE EPISODE
<p><b>IF NEVER USED DRUGS (F1=1, G1=1 &amp; H1=1) OR ALCOHOL (E1B), SKIP TO K5. OTHERS CONTINUE.</b></p> <p><b>HAND R CARD K.</b></p> <p>MAN3RF MAN4E MANICDD MANRDCA</p> <p>K4 During the 2 weeks before this episode of feeling (hyper/elated/ irritable) began, did you use any of these street drugs or abuse any prescription drugs? <b>IF YES:</b> Which ones? <b>CIRCLE DRUGS USED ON CARD K. CODE THE TWO USED MOST.</b></p> <p>DRUG 1: _____</p> <p>DRUG 2: _____</p> <p>A. During the 2 weeks before this episode of feeling (hyper/elated/ irritable) began, were you drinking alcohol, or taking any of the following drugs for a high or intoxication <u>daily or almost daily</u>? <b>IF YES:</b> Which ones? <b>CIRCLE DRUGS OR ALCOHOL.</b></p> <p>B. During that time, on average, how many days per week did you take (DRUGS) or drink?</p> <p>C. What is the average number of times you used (DRUGS) or drank on those days you were using?</p> <p>D. During the 2 weeks before this episode began, what was the <u>largest</u> number of times you used (DRUG) or drank in one day?</p> <p>E. On how many days during that 2-week period did you use (DRUG) or drink that much in a day?</p> <p>F. Did you have <u>another</u> episode of feeling (hyper/elated/ irritable) for 2 days or longer that was <u>not</u> after a time when you had been drinking or using drugs daily or almost daily?</p> <p>G. When did this episode begin?</p> <p>1. How old were you?</p>		<p>NO. . . . (SKIP TO K5) . 1</p> <p>YES. . . . (SPECIFY) . 5</p> <p>CODE: ____ ____ ____</p> <p>CODE: ____ ____ ____</p> <p>NO. . . . (SKIP TO D) . 1</p> <p>YES. . . . (SPECIFY) . 5*</p> <p>CIRCLE DRUG 1, DRUG 2, OR ALCOHOL</p> <p>DRUG 1: ____ DAYS</p> <p>DRUG 2: ____ DAYS</p> <p>ALCOHOL: ____ DAYS</p> <p>DRUG 1: ____ AVG</p> <p>DRUG 2: ____ AVG</p> <p>ALCOHOL: ____ AVG</p> <p>DRUG 1: ____ MAX</p> <p>DRUG 2: ____ MAX</p> <p>ALCOHOL: ____ MAX</p> <p>DRUG 1: ____ DAYS</p> <p>DRUG 2: ____ DAYS</p> <p>ALCOHOL: ____ DAYS</p> <div style="border: 1px solid black; padding: 5px; text-align: center;"> <p><b>BOX K4: IF K4A=1, SKIP TO K5. OTHERS CONTINUE.</b></p> </div> <p>NO. (SKIP TO BOX K8). 1*</p> <p>YES . . . . . 5</p> <p>____ / ____</p> <p>MO YEAR</p> <p>AGE: ____</p>

REMIND R WHICH EPISODE AS NEEDED.			MOST SEVERE EPISODE
MAN3RF MAN4E MANICDD MANRDCA	K5	<p>Did this episode of feeling (hyper/elated/irritable) begin within 2 weeks of starting or changing the dose of prescription medications such as decongestants, steroids, or antidepressants?  <b>SPECIFY:</b> 1. _____  2. _____</p> <p>A. Did you have <u>another</u> episode of feeling (hyper/ elated/ irritable) for 2 days or longer that did <u>not</u> follow change in prescription medication, did <u>not</u> follow a serious physical illness, and was <u>not</u> after the daily or almost daily use of alcohol or drugs?</p> <p>B. When did this episode begin?  1. How old were you?</p>	<p>NO. . . . (SKIP TO K6) 1  YES. . . (SPECIFY) . . 5</p> <p>CODE: _ _ _  CODE: _ _ _</p> <p>NO. (SKIP TO BOX K8). 1*  YES . . . . . 5</p> <p>___ / ___  MO YEAR</p> <p>AGE: _ _</p>
MAN3RF MAN4E MANICDD MANRDCA	K6	<p>Did this episode of feeling (hyper/elated/irritable) begin within the 2 weeks that followed an episode of a serious physical illness like multiple sclerosis, AIDS, hyperthyroidism, lupus, Cushings, or encephalitis?  <b>SPECIFY:</b> _____</p> <p>A. Did you have <u>another</u> episode of feeling (hyper/ elated/ irritable) for 2 days or longer that did <u>not</u> follow a serious physical illness and was <u>not</u> after the daily or almost daily use of alcohol or drugs?</p> <p>B. When did this episode begin?  1. How old were you?</p>	<p>NO. . . . (SKIP TO K7) 1  YES. . . (SPECIFY). . 5</p> <p>CODE: _ _ _</p> <p>NO..(SKIP TO BOX K8). 1*  YES . . . . . 5</p> <p>___ / ___  MO YEAR</p> <p>AGE: _ _</p>
MAN3RF MAN4E MANICDD MANRDCA	K7	<p>Did this episode of feeling (hyper/elated/irritable) begin shortly after receiving ECT (shock therapy) or bright light therapy?</p> <p>A. Did you have <u>another</u> episode of feeling (hyper/elated/ irritable) for 2 days or longer that did <u>not</u> follow shock or bright light therapy, did <u>not</u> follow change in prescription medication, did <u>not</u> follow a serious physical illness, and was <u>not</u> after the daily or almost daily use of alcohol or drugs?</p> <p>B. When did this episode begin?  1. How old were you?</p>	<p>NO. (SKIP TO BOX K8). 1  YES . . . . . 5</p> <p>NO. . . (SKIP TO K8) . 1*  YES . . . . . 5</p> <p>___ / ___  MO YEAR</p> <p>AGE: _ _</p>

<b>REMIND R WHICH EPISODE AS NEEDED.</b>	<b>MOST SEVERE EPISODE</b>
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**K8 IF NO CLEAN EPISODE EXISTS, CONTINUE THE SECTION ASKING ABOUT THE MOST SEVERE DIRTY EPISODE CODED IN K2. REMIND R WHICH EPISODE TO FOCUS ON AS FREQUENTLY AS NEEDED.**

I'd like to (return to/focus on) the most severe episode of feeling (hyper/elated/irritable) when you were \_\_\_\_ years old. **CHECK K2B.**

<b>BOX K8 A. IS EPISODE CLEAN? (DIRTY = ANY * ITEM)</b>	<b>NO, DIRTY ..... 1 YES, CLEAN ..... 5</b>
---	---

Now I would like to ask you about other experiences you may have had during this episode of feeling (hyper/elated/irritable). During this most severe episode when you were ____ years old . . .		<b>MOST SEVERE EPISODE</b>
(4) MAN3RB6 MAN4B6 MANICDB1 MANFGNB1 MANRDCB1	<b>K9</b> Were you much more active than usual, either socially, at work, at home, sexually, or were you physically restless?  <b>SPECIFY:</b> _____ _____	NO ..... 1 YES . . . (SPECIFY) . . . 5
(5) MAN3RB3 MAN4B3 MANICDB2 MANFGNB2 MANRDCB2	<b>K10</b> Were you much more talkative than usual, or did you feel pressure to keep talking?	NO ..... 1 YES ..... 5
(6) MAN3RB4 MAN4B4 MANICDB3 MANFGNB3 MANRDCB3	<b>K11</b> Did your thoughts race, or did you talk so fast that it was difficult for people to follow what you were saying (more than usual)?	NO ..... 1 YES ..... 5
(7) MAN3RB1 MAN4B1 MANICDB6 MANFGNB4 MANRDCB4	<b>K12</b> Did you feel you were a very important person, or that you had special powers, plans, talents, or abilities?  <b>SPECIFY:</b> _____	NO ..... 1 YES . . . (SPECIFY) . . . 5
(8) MAN3RB2 MAN4B2 MANICDB5 MANFGNB5 MANRDCB5	<b>K13</b> Did you <u>need</u> much less sleep than usual for several days in a row?  A. How many hours of sleep did you get per night during this episode?  B. How many hours do you <u>usually</u> get per night?	NO . . . (SKIP TO K14) . 1 YES ..... 5  ____ HOURS  ____ HOURS
(9) MAN3RB5 MAN4B5 MANICDB7 MANFGNB6 MANRDCB6	<b>K14</b> Did your attention keep jumping from one thing to another much more than is usual for you?	NO ..... 1 YES ..... 5

During this most severe episode, when you were __ years old . . .		<b>MOST SEVERE EPISODE</b>
(10) MAN3RB7 MAN4B7 MANICDB8 MANRDCB7	<p>K15 Did you do anything that could have gotten you into trouble -- like spending spree, foolish business investments, reckless driving, or sexual indiscretions?</p> <p><b>SPECIFY:</b> _____</p> <p>_____</p>	<p>NO . . . . . 1 YES . . . (SPECIFY) . . . 5</p>
MANICDB9	<p>A. Did your interest in sex become so much stronger than usual that you wanted to have sex a lot more frequently or with people you ordinarily would not be interested in?</p>	<p>NO . . . . . 1 YES . . . . . 5</p>
MANICDB9	<p>B. Did you talk about sexual activities, or did you approach people in a sexual manner that you ordinarily would not have? Or were you sexually indiscreet in any other way?</p>	<p>NO . . . . . 1 YES . . . . . 5</p>
<p><b>BOX K15      COUNT THE BOXES CODED 5 IN K9-15.</b></p> <p><b><u>IF 0 OR 1 BOX(ES) CODED 5, SKIP TO K25.</u></b></p> <p><b><u>IF 2 OR MORE BOXES CODED 5, RECORD EPISODE ON TIMELINE AND CONTINUE.</u></b></p>		<p><b>BOXES CODED 5:_____</b></p>
<p>K16 You told me that while you were feeling (hyper/elated/irritable), you also experienced (<b>LIST SX CODED 5</b>). When did you start experiencing these together? (<b>DATE CLUSTERING OF MOOD AND SX TOGETHER</b>)</p> <p>A. For how long did you experience these together?</p>		<p>____/____ MO      YEAR</p> <p>____ DAYS</p>
(13) MANRDCC1	<p>K17 During this episode, were you so excited that it was almost impossible to hold a conversation with you?</p> <p><b>SPECIFY:</b> _____</p> <p>_____</p>	<p>NO . . . . . 1 YES . . . (SPECIFY) . . . 5</p>
MAN3RC MAN4D MANICDB MANRDCB8	<p>A. Would you say your behavior was provocative, obnoxious, or manipulative enough to cause problems for your family, friends, or your co-workers?</p> <p><b>SPECIFY:</b> _____</p> <p>_____</p>	<p>NO . . . . . 1 YES . . . (SPECIFY) . . . 5</p>



		MOST SEVERE EPISODE
(14) MAN3RD MAN4D MANICDC MANFGNC	<p>K18 During this episode did you see or hear things that other people could not see or hear, that is, did you have hallucinations?</p> <p>SPECIFY: _____</p> <p>WHOM SAW: _____</p> <p>WHAT TOLD: _____</p>	<div>CODE: 1 2 3 4 5</div>
MAN3RD MAN4D MANICDC MANFGNC	<p>A. During this episode, did you have beliefs or ideas that you later found out were not true?</p> <p>SPECIFY: _____</p> <p>WHOM SAW: _____</p> <p>WHAT TOLD: _____</p>	<div>CODE: 1 2 3 4</div>
<div> <b>BOX K18A IF ANY 5 IN K18 OR K18A, CONTINUE. OTHERS SKIP TO K19.</b> </div>		
	<p>B. Did these (beliefs/ideas/hallucinations) occur before you felt (hyper/elated/irritable)?</p>	<p>NO . . (SKIP TO D) . . . 1</p> <p>YES . . . . . 5</p>
MAN3RD MANRDCE	<p>C. How long before you felt (hyper/elated/irritable) did you have these (beliefs/ideas/hallucinations)?</p>	<p>___ ___ ___ DAYS</p>
	<p>D. Did these (beliefs/ideas/hallucinations) persist after your mood came back to normal?</p>	<p>NO (SKIP TO BOX K18B) 1</p> <p>YES . . . . . 5</p> <p>EPISODE ONGOING . . 6</p> <p><b>IF ONGOING, SKIP TO BOX K18B.</b></p>
MAN3RD MANRDCE	<p>E. How long did they last after your mood came back to normal?</p>	<p>___ ___ ___ DAYS</p>
<div> <b>BOX K18B DID EXAMPLES IN K18 OR K18A HAVE CONTENT CONSISTENT WITH THEMES OF INFLATED WORTH, POWER, KNOWLEDGE, IDENTITY, OR WITH A SPECIAL RELATIONSHIP TO A DEITY OR FAMOUS PERSON?</b> </div>		<p>NO . . . . . 1</p> <p>YES . . . . . 5</p>

During this most severe episode when you were ____ years old . . .		<b>MOST SEVERE EPISODE</b>
(15)	<p>K19 Were you seen by a doctor or other professional?</p> <p><b>SPECIFY:</b> _____</p>	<p>NO . (SKIP TO K23) . . 1</p> <p>YES . . (SPECIFY) . . . 5</p>
(16) MANRDCD	<p>K20 Did you receive medication?</p> <p><b>SPECIFY:</b></p> <p>1. _____</p> <p>2. _____</p>	<p>NO . . . . . 1</p> <p>YES . . (SPECIFY) . . . 5</p> <p>CODE: _ _ _</p> <p>CODE: _ _ _</p>
(17) MANRDCD	<p>K21 Did you receive ECT (shock treatments)?</p>	<p>NO . . . . . 1</p> <p>YES . . . . . 5</p>
(18) MAN4A/D MANICDA	<p>K22 Were you hospitalized during this episode for these experiences?</p> <p>A. For how long?</p>	<p>NO . (SKIP TO K23) . . 1</p> <p>YES . . . . . 5</p> <p>_____ DAYS</p>
(19)	<p>K23 During this episode, were you (working/going to school) full-time?</p> <p>A. What was your major responsibility at that time?</p>	<p>NO . . . . . 1</p> <p>YES (SKIP TO K24) . . 5</p> <p>PART-TIME JOB . . . . 1</p> <p>HOME . . . . . 2</p> <p>PART-TIME SCHOOL 3</p> <p>OTHER. . (SPECIFY) . . 4</p> <p>_____</p>

During this most severe episode when you were ____ years old . . .		<b>MOST SEVERE EPISODE</b>
(20)	<p><b>K24</b> Was your functioning in this role affected?</p> <p>A. Did something happen as a result of this change in functioning?</p> <p>SPECIFY: _____</p> <p>_____</p> <p>MAN3RC MAN4D MANICDB MANRDCC2</p> <p>B. Did anyone notice that your functioning was affected? (If no one was around, could someone have noticed this?)</p> <p>(21) MAN3RC MAN4D</p> <p>C. Were you completely unable to function in this role for at least 2 days in a row?</p> <p>D. Was your functioning in any other area of your life affected, or did you get into trouble in any way?</p> <p>SPECIFY: _____</p> <p>_____</p>	<p>NO . . (SKIP TO D) . . . 1</p> <p>YES . . . . . 5</p> <p>NO . . . . . 1</p> <p>YES . . (SPECIFY) . . . 5</p> <p>NO . . . . . 1</p> <p>YES . . . . . 5</p> <p>NO . . . . . 1</p> <p>YES . . (SPECIFY) . . . 5</p>
(22)	<p><b>BOX K24 RATE FUNCTIONING</b></p> <p><b><u>INCAPACITATED --</u></b>  <b>(K24C=5) COMPLETELY UNABLE TO FUNCTION IN PRINCIPAL ROLE FOR 2+ DAYS , OR</b>  <b>(K22A=2+) HOSPITALIZED 2+ DAYS , OR</b>  <b>(K21=5) ECT, OR</b>  <b>(K18 OR K18A=5) DELUSIONS OR HALLUCINATIONS PRESENT, OR (K17=5) INABILITY TO CARRY ON A CONVERSATION.</b></p> <p><b><u>IMPAIRED --</u></b>  <b>(K24B=5 AND K24C=1) A DECREASE, NOTICEABLE TO OTHERS, IN QUALITY OF THE MOST IMPORTANT ROLE PERFORMANCE. THIS USUALLY REQUIRES A DECREASE IN THE AMOUNT OF PERFORMANCE.</b></p> <p><b><u>IMPROVED --</u></b>  <b>(CHECK EXAMPLE IN K24A) IMPROVEMENT IN FUNCTION.</b></p>	<p><b>INCAPACITATED . . 5</b></p> <p><b>IMPAIRED . . . . . 4</b></p> <p><b>IMPROVED . . . . . 3</b></p> <p><b>NEITHER . . . . . 1</b></p>

K25 Did you have at least one other episode of 2 days or longer when you felt extremely hyper, elated, or irritable, which was clearly different from your normal self, when it did not follow daily (or almost daily) use of alcohol or drugs, did not follow a serious physical illness, did not follow a change in medicine, and did not follow light therapy or shock therapy?

NO .. (SKIP TO K26) ... 1  
YES ..... 5

A. How old were you then?

AGE: \_\_\_\_

B. During this episode, were you... **(READ 1-7)**  
**AFTER THE FIRST YES, ASK:** And at that time, were you also:

**COUNT ONLY IF SX IS MORE THAN USUAL  
AND ONLY IF LASTED FOR 2 OR MORE  
DAYS:**

	<u>NO</u>	<u>YES</u>
1. More active than usual? .....	1	5
2. More talkative than usual? .....	1	5
3. Having racing thoughts or talking too fast? .....	1	5
4. Feeling you were an especially important person? ..	1	5
5. Needing less sleep than usual? .....	1	5
6. Easily distracted? .....	1	5
7. Going on spending sprees or having sexual indiscretions? .....	1	5

**IF 2 OR MORE ARE CODED 5, CONTINUE. OTHERS SKIP TO E.**

C. When did this episode begin?

\_\_\_\_ / \_\_\_\_  
MO YEAR

D. How long did this episode last?

\_\_\_\_ DAYS

E. Did you have trouble managing your work, school, or household responsibilities?

NO ..... 1  
YES .. (SPECIFY) .... 5

**SPECIFY:** \_\_\_\_\_

\_\_\_\_\_

- F. Did you seek help, receive any treatment (such as medications or ECT), or were you hospitalized during this episode? NO ..... 1  
YES .. (SPECIFY) .... 5

**SPECIFY:**

- |                                   | <u>NO</u> | <u>YES</u> |             |
|-----------------------------------|-----------|------------|-------------|
| 1. Sought professional help ..... | 1         | 5          |             |
| 2. Medications: _____             | 1         | 5          | CODE: _ _ _ |
| _____                             |           |            | CODE: _ _ _ |
| 3. ECT (Shock treatment) .....    | 1         | 5          |             |
| 4. Hospitalized .....             | 1         | 5          |             |

- 
- (27) K26 How old were you the (first/last) time you had an episode like this? AGE ONS: \_\_\_\_/\_\_\_\_  
ONS: 1 2 3 4 5  
AGE REC: \_\_\_\_/\_\_\_\_  
REC: 1 2 3 4 5
- 

- (28) K27 How many episodes have you had over your lifetime, including the one(s) we have already talked about? \_\_\_\_ NUMBER

**RECORD ALL EPISODES ON TIMELINE.**

- 
- (29) K28 **MIXED AFFECTIVE STATES:** During any of these episodes of feeling  
MAN4C (hyper/elated/irritable), did you also experience:

- |  | <u>NO</u> | <u>YES</u> |
|--|-----------|------------|
| 1. Depressed mood? .....               | 1         | 5          |
| 2. Loss of interest or pleasure? ..... | 1         | 5          |

**BOX K28 IF K28.1 AND K28.2 BOTH CODED 1, SKIP TO K29. OTHERS CONTINUE.**

- |  |   |   |
|--|---|---|
| 3. Sleep difficulty? .....                         | 1 | 5 |
| 4. A change in activity level? (PSYCHOMOTOR) ..... | 1 | 5 |
| 5. Fatigue or loss of energy? .....                | 1 | 5 |
| 6. A change in appetite or weight? .....           | 1 | 5 |
| 7. Low self-esteem or guilt? .....                 | 1 | 5 |
| 8. Decreased concentration? .....                  | 1 | 5 |
| 9. Thoughts of dying or suicide? .....             | 1 | 5 |

**IF FEWER THAN FIVE ARE CODED 5, SKIP TO K29. OTHERS CONTINUE.**

- A. How many episodes like this have you had (when you were both manic and depressed some of the time during the episode)? \_\_\_\_ NUMBER

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(30)	K29	Have you ever switched back and forth quickly between feeling (hyper/elated/irritable) and feeling depressed?	NO . . . (SKIP TO BOX K29) . . .	1
			YES . . . . .	5
	A.	Did that happen every few hours, every few days, or every few weeks?	HOURS . . . . .	2
			DAYS . . . . .	3
		<b>IF MORE THAN ONE, CODE THE MOST RAPID CYCLE.</b>	WEEKS . . . . .	4
	B.	Did you ever have 4 or more episodes like this within a 12-month period?	NO . . . . .	1
			YES . . . . .	5

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**BOX K29 IF R HAD 1+ BOX MARKED ON  
COCAINE, OPIATE, OR DRUG TALLY  
SHEET A, CONTINUE.  
OTHERS SKIP TO L1, p. 114.**

**K30 FOR EACH EPISODE OF MANIA, ASK A.**

- A. You told me about a time when you felt (unrealistically happy/elated/hyper/irritable) that started at (AGE).

**IF 3R CLUSTERING ON  
ALC/COCAINE/OPIATE/DRUG TALLY SHEET  
A, HAND TALLY(IES) TO R AND ASK 1.  
OTHERS SKIP TO 2.**

## CLUSTERING PER EPISODE

1. Around the time this episode of feeling (unrealistically happy/elated/hyper/irritable) began, were you having experiences from 3 or more boxes on this (ALC /COCAINE/OPIATE /DRUG) sheet?

**IF NO, CONTINUE TO 2.**

**IF YES, RETURN TO K30A FOR NEXT EPISODE. IF NO OTHER EPISODES, SKIP TO K30B.**

HEAVY USE  
PER EPISODE  
WHEN NOT  
CLUSTERING

2. Around the time this episode of feeling (unrealistically happy/elated/hyper/irritable) began, were you (drinking heavily/using DRUGS) daily or almost daily?

**IF NO, RETURN TO K30A FOR NEXT  
EPISODE. IF NO OTHER EPISODES,  
SKIP TO K30B.**

**IF YES, RETURN TO K30A FOR NEXT EPISODE. IF NO OTHER EPISODES, SKIP TO K30B.**

- B. So, according to the information you provided,

## CLUSTERING FOR ALL EPISODES

1. ... your episodes of feeling (unrealistically happy/elated/ hyper/irritable) (NEVER / SOMETIMES / ALWAYS) started around a time when you were experiencing some problems with alcohol, cocaine, opiates, or other drugs?

NEVER . . . . . 1  
SOMETIMES . . . . . 3  
ALWAYS . (SKIP TO L1, p. 114).5

HEAVY USE  
FOR THE  
EPISODES  
WHEN NOT  
CLUSTERING

2. . . . your episodes (that did not start when you were having problems with alcohol or drugs) (NEVER / SOMETIMES / ALWAYS) started around a time when you were drinking heavily or using drugs daily (or almost daily)?

NEVER . . . . .	1
SOMETIMES . . . . .	3
ALWAYS . . . . .	5

**BOX K30    SKIP TO L1, p. 114.**

(31)	K31 I have already asked you about episodes of extremely elated moods when you were clearly different from your normal self. Now I'd like to ask if you have ever had episodes lasting at least 2 days when you felt <u>unusually</u> cheerful, energetic, hyper, or irritable?	NO. . . (SKIP TO L1, p. 114) . 1 ALC/DRUG ONLY . . . . . 3 YES . . . . . 5
------	---	--

**DO NOT COUNT BRIEF EPISODES LASTING FEWER THAN 2 DAYS OR THAT CLEARLY FOLLOWED PERSONAL SUCCESSES, MARRIAGES, ENGAGEMENTS, OR RECOVERY FROM DEPRESSION TO NORMAL MOOD.**

**SPECIFY:** \_\_\_\_\_

**IF K31 IS CODED 5, CONTINUE.  
OTHERS SKIP TO L1, p. 114.**

A. During this period were you:	<u>NO</u>	<u>YES</u>
1. much more active than usual? . . . . .	1	5
2. much more talkative than usual? . . . . .	1	5
3. experiencing racing thoughts? . . . . .	1	5
4. feeling you were a very important person or had special powers, or talents? . . . . .	1	5
5. <u>needing</u> less sleep than usual? . . . . .	1	5
6. much more distractible than usual, when your attention kept jumping from one thing to another? . . . . .	1	5
7. doing anything that could have gotten you into trouble, like spending sprees, or sexual indiscretions? . . . . .	1	5
8. very friendly with people you normally would not be friendly with? . . . . .	1	5

**IF ALL ARE CODED 1, SKIP TO L1, p. 114. OTHERS CONTINUE.**

B. How long did this period last, when these experiences occurred together with your unusually (cheerful / energetic / hyper / irritable) mood? \_\_\_\_\_ DAYS

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(32)	K32 How many episodes like this have you had?	_____ NUMBER
------	---	--------------

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(33)	K33 How old were you the (first/last) time?	AGE ONS: _____/_____ ONS: 1 2 3 4 5  AGE REC: _____/_____ REC: 1 2 3 4 5
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**BEFORE CODING L1-L12, ASK FOR EXAMPLES.**

Now I'm going to ask you about very unusual experiences that some people have.

(1)  
Auditory  
hallucinations,  
when fully awake,  
word heard inside  
or outside the head.

L1 Did you ever hear things that other people couldn't hear, such as noises, or the voices of people whispering or talking, when you were completely awake?

NO. . . . (SKIP TO L2) . . 1  
YES . . . . . 5

A. What did you hear?

EXAMPLES: \_\_\_\_\_  
\_\_\_\_\_

B. For how long did you hear these things? \_\_\_\_

**CODE UNIT:** DAYS . . . 1  
WEEKS . . 2  
MONTHS . 3  
YEARS . . 4

More than 2 words  
heard more than  
twice - with no  
relation to  
expression or  
elation.

C. How many times did you hear it?

\_\_\_\_ NUMBER

**IF HEARD VOICE(S), CONTINUE.  
OTHERS SKIP TO G.**

D. Did it comment on what you were doing or thinking?

NO . . . . . 1  
YES . . . . . 5

E. How many voices did you hear?

\_\_\_\_ NUMBER

**IF ONLY 1 VOICE, CODE "NO" SILENTLY.**

F. Were they talking to each other?

NO . . . . . 1  
YES . . . . . 5

**G. BEGIN PROBING.**

WHOM SAW: \_\_\_\_\_

CODE: 2 3 4 5

WHAT TOLD: \_\_\_\_\_

(2)  
Visual  
hallucinations

L2 Did you ever see things that other people could not see or have visions when you were completely awake?

CODE: 1 2 3 4 5

**DISTINGUISH FROM AN ILLUSION, I.E., A  
MISPERCEPTION OF A REAL EXTERNAL  
STIMULUS.**

EXAMPLES: \_\_\_\_\_  
\_\_\_\_\_

WHOM SAW: \_\_\_\_\_

WHAT TOLD: \_\_\_\_\_

**BOX L2 IF NO 5'S CODED IN L1G AND L2,  
SKIP TO L5.**

(3)  
Tactile  
hallucinations

L3 What about strange sensations in your body or on your skin?

CODE: 1 2 3 4 5

EXAMPLES: \_\_\_\_\_

WHOM SAW: \_\_\_\_\_

WHAT TOLD: \_\_\_\_\_

(4)  
Olfactory  
hallucinations

L4 What about smelling things that other people could not smell?

CODE: 1 2 3 4 5

EXAMPLES: \_\_\_\_\_

WHOM SAW: \_\_\_\_\_

WHAT TOLD: \_\_\_\_\_

(5)

L5 Did you ever receive special messages from the TV, radio, or newspaper, or from the way things were arranged around you?

CODE: 1 2 3 4 5

EXAMPLES: \_\_\_\_\_

WHOM SAW: \_\_\_\_\_

WHAT TOLD: \_\_\_\_\_

(8)  
Somatic delusions:  
Content involves  
change or  
disturbance in body  
functioning.

L6 Did you ever feel that parts of your body had changed or stopped working? (What did your doctor say?)

CODE: 1 2 3 4 5

EXAMPLES: \_\_\_\_\_

WHOM SAW: \_\_\_\_\_

WHAT TOLD: \_\_\_\_\_

(10)  
Other delusions:  
Guilt, jealousy,  
nihilism, poverty.

L7 Did you ever feel that you had committed a crime or done something terrible for which you should be punished?

CODE: 1 2 3 4 5

EXAMPLES: \_\_\_\_\_

WHOM SAW: \_\_\_\_\_

WHAT TOLD: \_\_\_\_\_

(12)  
Thought  
broadcasting: The  
delusion that one's  
thoughts are  
audible to others.

L8 Did you ever feel as if your thoughts were being  
broadcast out loud so that other people could actually  
hear what you were thinking?

CODE: 1 2 3 4 5

EXAMPLES: \_\_\_\_\_  
\_\_\_\_\_

WHOM SAW: \_\_\_\_\_

WHAT TOLD: \_\_\_\_\_

(11)  
Delusions of being  
controlled: outside  
force controlling  
own feelings,  
impulses, thoughts.

L9 Did you ever feel that someone or something outside  
yourself was controlling your thoughts or actions  
against your will?

CODE: 1 2 3 4 5

EXAMPLES: \_\_\_\_\_  
\_\_\_\_\_

WHOM SAW: \_\_\_\_\_

WHAT TOLD: \_\_\_\_\_

Thought insertion.

A. Did you ever feel that certain thoughts, that were  
not your own, were put into your head?

CODE: 1 2 3 4 5

EXAMPLES: \_\_\_\_\_  
\_\_\_\_\_

WHOM SAW: \_\_\_\_\_

WHAT TOLD: \_\_\_\_\_

Thought  
withdrawal.

B. What about thoughts taken out of your head?

CODE: 1 2 3 4 5

EXAMPLES: \_\_\_\_\_  
\_\_\_\_\_

WHOM SAW: \_\_\_\_\_

WHAT TOLD: \_\_\_\_\_

**BOX L9 IF NO 5'S IN L5-L9, SKIP TO BOX L13.  
OTHERS CONTINUE.**

(6)  
Delusions of  
reference: personal  
significance is  
falsely attributed to  
objects or events in  
the environment

L10 Did it ever seem that people were talking about you or  
taking special notice of you?

CODE: 1 2 3 4 5

EXAMPLES: \_\_\_\_\_  
\_\_\_\_\_

WHOM SAW: \_\_\_\_\_

WHAT TOLD: \_\_\_\_\_

(7)  
Grandiose  
delusions: Content  
involves  
exaggerated power,  
knowledge or  
importance.

L11 Did you ever feel that you were especially important in some way, or that you had powers to do things that other people could not do?

CODE: 1 2 3 4 5

EXAMPLES: \_\_\_\_\_  
\_\_\_\_\_

WHOM SAW: \_\_\_\_\_

WHAT TOLD: \_\_\_\_\_

(9)  
Persecutory  
delusion:  
individual or  
his/her group is  
being attacked,  
harassed, cheated,  
persecuted, or  
conspired against.

L12 Did you ever feel that people were going out of the way to give you a hard time or trying to hurt you?

CODE: 1 2 3 4 5

EXAMPLES: \_\_\_\_\_  
\_\_\_\_\_

WHOM SAW: \_\_\_\_\_

WHAT TOLD: \_\_\_\_\_

**BOX L13 IF ANY 5 CODED IN L1G-L12, CONTINUE.  
OTHERS SKIP TO M1, p. 120.**

(13A)  
Systematized  
delusions: A single  
delusion with  
multiple  
elaborations or a  
group of delusions  
related to a single  
theme.  
Bizarre delusions:  
Involving a  
phenomenon that  
R's subculture  
would regard as  
totally  
implausible.

L13 What is your understanding of why you (CONTENT IN L1-L12)?

RECORD: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

EDITOR/CLINICIAN  
CODE:

Systematized delusions . . 1  
Bizarre delusions . . . . . 2  
Other . . . . . 3

(14)

L14 Did (EXPERIENCES CODED 5 IN L1-L12) last for 6 months or longer?

NO . . . . . 1  
YES . . . . . 5

A. Did (this experience/any of these experiences) cause you to miss work or school, or affect your ability to function at home?

NO . . . . . 1  
YES. . . . (SPECIFY) . . . 5

SPECIFY: \_\_\_\_\_  
\_\_\_\_\_

**BOX L14 IF L14=1 AND L14A=1, SKIP TO M1, p. 120.  
OTHERS CONTINUE.**

---

(15) L15 How old were you the (first/last) time you had any of these experiences?

AGE ONS:        /  
ONS: 1 2 3 4 5

AGE REC:        /  
REC: 1 2 3 4 5

---

**BOX L16 CHECK J1, J2 (p. 82) AND K1A, K1B (p. 101). IF ANY ARE CODED 5, CONTINUE. OTHERS SKIP TO BOX L17.**

(16) L16 Were the episodes of feeling (depressed/elated/irritable) ever present at the same time you were having (beliefs/ experiences) such as (SX CODED 5 IN L1-L12)?

NO ..... 1  
YES ..... 5

---

(17)	<b>BOX L17</b>	<b>RESPONDENT'S PRESENT STATE:</b>	<b><u>NO</u></b>	<b><u>YES</u></b>
		<b>A. CATATONIC BEHAVIOR? .....</b>	<b>1</b>	<b>5</b>
		<b>B. FLAT AFFECT? .....</b>	<b>1</b>	<b>5</b>
		<b>C. GROSSLY INAPPROPRIATE AFFECT? .....</b>	<b>1</b>	<b>5</b>
		<b>D. INCOHERENCE? .....</b>	<b>1</b>	<b>5</b>
		<b>E. MARKED LOOSENING OF ASSOCIATION? ....</b>	<b>1</b>	<b>5</b>
		<b>F. EMOTIONAL TURMOIL? .....</b>	<b>1</b>	<b>5</b>

---

**BOX L18 IF R HAD 1+ BOX MARKED ON ALC, COCAINE, OPIATE, OR OTHER DRUG TALLY SHEET A, CONTINUE. OTHERS SKIP TO M1, p. 120.**

**L18 FOR EACH EPISODE, ASK A.**

- A. You told me about a time when (NAME SX/your mind was playing tricks on you) when you were (AGE).

**IF 3R CLUSTERING ON ALC/COCAINE/OPIATE/OTHER DRUG TALLY SHEET A, HAND TALLY(IES) TO R AND ASK 1. OTHERS SKIP TO 2.**

CLUSTERING  
PER EPISODE

1. Around this time when (NAME SX/your mind was playing tricks on you), were you also having experiences from 3 or more boxes found on this (ALC / MJ / DRUG) sheet?

**IF NO, CONTINUE TO 2.**

**IF YES, RETURN TO L18A FOR NEXT EPISODE OF PSYCHOSIS. IF NO OTHER EPISODES, SKIP TO L18B.**

HEAVY USE  
PER EPISODE  
WHEN NOT  
CLUSTERING

2. Around this time when (NAME SX/your mind was playing tricks on you), were you (drinking heavily / using DRUGS) daily or almost daily?

**IF NO, RETURN TO L18A FOR NEXT EPISODE. IF NONE, SKIP TO L18B.**

**IF YES, RECORD ON TIMELINE AND RETURN TO L18A FOR NEXT EPISODE. IF NONE, SKIP TO L18B.**

- B. So, according to the information you gave me,

CLUSTERING  
FOR ALL  
EPISODES

1. . . . the time(s) when (NAME SX/your mind was playing tricks on you) (NEVER / SOMETIMES / ALWAYS) started around a time when you were experiencing some problems with alcohol, cocaine, opiates, or other drugs?

NEVER ..... 1  
SOMETIMES ..... 3  
ALWAYS (SKIP TO M1,p.120).5

HEAVY USE FOR  
THE EPISODES  
WHEN NOT  
CLUSTERING

2. . . . the time(s) when (NAME SX/your mind was playing tricks on you) (that did not start when you were having problems with alcohol or drugs) (NEVER / SOMETIMES / ALWAYS) started around a time when you were drinking heavily or using drugs daily (or almost daily)?

NEVER ..... 1  
SOMETIMES ..... 3  
ALWAYS ..... 5

<hr/>				
	M1.	In this section, I'll ask you some questions about your ability to concentrate, whether you were often restless, and related questions, including how you got along with your family and friends, and what school was been like for you.		
ADHD4A1a ICDG1-1	A1.	Were you a very distractable child?	NO ..... 1 YES ..... 5	
	A2.	As an adult, are you easily distracted?	NO ..... 1 YES ..... 5	
	B.	Did you used to have a really hard time doing your schoolwork, because you had trouble paying attention to details?	NO ..... 1 YES ..... 5	
	C.	Did you make a lot of careless mistakes in your schoolwork or homework?	NO ..... 1 YES ..... 5	
	<p><b>IF ALL RESPONSES ARE CODED "1," SKIP TO M10.</b></p>			
	<hr/>			
ADHD4A1b	M2	A.	As a child, did you have difficulty keeping your mind on schoolwork, homework, or anything you were supposed to be doing?	NO ..... 1 YES ..... 5
ADHD4A1b		B.	When playing games (or participating in sports), did you have a lot of trouble paying attention to the rules or remembering whose turn it was?	NO ..... 1 YES ..... 5
		C.	As an adult, do you have difficulties keeping score in leisure activities such as sports because you get confused or cannot remember the score?	NO ..... 1 YES ..... 5
<hr/>				
ADHD4A1c	M3.	Did your parents or teachers often tell you that you didn't seem to be listening to them, even when they were talking directly to you; or did you notice yourself that you often didn't listen when people were speaking to you?		NO ..... 1 YES ..... 5
<hr/>				
ADHD4A1d	M4.	As a child, did you often fail to follow through on instructions, or fail to finish schoolwork, chores, or duties?		NO . . (SKIP TO M4-B) . . 1 YES ..... 5
	A.	Was this because you just didn't want to finish your work or your chores?		NO ..... 1 YES ..... 5
	B.	Did you have a lot of problems understanding what you were supposed to do, even after the teacher or your parents explained it to you?		NO ..... 1 YES ..... 5
<hr/>				
ADHD4A1e	M5.	As a child, did you have a lot of difficulty getting organized for tasks and activities?		NO ..... 1 YES ..... 5
<hr/>				
ADHD4A1f	M6.	Did you dislike or avoid doing school work or homework, or other activities that you had to think hard about?		NO ..... 1 YES ..... 5
<hr/>				

ADHD4A1g	M7.	Did you lose things a lot, like toys, books, or things you needed for school?	NO ..... 1 YES. .... 5
ADHD4A1h	M8.	Were you often distracted from schoolwork or other things that required concentration when something else was going on around you?	NO ..... 1 YES. .... 5
ADHD4A1i	M9.	Did you often forget to do things that you were supposed to do? For example, did you forget appointments or things you were asked to do?	NO ..... 1 YES. .... 5
	A.	Have these problems continued into adulthood?	NO ..... 1 YES. .... 5
ADHD4A2a-i	M10.	When you were a child, were any of the following serious problems – to the extent that they caused trouble for you – for at least six months?	
	1.	Did you often fidget with your hands or feet, or squirm in your seat?	NO ..... 1 YES ..... 5
	2.	Did you often leave your seat in class, or at other times when you were expected to stay seated?	NO ..... 1 YES ..... 5
	3.	Did you often run or climb when you knew you weren't supposed to?	NO ..... 1 YES ..... 5
	4.	Did you have difficulty playing or resting quietly?	NO ..... 1 YES ..... 5
	5.	Were you often "on the go," as if you were "driven by a motor"?	NO ..... 1 YES ..... 5
	6.	Did people say that you used to talk too much?	NO ..... 1 YES ..... 5
	7.	Did you used to start answering questions before they were completed?	NO ..... 1 YES ..... 5
	8.	Was it very hard for you to wait your turn, for example when standing in line or when playing a game?	NO ..... 1 YES ..... 5
	9.	Did you often jump in and start talking when you shouldn't have, or would you intrude into games or activities without being asked?	NO ..... 1 YES ..... 5

**IF 6 OR MORE RESPONSES IN THIS SECTION OR 6 OR MORE RESPONSES FROM M2 to M9 ARE CODED 5, CONTINUE. OTHERS SKIP TO SECTION N, p. 125**



ADHD4A2b      M11      A.      How old were you when these things started happening?      AGE ONS:       /     
ONS: 1 2 3 4 5

(PROBE: WERE YOU LIKE THAT IN KINDERGARTEN OR FIRST GRADE? WERE YOU LIKE THAT IN NURSERY SCHOOL?)

IF 3 YEARS OLD OR YOUNGER OR IF ALWAYS, CODE 03.

**IF ONSET WAS AT AGE 7 OR OLDER, SKIP TO SECTION N, p. 125**

B.      How old were you the last time? (Code current age if R. reports that these problems have continued into adulthood.)      AGE REC:       /     
REC: 1 2 3 4 5

ADHD4A2c      C.      Did you have problems or get into trouble because of some of these things in school? at work? at home?      NO ..... 1  
(CODE 5 ONLY IF SYMPTOMS WERE PRESENT IN TWO OR MORE SETTINGS)      YES. . (two or more) .... 5

---

ADHD4A2d      M12      Because of the problems we just discussed like (NAME POSITIVES), did any of these ever happen?

1.	Did your parents get really angry with you?	NO ..... 1 YES ..... 5
2.	Were your parents very worried about you?	NO ..... 1 YES ..... 5
3.	Did other kids not want you around?	NO ..... 1 YES ..... 5
4.	Did the teacher tell your parent(s) you were having problems in school?	NO ..... 1 YES ..... 5
5.	Did you get low grades in school?	NO ..... 1 YES ..... 5
6.	Did you have other big problems? (Specify: _____)	NO ..... 1 YES ..... 5

---

M13.	Did your parents ever take you to anyone like a doctor, a social worker, or another professional because you were having problems like the ones we've been talking about; or did you ever take medication for these problems?	NO. . (SKIP TO N1, p. 125 ) 1 YES ..... 5
A.	Did you see:	NO    YES
	1. a psychiatrist or psychologist? .....	1      5
	2. another medical doctor? .....	1      5
	3. a school counselor or social worker? .....	1      5
	4. another professional? .....	1      5
B.	Did you ever receive any medicine for the problems you were having?	NO ..... 1 YES. . .(RITALIN) ..... 3 YES. (OTHER -SPECIFY). 5
	SPECIFY, IF OTHER THAN RITALIN:	
	_____	CODE: ____ ____ ____
C.	Are you still taking medicine for similar problems?	NO ..... 1 YES. . .(RITALIN) ..... 3 YES. (OTHER -SPECIFY). 5
	SPECIFY, IF OTHER THAN RITALIN:	
	_____	CODE: ____ ____ ____
D.	<b>(IF R IS NO LONGER TAKING MEDICATION, ASK)</b> How old were you when you stopped taking the medicine?	AGE: ____ ____

---

[illegible]

---

Now I am going to ask you some (further) questions about suicide.

N1 Have you ever thought about killing yourself? NO . . . (SKIP TO N2) . . . . . 1  
YES . . . . . 5

A. Did those thoughts persist for at least 7 days in a row? NO . . . . . 1  
YES . . . . . 5

B. Did you have a plan?  
(Did you actually consider a way to take your life?) NO . . . (SKIP TO D) . . . . . 1  
YES . . . . . 5

C. What were you going to do?  
**SPECIFY:** \_\_\_\_\_  
\_\_\_\_\_

D. How old were you when you (first/last) had these thoughts? AGE ONS: \_\_\_\_/\_\_\_\_  
AGE REC: \_\_\_\_/\_\_\_\_

---

N2 Have you ever tried to kill yourself? NO . . . . . (SKIP TO N12) . . . 1  
YES . . . . . 5

A. How many times? \_\_\_\_\_ TIMES

B. How old were the (first/last) time? AGE ONS: \_\_\_\_/\_\_\_\_  
ONS: 1 2 3 4 5  
AGE REC: \_\_\_\_/\_\_\_\_  
REC: 1 2 3 4 5

---

N3 How did you try to kill yourself? **IF MORE THAN 1, ASK ABOUT THE MOST SERIOUS ATTEMPT.**

RECORD METHOD: \_\_\_\_\_  
\_\_\_\_\_

---

N4 How old were you then? AGE: \_\_\_\_ \_\_\_\_

---

N5 Did you require medical treatment after you tried to kill yourself? NO . . . . . 1  
YES. . . . . (SPECIFY) . . . . . 5  
**SPECIFY:** \_\_\_\_\_

---

N6 Were you admitted to a hospital after the attempt (for medical reasons)? NO . . . . . 1  
YES. . . . . (SPECIFY) . . . . . 5  
**SPECIFY:** \_\_\_\_\_

---

N7 Did you really want to die? NO . . . . . 1  
YES . . . . . 5

A. Afterwards, were you sorry that you didn't die? NO . . . . . 1  
YES . . . . . 5

---

---

N8	Did you think you would die from what you had done?	NO .....	1
		YES .....	5
		MAYBE .....	3

---

N9	Did you try to kill yourself:		
		<u>NO</u>	<u>YES</u>
1.	While feeling depressed? .....	1	5
2.	While feeling extremely good or high? .....	1	5
3.	After you had been drinking? .....	1	5
4.	After using drugs? .....	1	5
5.	While having strange thoughts or experiences, or while seeing visions? .....	1	5
6.	Other: <b>IF YES, SPECIFY:</b> _____ .....	1	5

---

<b>N10A</b>	<b>CODE SILENTLY: TYPE OF METHOD INTENDED (SEE N3).</b>	<b>CODE: _____</b>
	1. Fire gun.	
	2. Crash car.	
	3. Carbon monoxide poisoning.	
	4. Cut wrists or stab self.	
	5. Take pills.	
	6. Jump from height.	
	7. Jump in front of train/car/vehicle.	
	8. Strangulation, choking, suffocation, hanging, drowning.	
	9. Other or combination.	
<b>N10B</b>	<b>CODE SILENTLY: DEGREE OF COMPLETION.</b>	<b>CODE: _____</b>
	1. Contemplated only.	
	2. Put self in vicinity (e.g., brought gun/pills into room, walked into train station).	
	3. Stopped short of completing act (held gun/pills, stood on edge of platform, sat in car).	
	4. Attempted act (jumped, pulled trigger, swallowed pills).	
<b>N11</b>	<b>CODE SILENTLY: INTENT.</b>	<b>CODE: _____</b>
	1. Unclear (no information or not sure)	
	2. Denies intent	
	3. Reports minimal intent	
	4. Reports significant intent with some ambivalence	
	5. Very severe/extreme intent to die	

---

N12 (Other than when you tried to take your own life,) did you ever hurt yourself on purpose, for example, by cutting or burning yourself?

NO. . . (SKIP TO O1, p. 128) . 1  
YES . . . . . 5

A. How many times?

\_\_ \_\_ TIMES

B. How old were you the (first/last) time?

AGE ONS:                    \_\_/\_\_\_\_  
ONS:            1    2    3    4    5

AGE REC:                    \_\_/\_\_\_\_  
REC:            1    2    3    4    5

---

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## HAND R CARD O.

PTS3RA  
PTS4A1

- O1 Please look at this list. Have you ever experienced or witnessed something that is so horrible that it would be distressing or upsetting to almost anyone? Examples are included on this list: military combat; an assault, rape, or kidnapping; seeing someone seriously injured or killed; a flood, earthquake, large fire, or other disaster; an airplane crash or serious car accident; a shooting or bombing; or any situation where you feared there was a serious threat to your life or to the life of another person? **IF YES, RECORD EVENT AND CODE.**

NO... (SKIP TO P1, p.133) 1  
YES ..... 5

EVENT 1. \_\_\_\_\_  
\_\_\_\_\_

CODE: \_\_\_\_

EVENT 2. \_\_\_\_\_  
\_\_\_\_\_

CODE: \_\_\_\_

EVENT 3. \_\_\_\_\_  
\_\_\_\_\_

CODE: \_\_\_\_

**IF ONLY ONE EVENT, SKIP TO B.  
OTHERS CONTINUE.**

- A. Which event was the most disturbing to you?  
**CIRCLE EVENT NUMBER AND REFER TO  
THIS EVENT THROUGHOUT SECTION.**

EVENT: 1 2 3

PTS4A2

- B. When this most disturbing event occurred, did you feel intense fear, helplessness, or horror?

NO ..... 1  
YES ..... 5

- C. When did this (EVENT) occur?

\_\_\_\_ / \_\_\_\_  
MO YEAR

1. How old were you then?

AGE: \_\_\_\_

- D. Was there ever a period of time lasting one month or longer when you had strong feelings or thoughts about (EVENT), which made you anxious or upset?

NO... (SKIP TO P1, p.133) 1  
YES ..... 5

1. When did this start?

\_\_\_\_ / \_\_\_\_  
MO YEAR

2. So, that was when you were \_\_\_\_ years old?

AGE: \_\_\_\_

---

---

I am going to ask you some questions about that period when you were (AGE IN O1D.2), when you were having the most, or most intense, feelings or experiences about (EVENT) . . .

---

PTS3RB1 PTS4B1	O2	Did memories, visions, thoughts, or feelings about (EVENT) <u>often</u> keep coming to your mind, even though you didn't want them to?	NO . . . . . 1 YES . . . . .(SPECIFY) . . . . 5
-------------------	----	--	--

**IF YES:** Can you give me some examples?

---

---

---

PTS3RB2 PTS4B2	O3	Did you have unpleasant dreams again and again about (EVENT)?	NO . . . . . 1 YES . . . . . 5
-------------------	----	---	-----------------------------------

---

Still focusing on the period that started (DATE IN O1D.1). . .  
(that is, the period of a month or longer when you were having the most, or most intense, feelings or experiences about (EVENT))

---

PTS3RB3 PTS4B3	O4	Did you ever suddenly act or feel as if (EVENT) was happening again? This may include flashbacks or hallucinations, even if they occur when you are just waking up.	NO . . . . . 1 YES . . . . .(SPECIFY) . . . . 5
-------------------	----	---	--

**IF YES:** Can you give me some examples?

---

---

---

PTS3RB4 PTS4B4	O5	Did you feel very upset when you were reminded of (EVENT)? For example, on the anniversary of (EVENT).	NO . . . . . 1 YES . . . . . 5
-------------------	----	--	-----------------------------------

---

PTS3RD6 PTS4B5	O6	Did things that reminded you of (EVENT) make you sweat, tense up, breathe hard, tremble, or respond in some other physical way?	NO . . . . . 1 YES . . . . . 5
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<b>BOX O7</b>	<b>IF O2-O6 ALL CODED 1, SKIP TO P1, p. 133. OTHERS CONTINUE.</b>
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During that period of a month or longer when you were having the most, or most intense, feelings or experiences about (EVENT),  
(REMINDE R OF DATE IN O1D.1) . . .

---

PTS3RC1 PTS4C1	O8	Did you ever try to avoid thinking or having feelings about (EVENT) and find that you couldn't?	NO . . . . . 1 YES . . . . . 5
-------------------	----	---	-----------------------------------

---

PTS3RC2 PTS4C2	O9	Did you avoid activities, places, or people that reminded you of (EVENT)?	NO . . . . . 1 YES . . . . (SPECIFY) . . . . 5
-------------------	----	---	---

**IF YES:** Can you give me some examples?

\_\_\_\_\_  
\_\_\_\_\_

---

PTS3RC3 PTS4C3	O10	Did you find that you sometimes could <u>not</u> remember important things about (EVENT)?	NO . . . . . 1 YES . . . . . 5
-------------------	-----	---	-----------------------------------

---

PTS3RC4 PTS4C4	O11	During that period of time, did you lose interest in some things or stop doing some things that had been important to you before (EVENT) happened?	NO . . . . . 1 YES . . . . . 5
-------------------	-----	--	-----------------------------------

---

PTS3RC5 PTS4C5	O12	During that period of time, did you feel more cut off, distant, or separated from people than before (EVENT) happened?	NO . . . . . 1 YES . . . . (SPECIFY) . . . . 5
-------------------	-----	--	---

**IF YES:** Can you give me some examples?

\_\_\_\_\_  
\_\_\_\_\_

---

PTS3RC6 PTS4C6	O13	Were there times when you believed you had lost your ability to experience emotions that you had before (EVENT) happened? For example, did you feel you couldn't have loving feelings or anything like that?	NO . . . . . 1 YES . . . . . 5
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PTS3RC7 PTS4C7	O14	Were there times when you felt that there was no point in planning for the future--that you might not have a rewarding career; a happy family; or a long, good life?	NO . . . . . 1 YES . . . . . 5
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**BOX O15 REVIEW O8-O14. IF 3 OR MORE CODED 5, CONTINUE. OTHERS, SKIP TO P1, p. 133.**

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During that period of a month or longer when you were having the most, or most intense, feelings or experiences about (EVENT),  
(REMIND R OF DATE IN O1D.1) . . .

PTS3RD1 PTS4D1	O16	Did you have more trouble falling asleep or staying asleep than before (EVENT)?	NO . . . . .	1
			YES . . . . .	5

PTS3RD2 PTS4D2	O17	Did you find that you got irritated or lost your temper more easily than before (EVENT)?	NO . . . . .	1
			YES . . . . .	5

PTS3RD3 PTS4D3	O18	Were there times when you had more trouble concentrating than before (EVENT)?	NO . . . . .	1
			YES . . . . .	5

PTS3RD5 PTS4D5	O19	Were there times when unexpected noise, movement, or touch startled you more than before (EVENT)?	NO . . . . .	1
			YES . . . . .	5

PTS3RD4 PTS4D4	O20	Were you more watchful or extremely aware of things around you? For example, were you more aware of certain sounds, smells, or sights?	NO . . . . .	1
			YES . . . . .	5

**BOX O21 REVIEW O16-O20. IF 2 OR MORE CODED 5, CONTINUE. OTHERS, SKIP TO P1, p. 133.**

PTS3RE PTS4E	O22	You have told me about things such as reliving the event through dreams, memories, or feelings; avoiding things that reminded you of the event; and problems with sleep, mood, or thinking. Did these experiences last longer than one month?	NO . (SKIP TO P1, p.135) . .	1
			ALC/DRUG ONLY . . . . .	3
			YES, CLEAN . . . . .	5
			BOTH A/D & CLEAN . . .	6

A.	What is the longest amount of time that these experiences lasted?	MONTHS:   __ __ __
----	---	--------------------

B.	How soon after (EVENT) did you begin to experience these things?	______ UNITS
----	--	--------------

**CODE UNITS:**  
DAYS . . . . . 1  
WEEKS . . . . . 2  
MONTHS . . . . . 3  
YEARS . . . . . 4

C.	How old were you the last time you had a period of time like this?	AGE REC:        /
		REC:   1   2   3   4   5

PTS4F	D.	Did these experiences interfere with your work, school, household activities, or how you got along with other people? <b>SPECIFY:</b> _____	NO . . . . .	1
			YES. . . (SPECIFY) . . . . .	5

---

O23	Did you ever talk to a doctor or other professional about the problems you had after the (EVENT)?	NO . . . . . 1
		YES. . . (SPECIFY) . . . . 5

**SPECIFY:** \_\_\_\_\_

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**BOX O24 IF R HAD 1+ BOX MARKED ON ALCOHOL, COCAINE, OPIATE OR OTHER DRUG TALLY SHEET A, CONTINUE. OTHERS SKIP TO P1, p. 133.**

O24 We talked about the time when you had very intense feelings after you experienced (EVENT). I recorded that this troubling period of time started at (AGE).

**IF 3R CLUSTERING ON ALCOHOL/COCAINE/OPIATES/OTHER DRUG TALLY SHEET A, HAND TALLY(IES) TO R AND ASK A. OTHERS SKIP TO B.**

CLUSTERING  
AT ONSET

A.	Around the time you first had these very intense feelings, were you having experiences from 3 or more boxes found on this (ALCOHOL /COCAINE/ OPIATES /OTHER DRUG) sheet?	NO . . . . . 1
		YES . . . . (SKIP TO P1, p. 133) . . 5

HEAVY USE  
WHEN NOT  
CLUSTERING

B.	Around the time you first had these very intense feelings, were you (drinking heavily/using DRUGS) daily or almost daily?	NO . . . . . 1
		YES . . . . . 5

---

Now I would like to ask you about long periods of feeling worried or anxious.

P1	Have you ever been anxious, worried, nervous, or "on edge" more days than not for at least 6 months? For example, worrying about possible harm to a loved one who was not in danger, or worrying about finances for no good reason?	NO. . . (SKIP TO Q1, p.137) . . 1
		YES . . . . . 5

A. Please describe the different things you worried about.

EXAMPLES:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

GAD3RB/C  
GAD4D

**CIRCLE THE NUMBER IF THE WORRY IS NOT ABOUT BEING EMBARRASSED IN PUBLIC, HAVING A PANIC ATTACK, ALC/DRUG PROBLEMS, HEALTH/APPEARANCE, OR REALISTIC FINANCIAL/FAMILY PROBLEMS.**

GAD3RB  
GAD3RC

<b>B. ARE THERE 2 OR MORE WORRIES CIRCLED?</b>	NO . . (SKIP TO Q1, p. 137) . . 1
	YES . . . . . 5

GAD3RF  
GAD4F

C. BEGIN PROBING.

CODE: 2 3 4 5
---------------

WHOM SAW: \_\_\_\_\_  
WHAT TOLD: \_\_\_\_\_

**IF CODED 2, SKIP TO Q1, p.139.**

GAD3RA  
GAD4A

D.	Did people around you, such as family and friends, tell you that you worried far too much about these problems?	NO . . . . . 1
		YES. . . . . 5

GAD3RA  
GAD4A

1.	Have <u>you</u> ever thought that you worried far too much about these problems?	NO. . . (SKIP TO Q1, p. 137) . . 1
		YES . . . . . 5
2.	Did this anxiety or worry occur for more days than not for a period of at least 6 months?	NO. . . . . 1
		YES . . . . . 5

---

	P2	During that 6-month (or longer) period when you were anxious and worried about a number of things, did you also experience for more days than not...	<u>NO</u>	<u>YES</u>
GAD3RD1	1.	Trembling, twitching, or feeling shaky? . . . . .	1	5
GAD3RD2 GAD4C5	2.	Sore, aching, or tense muscles? . . . . .	1	5
GAD3RD3 GAD4C1	3.	Restlessness or feeling "keyed up" or on edge? . . . . .	1	5
GAD4C2 GAD3RD4	4.	Feeling easily tired or fatigued? . . . . .	1	5
GAD3RD5	5.	Shortness of breath or feeling like you were smothering? . . . . .	1	5
GAD3RD6	6.	Heart palpitations or a racing heart? . . . . .	1	5
GAD3RD7	7.	Sweating? Or cold, clammy hands? . . . . .	1	5
GAD3RD8	8.	Dry mouth? . . . . .	1	5
GAD3RD9	9.	Dizziness or lightheadedness? . . . . .	1	5
GAD3RD10	10.	Nausea, diarrhea, or stomach problems? . . . . .	1	5
GAD3RD11	11.	Flushes, hot flashes, or chills? . . . . .	1	5
GAD3RD12	12.	Frequent urination? . . . . .	1	5
GAD3RD13	13.	Trouble swallowing, or feeling a "lump" in your throat? . . . . .	1	5
GAD3RD14 GAD4C1	14.	Feeling "keyed up" or "on edge"? . . . . .	1	5
GAD3RD15	15.	Being easily startled? . . . . .	1	5
GAD3RD16 GAD4C3	16.	Difficulty concentrating or having your mind go blank? . . . . .	1	5
GAD3RD17 GAD4C6	17.	Difficulty falling asleep or staying asleep, or having restless, unsatisfying sleep so that when you woke up you did not feel rested? . . . . .	1	5
GAD3RD18 GAD4C4	18.	Irritability? . . . . .	1	5

**IF 3 OR MORE ARE CODED 5, CONTINUE.**  
**OTHERS SKIP TO Q1, p. 137.**

---

GAD3RE  
GAD4F

P3 During that 6-month (or longer) period, were you drinking caffeinated drinks like coffee, tea, or caffeinated soft drinks daily or almost daily?

NO. . . . . (SKIP TO C) . . . . . 1  
YES . . . . . 5

A. How many caffeinated drinks did you typically have each day? (CODE A 6 OZ. CUP OF COFFEE OR TEA OR A 12 OZ. CAN OF CAFFEINATED SODA AS 1 DRINK; E.G. 12 OZ COFFEE = 2 DRINKS)

\_\_\_\_ DRINKS

1. Which did you drink most often: coffee, tea, or caffeinated soft drinks?

COFFEE . . . . . 1  
TEA . . . . . 2  
SOFT DRINKS . . . . . 3

B. Did your anxiousness, worry, or feeling "on edge" usually occur soon after you drank caffeinated beverages (like coffee, tea, or soft drinks)?

NO . . . . . 1  
YES . . . . . 5

GAD3RE  
GAD4F

C. During that period, were you drinking heavily or using drugs, or had you recently cut down?

NO . . . . . 1  
YES . . . . . 5

GAD4E

P4 Did feeling anxious or worried for 6 months or longer cause you to have difficulty getting along with your friends or family, or to have problems at work or school?

NO . . . . . 1  
YES . . . (SPECIFY) . . . . . 5

**SPECIFY:** \_\_\_\_\_

\_\_\_\_\_

P5 During that 6-month (or longer) period, did you begin to drink or use drugs, or did you increase the amount of alcohol or drugs you were taking to help you feel less anxious or worried?

NO. . . . . (SKIP TO P6) . . . . . 1  
YES. . . . . (SPECIFY) . . . . . 5

**SPECIFY:**

1. \_\_\_\_\_

CODE: \_\_\_\_

2. \_\_\_\_\_

CODE: \_\_\_\_

A. Did (drinking/using drugs) help?

NO . . . . . 1  
YES . . . . . 5

P6 How old were you the (first/last) time you were anxious or worried about 2 or more problems for 6 months or longer and had some other problems like (SEVERAL SX ENDORSED IN P2) at the same time?

AGE ONS: \_\_\_\_/\_\_\_\_  
ONS: 1 2 3 4 5

AGE REC: \_\_\_\_/\_\_\_\_  
REC: 1 2 3 4 5

---

**BOX P7 IF I25E, I34C, OR I35C = 2+ WEEKS, ASK P7.  
OTHERS SKIP TO BOX P8.**

P7 You said earlier that you had periods of feeling depressed or had lost interest in things. Did these periods of feeling anxious and worried fall within a time when you were also depressed or had lost interest in your usual activities?

NO ..... 1  
YES ..... 5

---

**BOX P8 IF R HAD 1+ BOX MARKED ON ALC, COC, OP, OR DRUG TALLY SHEET A, CONTINUE.  
OTHERS SKIP TO Q1, p. 137.**

P8 We talked about the long period of time when you felt anxious or worried, which started at (AGE).

**IF DSM3R CLUSTERING ON ALC/COC/OP/DRUG  
TALLY SHEET A, HAND TALLIES TO R AND  
ASK A. OTHERS SKIP TO B.**

CLUSTERING  
AT ONSET

A. Around the time you first felt anxious or worried, were you having experiences from 3 or more boxes found on this ( ALC/COC/OP/ DRUG ) sheet?

NO ..... 1  
YES .. (SKIP TO Q1, p. 137) 5

HEAVY USE  
WHEN NOT  
CLUSTERING

B. Around the time you first felt anxious or worried, were you (drinking heavily / using DRUGS) daily or almost daily?

NO ..... 1  
YES ..... 5

---

(1)  
OCD3RA1  
OCD4A1/2

Q1 Have you ever had thoughts, images, or impulses that bothered you a lot and kept coming back? Ideas that are senseless -- like thinking your hands are dirty no matter how often you wash them or thinking of hurting someone you love when you're not even mad at them. Other examples are the repeated urge to curse in church or feeling sure many times that you have run over someone with your car.

NO... (SKIP TO Q9) . . . . . 1  
YES . . . . . 5

Please describe these to me:

EXAMPLES: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

A. **CODE SILENTLY:** ARE EXAMPLES IN Q1 ONLY ABOUT OWN EMOTIONAL PROBLEMS, ALC/ DRUG PROBLEMS, HEALTH/APPEARANCE, OR REALISTIC FINANCIAL/FAMILY PROBLEMS?

NO... (SKIP TO D) . . . . . 1  
YES . . . . . 5

OCD4D/E

B. Were the kinds of thoughts, images, or impulses that bothered you only about ( your emotional problems / problems you had with alcohol or drugs / other problems you had with your health or appearance / realistic money or family problems ) ?

NO . . . . . 1  
YES ... (SKIP TO Q9) . . . . . 5

C. What other kinds of thoughts or ideas bothered you?

EXAMPLE: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

D. **BEGIN PROBING**

CODE: 2 3 4 5

WHOM SAW: \_\_\_\_\_  
WHAT TOLD: \_\_\_\_\_

**IF CODED 2, SKIP TO Q9. OTHERS CONTINUE.**

OCD3RA2  
OCD4A3

Q2 Did you try to block these thoughts by doing something or thinking about something else?

NO... (SKIP TO Q9) . . . . . 1  
YES . . . . . 5

OCD3RA3  
OCD4A4

Q3 Were these your own thoughts or were they put in your head by someone else?

SOMEONE ELSE . . . . . 1  
OWN THOUGHTS . . . . . 5

**IF CODED 1, SKIP TO Q9. OTHERS CONTINUE.**

OCD4B

Q4 Did you think that these (thoughts/images/impulses) were unreasonable or excessive?

NO... (SKIP TO Q9) . . . . . 1  
YES . . . . . 5



**BOX Q5 IF J25A=5 OR J25C=5, CONTINUE.  
OTHERS SKIP TO Q6.**

OCD3RA4 OCD4D	Q5	Did these thoughts <u>only</u> occur when you were feeling sad, blue, or depressed, like the times we talked about earlier?	NO ..... 1 YES ..... 5
------------------	----	---	---------------------------

OCD3RA4 OCD4E	Q6	Did these thoughts <u>only</u> occur when you were using alcohol or drugs or had recently cut down?	NO ..... 1 YES ..... 5
------------------	----	---	---------------------------

(4) OCD3RB OCD4C	Q7	Did these thoughts really upset you or interfere with your normal routine? <b>SPECIFY:</b> _____	NO ..... 1 YES... (SPECIFY) ..... 5
------------------------	----	---	--

(5) OCD3RB OCD4C	A.	Did you find yourself having these thoughts or impulses for at least an hour a day?	NO ..... 1 YES ..... 5
------------------------	----	---	---------------------------

**BOX Q7 IF Q7 AND Q7A ARE BOTH CODED 1,  
SKIP TO Q9.**

Q8	When was the (first/last) time you experienced these thoughts to the point that they interfered with your normal routine or caused you to feel really upset?	AGE ONS: _____/_____ ONS: 1 2 3 4 5  AGE REC: _____/_____ REC: 1 2 3 4 5
----	--	--

(3) OCD3RA1 OCD4A1	Q9	Have you ever found that you <u>had</u> to do or think certain things over and over? For example, washing your hands so often your skin became sore or checking things like doors many times because you thought you hadn't locked them? What about performing behaviors in a set pattern? For example, putting on your clothes in a certain order, counting repeatedly, saying words to yourself over and over, or other rituals like that?	NO. (SKIP TO R1, p.143) . . 1 YES... (SPECIFY) ..... 5
--------------------------	----	--	---

**SPECIFY:** \_\_\_\_\_  
\_\_\_\_\_

OCD3RA2 OCD4A2	A.	Did you do those things to keep something bad from happening?	NO ..... 1 YES... (SPECIFY) ..... 5
-------------------	----	---	--

**SPECIFY:** \_\_\_\_\_  
\_\_\_\_\_

**B. BEGIN PROBING.**

CODE: 2 3 4 5
---------------

WHOM SAW: \_\_\_\_\_  
WHAT TOLD: \_\_\_\_\_

**IF CODED 2, SKIP TO R1,  
p.141. OTHERS CONTINUE.**

OCD3RA2 OCD4A2	Q10	If you tried to stop doing (BEHAVIOR), did you become anxious or very nervous?	NO ..... 1 YES... (SPECIFY) ..... 5
<b>SPECIFY:</b> _____ _____			
(Q3C) OCD3RA3 OCD4B	Q11	Did you think that these activities were unreasonable or excessive?	NO ..... 1 YES ..... 5
OCD4D	Q12	Were these activities <u>always</u> related to feelings about your body size or weight?	NO ..... 1 YES... (SPECIFY) ..... 5
<b>SPECIFY:</b> _____ _____			
<div style="background-color: #e0e0e0; padding: 10px; text-align: center;"> <b>BOX Q13      IF J25A = 5 OR J25C = 5, CONTINUE. OTHERS SKIP TO Q14.</b> </div>			
OCD4D	Q13	Did you perform these behaviors <u>only</u> when you were feeling sad, blue, or depressed, like the times we talked about earlier?	NO ..... 1 YES ..... 5
OCD4E	Q14	Did these behaviors <u>only</u> occur when you were using alcohol or drugs or had recently cut down?	NO ..... 1 YES ..... 5
(Q4) OCD3RB OCD4C	Q15	Did those activities really upset you or interfere with your normal routine?	NO ..... 1 YES... (SPECIFY) ..... 5
<b>SPECIFY:</b> _____ _____			
(Q5) OCD3RB OCD4C	A.	Did you find yourself performing these behaviors at least an hour at a time each day?	NO ..... 1 YES ..... 5
<div style="background-color: #e0e0e0; padding: 10px; text-align: center;"> <b>BOX Q15      IF Q15 AND Q15A ARE BOTH CODED 1, SKIP TO R1, p.143. OTHERS CONTINUE.</b> </div>			
Q16 When was the (first/last) time you performed these activities to the point that they caused you to feel really upset, interfered with your normal routine, or took up a lot of your time?			AGE ONS:      ____/____ ONS:      1   2   3   4   5  AGE REC:      ____/____ REC:      1   2   3   4   5

**BOX Q17 IF R HAD 1+ BOX MARKED ON ALCOHOL, COCAINE, OPIATE OR OTHER DRUG TALLY SHEET A, CONTINUE. OTHERS SKIP TO R1, p. 141.**

Q17 You told me about the (thoughts/behaviors) that occurred over and over, which first started at (AGE).

**IF 3R CLUSTERING ON ALC/COCAINE/OPIATE/ OTHER DRUG TALLY SHEET A, HAND TALLY(IES) TO R AND ASK A OTHERS SKIP TO B.**

CLUSTERING  
AT ONSET

A.	Around the time you first had repeated (thoughts/ behaviors), were you having experiences from 3 or more boxes found on this (ALCOHOL/ COCAINE/OPIATE /OTHER DRUG) sheet?	NO ..... 1 YES ... (SKIP TO R1, p.143) ... 5
----	---	---

HEAVY USE  
WHEN NOT  
CLUSTERING

B.	Around the time you first had repeated (thoughts/ behaviors), were you (drinking heavily/using DRUGS) daily or almost daily?	NO ..... 1 YES ..... 5
----	--	---------------------------

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(P7)  
SP3RA  
SP4A

R1 Some people have a strong and persistent fear of doing certain things in front of people like speaking, eating, or writing because they think they might embarrass themselves. These fears are stronger than the feelings that most people have.

Have you ever had a strong and persistent fear of: NO YES

- |   |   |   |
|---|---|---|
| 1. starting or keeping up conversations or talking to people you don't know well? | 1 | 5 |
| 2. speaking to your teachers, boss or other people in authority? . . . . .        | 1 | 5 |
| 3. speaking in public or answering questions in a meeting or a class? . . . . .   | 1 | 5 |
| 4. eating or drinking in public? . . . . .  | 1 | 5 |
| 5. writing while someone watches? . . . . .                                       | 1 | 5 |
| 6. using public restrooms (other than worry about germs)? . . . . .               | 1 | 5 |

**IF R1.1-6 ARE ALL NO, CODE 1 AND SKIP TO S1, p. 144. OTHERS, BEGIN PROBING.**

CODE: 1 2 3 4 5
-----------------

SPECIFY: \_\_\_\_\_

**IF CODED 1 OR 2, SKIP TO S1, p. 144.**

WHOM SAW: \_\_\_\_\_

WHAT TOLD: \_\_\_\_\_

SP3RB  
SP4G/H

**IF PHYSICAL DISABILITY/CONDITION MADE THE ACT DIFFICULT, CODE 4.  
IF R FEARED REVEALING A PSYCHIATRIC DISORDER OR IF SX WERE DUE TO A PSYCHIATRIC DISORDER, CODE 5.**

R1A. EDITOR'S CODE: CAN SX BE EXPLAINED BY OTHER DISORDER?	
NO . . . . .	1
YES . . . . .	5

(P8)  
SP3RC  
SP4B

R2 Did being in (this/these) situation(s) almost always make you extremely nervous (when you were not using alcohol or drugs)?

NO . . (SKIP TO S1, p. 144) . 1  
YES . . . . . 5

(P10)  
SP3RD  
SP4D

A. Did you try to avoid that situation?

NO . . . . . 1  
YES . . . . .  
..... 5

(P10A)  
SP4D

B. When you had to be in that situation, did you almost always feel extremely nervous or panicky?

NO . . (SKIP TO S1, p. 144) . 1  
YES . . . . . 5

(P12)  
SP3RF  
SP4C

R3 Do you think that your fear was excessive or unreasonable?

NO . . (SKIP TO S1, p. 144) . 1  
YES . . . . . 5

(P11) SP3RE SP4E	R4	Did this fear or avoiding the situation ever interfere with your job, school, social functioning, or normal routine?	NO ..... 1 YES....(SPECIFY) ..... 5
------------------------	----	--	--

**SPECIFY:** \_\_\_\_\_

SP3RE SP4E	A.	Have you been very upset with yourself for having any of these fears?	NO ..... 1 YES ..... 5
---------------	----	---	---------------------------

**BOX R4 IF R4 AND R4A ARE BOTH CODED 1, SKIP TO S1, p. 144. OTHERS CONTINUE.**

SP4-Generalized	R5	Would you say that these problems occurred in <i>most</i> social situations?	NO ..... 1 YES ..... 5
-----------------	----	--	---------------------------

R6	About how long did your fear (interfere with your functioning/make you upset with yourself)?	MONTHS: ____ ____ ____
----	--	------------------------

R7	How old were you the (first/last) time (this fear/any of these fears) (interfered with your functioning/made you upset with yourself)?	AGE ONS:        ____/____ ONS:     1   2   3   4   5 AGE REC:        ____/____ REC:     1   2   3   4   5
----	--	--

R8	Did you ever take medicine, begin to drink or use drugs, or increase the amount of alcohol or drugs that you were using because of (this fear/these fears)?	NO... (SKIP TO BOX R9) .. 1 YES... (SPECIFY) ..... 5
----	---	---

**SPECIFY:**

1. \_\_\_\_\_

2. \_\_\_\_\_

CODE: \_\_\_\_ \_\_\_\_ \_\_\_\_

CODE: \_\_\_\_ \_\_\_\_ \_\_\_\_

A.	Did (taking medicine/drinking alcohol/using drugs) help?	NO ..... 1 YES ..... 5
----	--	---------------------------

**BOX R9 IF R1.4 = 5 CONTINUE. OTHERS SKIP TO S1, p. 144.**

(P14) SP3RB SP4H	R10	A.	Did any of these fears occur because you were afraid people would notice you had an eating problem?	NO . . . . . 1
				YES . . . . . 5
		B.	Did any of these fears occur because you were afraid people would notice you have a stuttering problem or another problem speaking?	NO . . . . . 1
				YES . . . . . 5

IF B IS CODED 5, NOTE IF YOU OBSERVED SUCH A  
PROBLEM (SPECIFY): \_\_\_\_\_

**BOX R11 IF R HAD 1+ BOX MARKED ON  
ALCOHOL, COCAINE, OPIATE, OR  
OTHER DRUG TALLY SHEET A,  
CONTINUE.  
OTHERS SKIP TO S1, p. 144.**

R11 You told me about feeling very concerned about  
(SITUATIONS) in public and that first started at  
(AGE).

**IF DSM3R CLUSTERING ON  
ALC/COC/OP/DRUG TALLY SHEET A, HAND  
TALLIES TO R AND ASK A. OTHERS SKIP TO  
B.**

CLUSTERING AT ONSET	A.	Around the time you first felt concerned about (SITUATIONS), were you having experiences from 3 or more boxes found on this (ALC/COC/OP/DRUG) sheet?	NO . . . . . 1
			YES . . (SKIP TO S1, p. 144) . 5
HEAVY USE WHEN NOT CLUSTERING	B.	Around the time you first felt concerned about (SITUATIONS), were you (drinking heavily / using DRUGS) daily or almost daily?	NO . . . . . 1
			YES . . . . . 5

AGP3RA  
AGP4A

S1 Some people have a fear of being in certain places or situations where they feel it would be difficult to leave easily. They are worried that they could not escape or get help if they suddenly became panicky. Some situations like this include being alone away from home; being in a crowd; being in a place where there was a long distance between exits, like in a tunnel or on a bridge; traveling in a bus, car, or train; or being in an elevator. Have you ever had a period of time when you had a fear like that (that you might become panicky and wouldn't be able to leave easily if that happened)?

NO .. (SKIP TO T1, p.147) .. 1  
YES ..... 5

AGP3RA

S2 Did you feel this way about:

NO YES

1. going outside of the house alone? ..... 1 5
2. being in a crowd or standing in a line? ..... 1 5
3. being on a bridge or in a tunnel? ..... 1 5
4. traveling in a bus, train, or car? ..... 1 5
5. being in an elevator? ..... 1 5

**IF ALL ARE CODED 1, CONTINUE.  
OTHERS SKIP TO B.**

A. What situation did you have in mind when you said some situations made you unreasonably afraid?

NONE. . (SKIP TO T1, p. 147) 1  
ANY ..... 5

EXAMPLE: \_\_\_\_\_

AGP4A

B. Did more than one situation make you feel this way?

NO ..... 1  
YES ..... 5

AGP4C

C. **BEGIN PROBING. SPECIFY FEAR AND  
RECORD EXAMPLES.**

CODE: 2 3 4 5

What was it about (SITUATIONS) that was frightening to you?

**IF CODED 2, SKIP TO T1, p. 147.  
OTHERS CONTINUE.**

EXAMPLES: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

WHOM SAW: \_\_\_\_\_

WHAT TOLD: \_\_\_\_\_

S2D. EDITOR'S CODE:  
CAN SX BE EXPLAINED  
BY ANOTHER  
DISORDER?  
NO ..... 1  
YES ..... 5

AGP3RA AGP4B	S3	A. When you were in those situations, did you <u>usually</u> :	NO	YES
		1. get sweaty? . . . . .	1	5
		2. tremble? . . . . .	1	5
		3. have a dry mouth? . . . . .	1	5
		4. feel dizzy? . . . . .	1	5
		5. feel your heart pound? . . . . .	1	5
		6. get nauseated or vomit? . . . . .	1	5
		7. feel like you couldn't control your bodily functions? . . . . .	1	5
		8. feel tightness or pain in your chest or stomach? . . . . .	1	5
		9. feel that you, or things around you, seemed unreal? . . . . .	1	5
AGP4A		B. When you were in situations like (SITUATIONS IN S2), were you afraid that any of these things might happen?	NO . . . . . YES . . . . .	1 5

---

AGP3RA AGP4B	S4	Did you almost always avoid these situation(s) or stop going places because of your fear that you would feel sick or be embarrassed?	NO . . . . . YES . . . . . (SPECIFY) . . . . .	1 5
SPECIFY: _____ _____				
AGP3RA AGP4B		A. Has your fear kept you from going somewhere you wanted to go 3 or more times?	NO . . . . . YES . . . . . (SPECIFY) . . . . .	1 5
SPECIFY: _____ _____				
AGP3RA AGP4B		B. When you had to be in one of these situations, did it almost always make you extremely nervous or panicky?	NO . . . . . YES . . . . . (SPECIFY) . . . . .	1 5
SPECIFY: _____ _____				
AGP3RA AGP4B		C. When you had to be in one of these situations, did you begin to need someone to be with you?	NO . . . . . YES . . . . . (SPECIFY) . . . . .	1 5
SPECIFY: _____ _____				

**BOX S4 IF S4, S4A, S4B, AND S4C ARE ALL CODED 1, SKIP TO T1, p. 147. OTHERS CONTINUE.**



---

S5	How old were you the (first/last) time you had this fear and had some other problems like (SX ENDORSED IN S3 AND S4) at the same time?	AGE ONS: ____/____ ONS: 1 2 3 4 5  AGE REC: ____/____ REC: 1 2 3 4 5
----	--	--

---

S6	Did you ever take medicine, begin to drink or use drugs, or increase the amount of alcohol or drugs that you were using because of this fear?	NO .. (SKIP TO BOX S7) .. 1 YES .... (SPECIFY) ..... 5
----	---	---

**SPECIFY:**

1. \_\_\_\_\_

CODE: \_\_\_\_ \_

2. \_\_\_\_\_

CODE: \_\_\_\_ \_

A.	Did (taking medicine/drinking alcohol/using drugs) help?	NO ..... 1 YES ..... 5
----	--	---------------------------

**BOX S7 IF R HAD 1+ BOX MARKED ON ALC, COC, OP, OR DRUG TALLY SHEET A, CONTINUE. OTHERS SKIP TO T1, p. 147.**

S7 You told me you had a concern about being in a situation where you could not escape if something bad would happen to you. I recorded that this started for you at (AGE).

**IF 3R CLUSTERING ON ALC/COC/OP/DRUG TALLY SHEET A, HAND TALLIES TO R AND ASK A. OTHERS SKIP TO B.**

CLUSTERING  
AT ONSET

A.	Around the time you first started feeling concerned about not being able to escape if needed, were you having experiences from 3 or more boxes found on this ( ALC/COC/OP/DRUG ) sheet?	NO ..... 1 YES .... (SKIP TO T1, p. 147) .. 5
----	---	--

HEAVY USE  
WHEN NOT  
CLUSTERING

B.	Around the time you first started feeling concerned about not being able to escape if needed, were you (drinking heavily/ using DRUGS) daily or almost daily?	NO ..... 1 YES ..... 5
----	---	---------------------------

---

(O1)  
PAN3RA/E  
PAN4A  
AGPAN3R  
A  
AGPAN4A1

T1 Have you ever had a spell or attack when all of a sudden you felt frightened, anxious, or panicky in situations when most people would not be afraid or anxious; that is, during times when you were not in danger, or were not making a speech, or something like that?

CODE: 1 2 3 4 5

**IF CODED 1 OR 2, SKIP TO U1, p. 151 . OTHERS CONTINUE.**

EXAMPLE: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

WHOM SAW: \_\_\_\_\_

WHAT TOLD: \_\_\_\_\_

(O2)  
PAN3RB  
AGPAN3R  
A

T2 Have you ever had...

NO YES

A. 3 attacks within a three-week period? ..... 1 5

B. 4 attacks within a four-week period? ..... 1 5

(O3)  
PAN3RB  
PAN4A2A  
AGPAN3R  
A  
AGPAN4A2  
A

T3 After having an attack, did you ever have a month or more when you worried a lot about having an attack or you were afraid that you might have another attack?

NO ..... 1  
YES ..... 5

A. Did you think that having attacks like this must mean that you had a serious illness or that you were going crazy?  
NO ..... (SKIP TO B) .... 1  
YES ..... 5

PAN4A2B  
AGPAN4A2  
B

1. Did you think that for a month or longer?  
NO ..... 1  
YES ..... 5

B. Did having an attack like this cause you to stop doing anything that you used to do or stop going places you used to go?  
NO. .... (SKIP TO C) .... 1  
YES ..... 5

PAN4A2C  
AGPAN4A2  
C

1. Did you stop doing things or going places for a month or longer?  
NO ..... 1  
YES ..... 5

C. After having an attack like this, did you begin to need someone to go with you?  
NO. .... (SKIP TO T4) ... 1  
YES ..... 5

1. Did that last for a month or longer?  
NO ..... 1  
YES ..... 5

PAN4A2C  
AGPAN4A2  
C

(O4)  
PAN3RC  
PAN4A1  
AGPAN3R  
A  
AGPAN4A1

T4 During one of your worst attacks, did you have...

NO    YES

PAN3RC1  
PAN4A1.4

1. Shortness of breath or feeling that you were smothering? ..... 1    5

PAN3RC3  
PAN4A1.1

2. Palpitations or a pounding heart? ..... 1    5

PAN3RC2  
PAN4A1.8

3. Dizziness, light-headedness, unsteadiness, or feeling faint? ..... 1    5

PAN3RC11  
PAN4A1.6

4. Chest tightness or chest pain? ..... 1    5

PAN3RC9  
PAN4A1.12

5. Numbness or tingling in your face, feet, or fingers? ..... 1    5

PAN3RC6  
PAN4A1.5

6. Choking sensation? ..... 1    5

PAN3RC5  
PAN4A1.2

7. Sweating? ..... 1    5

PAN3RC4  
PAN4A1.3

8. Shaking or trembling? ..... 1    5

PAN3RC10  
PAN4A1.13

9. Flushing, hot flashes, or chills? ..... 1    5

PAN3RC8  
PAN4A1.9

10. A feeling that things were unreal? ..... 1    5

PAN3RC12  
PAN4A1.11

11. A fear that you might die? ..... 1    5

PAN3RC13  
PAN4A1.10

12. A fear that you were going crazy or losing control? ..... 1    5

PAN3RC7  
PAN4A1.7

13. Nausea or discomfort in your stomach or abdomen? ..... 1    5

**BOX T4    IF 4 OR MORE ARE CODED 5 IN T4.1-13,  
CONTINUE. OTHERS SKIP TO U1, p. 151.**

(O5)  
PAN3RD  
PAN4A1  
AGPAN3R  
A  
AGPAN4A1

T5 You mentioned you had attacks of feeling frightened and some problems like (SX IN T4.1-13). How many episodes have you had in your lifetime that had 4 or more of these problems?

\_\_\_ NUMBER

**BOX T5    IF ONLY 1 ATTACK, SKIP TO U1, p. 151.  
OTHERS CONTINUE.**

(O6)  
PAN3RD  
PAN4A1  
AGPAN3R  
A  
AGPAN4A1

T6 During at least several of your attacks, did some of these problems such as: (UP TO 4 SX CODED IN T4) begin suddenly, and get worse in the first 10 minutes of the attacks?

NO ..... 1  
YES ..... 5

PAN4D	T7	A. <b>IF ANY 5 CODED IN R1.1-6 (SOCPHOB, p. 143), ASK:</b> Did you have attacks like that when you were (SOCPHOB SITUATIONS CODED 5 IN R1.1-6)?	NO ..... 1 YES ..... 5
PAN4D		B. <b>IF ANY 5 CODED IN S2.1-5 (AGPHOB, p. 146), ASK:</b> Did you have attacks like that when you were (AGPHOB SITUATIONS CODED 5 IN S2.1-5)?	NO ..... 1 YES ..... 5
		C. Did being in any (other) particular situations make it likely that you would have an attack like this?	NO ..... (SKIP TO D) ..... 1 YES ..... (SPECIFY) ..... 5
		<b>SPECIFY:</b> _____ _____	
		D. Have you had these attacks at times when you had no reason to expect one because you were not in any special situation?	NO ..... 1 YES ..... 5

---

(07)	T8	How old were you the (first/last) time you had one of these sudden attacks of feeling frightened or anxious when you had 4 or more problems like (ALL SX CODED 5 IN T4.1-13)?	AGE ONS:    /    / ONS:1   2   3   4   5  AGE REC:    /    / REC:1   2   3   4   5
		<b>IF DK AND R IS UNDER 40, CODE T8A "YES" WITHOUT ASKING. IF DK AND R IS 40 OR OLDER, ASK A. OTHERS SKIP TO T9.</b>	
		A. <b>IF DK:</b> Would you say that the first time was before you were 40?	NO ..... 1 YES ..... 5

---

(08)	T9	Have you ever been nervous or anxious much of the time between attacks?	NO ..... 1 YES ..... 5
------	----	---	---------------------------

---

(09)	T10	Did these attacks ever cause you to have difficulty in getting along with your family or to have problems at work or at school? <b>SPECIFY:</b> _____	NO ..... 1 YES ..... (SPECIFY) ..... 5
------	-----	--	---

---

---

T11	Did you ever take medicine, begin to drink or use drugs, or increase the amount of the alcohol or drugs that you were using because of these attacks?	NO . . . (SKIP TO BOX T12) 1 YES . . . . (SPECIFY) . . . . 5
-----	---	---

**SPECIFY:**

- |    |       |
|----|-------|
| 1. | _____ |
| 2. | _____ |

CODE: \_\_\_\_\_

CODE: \_\_\_\_\_

A. Did (drinking/using drugs) help?

NO . . . . . 1  
YES . . . . . 5

---

**BOX T12 IF R HAD 1+ BOX MARKED ON ALC, COC, OP, OR DRUG TALLY SHEET A, CONTINUE. OTHERS SKIP TO U1, p. 151.**

T12 We talked about sudden attacks of feeling panicky, frightened, or nervous. You said that first happened at (AGE).

**IF 3R CLUSTERING ON ALC/MJ/DRUG TALLY SHEET A, HAND TALLIES TO R AND ASK A. OTHERS SKIP TO B.**

CLUSTERI  
NG  
AT ONSET

A. Around the time the attacks first started, were you having experiences from 3 or more boxes found on this (ALC/COC/OP/DRUG ) sheet?

NO . . . . . 1  
YES . . (SKIP TO U1, p. 151) . . . . 5

HEAVY  
USE  
WHEN  
NOT  
CLUSTERI  
NG

B. Around the time the attacks first started, were you (drinking heavily/ using DRUGS) daily or almost daily?

NO . . . . . 1  
YES . . . . . 5

---

Now I'm going to ask you some questions about gambling.

U1. Have you ever gambled (for money)? For example  
have you ever placed a bet on a sporting event,  
gone to a casino, or bought a lottery ticket.

NO (SKIP TO V1, p. 158) 1  
YES ..... 5

A. When you were gambling the most, how  
often did you gamble? **CONTINUE**  
**ONLY IF YOU CODED 2, 3, OR 4; IF**  
**YOU CODED 5, END OF SSAGA**

\_\_\_\_\_  
CODE:  
2 - daily  
3 - weekly (1-6 times/wk)  
4 - monthly (1-3 times/mo)  
5 - less than monthly

B. When you were gambling the most, how  
much money did you typically gamble in a  
month? **CONTINUE ONLY IF**  
**MONTHLY AMOUNT EXCEEDS \$10;**  
**IF NOT, END OF SSAGA**

**CODE IN DOLLARS:**  
\$ \_\_\_\_

C. When was the first/last time you gambled?

AGE ONS: \_\_\_\_/\_\_\_\_

AGE REC: \_\_\_\_/\_\_\_\_

---

U2. How old were you during the period of time when  
you gambled most?

AGE SEV: \_\_\_\_/\_\_\_\_

A. How long did that period (of heaviest  
gambling) last?

\_\_\_\_ MONTHS

B. During the period when you were gambling the most, how often did you do each kind of gambling?

CODE:  
 2 - daily  
 3 - weekly (1-6 times/wk)  
 4 - monthly (1-3 times/mo)  
 5 - less than monthly  
 (code "5" for *never*)

1. Bets on horse, dog or other animal racing (include betting at the track, off-track betting, and bets with bookies). . . . .

2. Bets on other sports (include pools, with a bookie, jai alai). . . . .

3. Card games (including blackjack). . . . .

4. Dice games (including craps). . . . .

5. Slot machines, poker machines, or other electronic machines . . . . .

6. Roulette . . . . .

7. Bought daily numbers, lotto, or lottery tickets. . . . .

8. Bought scratch tickets or pull tabs. . . . .

9. Played bingo for money . . . . .

10. Played sports (e.g., pool, golf) for money. . . . .

11. Bought high-risk stocks or commodities

12. Gambled on the internet . . . . .

---

U3. During that time, did your gambling cause problems for you?

NO. . . . . 1  
 YES . . . . . 5

---

U4. During that time, did anyone object to your gambling?

NO. . . . . 1  
 YES . . . . . 5

**BOX U4**      **IF ANY CATEGORY UNDER QUESTION U2-B IS SCORED 2, 3, OR 4, OR IF THE ANSWER TO U3 OR U4 IS SCORED 5, CONTINUE; OTHERWISE, SKIP TO SUBJECT COMMENTS, p. 158**

---

U5.	Let me ask you a few more questions about your gambling. We will be talking primarily about the times you were gambling most.	CODE:	
			1 - more than once a day
			2 - daily
			3 - weekly (1-6 times/week)
			4 - monthly (1-3 times/mo)
			5 - less than monthly (code "5" for <i>never</i> )
	A.      How often do (did) you think about gambling? . . . . .		_____
	B.      How much do you think about past gambling experiences? . . . . .		_____
	C.      How often do you imagine or plan future gambling? . . . . .		_____
	D.      How often do you think about getting money to gamble or pay back gambling debts? . . . . .		_____
	E.      Do your thoughts about gambling get in the way of concentration on work, family or other responsibilities?		
		NO. . . . .	1
		YES . . . . .	5

---

U6.	A.      At the time you were gambling the most, what were the reasons you gambled? Did you ever gamble to...		
	1.      escape problems in your life?	NO . . . . .	1
		YES . . . . .	5
	2.      relieve uncomfortable or bad feelings or moods?	NO . . . . .	1
		YES . . . . .	5

**IF BOTH A1 AND A2 ARE CODED 1, SKIP TO U7. OTHERS CONTINUE**



B. At the time you were gambling the most,  
how often did you gamble for either of  
these reasons? .....

CODE:

- 1 - more than once a day
  - 2 - daily
  - 3 - weekly (1-6 times/week)
  - 4 - monthly (1-3 times/mo)
  - 5 - less than monthly
- 

U7. Have you ever needed to increase the amount of  
money you gambled in order to maintain the  
excitement, or the hope of "winning big," or any of  
the other effects you got from gambling?

NO ... (SKIP TO B). ... 1  
YES ..... 5

A. How large was the increase in money?

**CODE AMOUNT OF  
INCREASE IN DOLLARS:**

**IF R IS UNABLE TO ANSWER THE  
QUESTION, CODE 9999**

\$ \_\_\_\_\_

B. Did you find that when you gambled the  
same amount as when you started  
gambling it had much less effect than  
before?

NO ..... 1  
YES ..... 5

---

U8. When you have lost money gambling, have you  
ever chased after your losses? In other words, have  
you often returned to try and get even?

NO ..... 1  
YES ..... 5

---

- U9. Have you ever lied to anyone about gambling, such as how long you gambled, or the amount of money gambled, or that you were gambling at all?
- NO .. (SKIP TO U 10). . . 1  
YES ..... 5
- A. To whom did you lie?
1. Spouse or significant other. .... NO ..... 1  
YES ..... 5
2. Work supervisor or co-workers. .... NO ..... 1  
YES ..... 5
3. Friends. .... NO ..... 1  
YES ..... 5
4. Others. .... NO ..... 1  
YES ..... 5
- \_\_\_\_\_ TIMES
- B. About how many times have you lied to others about how much you were gambling?

- U10. Has your gambling ever caused problems for you in your family, work, school or social life to the extent that you lost or risked losing something or someone important?
- NO ..... 1  
YES ..... 5

- U11. Has gambling ever resulted in any other losses such as damage or risk to your reputation or your mental or physical health?
- NO ..... 1  
YES ..... 5

- U12. Have you ever attempted to control your gambling by repeated unsuccessful efforts at cutting back or stopping?
- NO. .... 1  
YES ..... 5

- A. How many times? \_\_\_\_\_ TIMES

- U13. Did you ever stop gambling entirely? NO. .... 1  
YES. .... 5
- A. What is the longest period of time that you  
have ever been able to keep from  
gambling? \_\_\_\_\_ MONTHS
- B. Did you (or do you) want to stop or cut  
down? NO. .... 1  
YES .... 5
- C. Is this something you have been worrying  
about? NO .... 1  
YES .... 5
- 

- U14. Did you ever experience restlessness or irritability  
when you tried to cut back or stop gambling? NO. .... 1  
YES .... 5
- A. Did you ever experience any other  
discomfort or upset when cutting back or  
stopping gambling such as trouble  
sleeping, sweating, handshaking, or  
anxiety? NO. .... 1  
YES .. (SKIP TO U16) 5
- 

- U15. Did you ever experience any of the signs I just  
listed when you wanted to gamble but the situation  
prevented gambling (for example, when you had  
no money, or when there was no gambling  
opportunity)? NO. .... 1  
YES .... 5
- 

- U16. Have you ever done any of the following to get  
money to gamble or to pay gambling debts:
- A. Asked for money or been given money  
from a family member or close friend? NO. .... 1  
YES .... 5
- B. Borrowed money against a credit  
card or from a bank or other lender? NO. .... 1  
YES .... 5
- C. Cashed in bonds, stocks, or retirement  
accounts? NO. .... 1  
YES .... 5
- D. Sold personal property or family property? NO .... 1  
YES .... 5
-

U17. Have you ever done anything illegal to get money to gamble or to pay gambling debts, for example:

- |    |   |                           |
|----|---|---------------------------|
| A. | Have you ever written a bad check, such as writing a check when you knew there was not enough money in the bank account to cover it?        | NO. .... 1<br>YES ..... 5 |
| B. | Have you written checks to accounts in different banks to keep bad checks afloat (“kiting” checks)?   | NO. .... 1<br>YES ..... 5 |
| C. | Have you passed a check after signing or forging someone else’s name on it?   | NO. .... 1<br>YES ..... 5 |
| D. | Have you lied about the facts when submitting an insurance claim?   | NO. .... 1<br>YES ..... 5 |
| E. | Have you taken money from someone or from somewhere without permission (including a family member) even if you planned to return the money? | NO. .... 1<br>YES ..... 5 |

**V: SUBJECT COMMENTS**

---

As you can see, I tried to ask you about a lot of different kinds of emotional problems, physical and medical problems, and habits that people might have. But, of course, everyone is different, and I might have skipped something that has been important to you. Have you had any problems I should have covered but didn't?

**RECORD VERBATIM:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you have any comments about the interview itself?

**RECORD VERBATIM:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**RECORD TIME ENDED:** \_\_\_\_ : \_\_\_\_ : \_\_\_\_  
(USE 24 HOUR CLOCK)

---

## W: INTERVIEWER OBSERVATIONS

<b>BORDERLINE</b>	<b>= 3</b>
<b>DEFINITE</b>	<b>= 4</b>
<b>DOES NOT APPLY</b>	<b>= 9</b>

### TYPE OF INTERVIEW: (Choose 1)

<b>PERSONAL INTERVIEW</b>	<b>..... 1</b>
<b>TELEPHONE INTERVIEW</b>	<b>..... 2</b>
<b>PROXY INTERVIEW</b>	<b>..... 3</b>

IF CODED 5 OR 9, SKIP TO NEXT QUESTION.

**A. FACIAL EXPRESSION IS NORMAL?** NO.....1  
YES.....5  
PHONE...9

- |                |   |   |   |
|----------------|---|---|---|
| 1. Sad         | 3 | 4 | 9 |
| 2. Gloomy      | 3 | 4 | 9 |
| 3. Hostile     | 3 | 4 | 9 |
| 4. Worried     | 3 | 4 | 9 |
| 5. Avoids gaze | 3 | 4 | 9 |
| 6. Immobile    | 3 | 4 | 9 |

**B. DRESS IS NORMAL?** NO.....1  
YES.....5  
PHONE...9

- |   |   |   |   |
|---|---|---|---|
| 1. Meticulous                           | 3 | 4 | 9 |
| 2. Clothing, hygiene poor               | 3 | 4 | 9 |
| 3. Eccentric                            | 3 | 4 | 9 |
| 4. Seductive                            | 3 | 4 | 9 |
| 5. Inadequate for warmth and protection | 3 | 4 | 9 |

**C. MOTOR ACTIVITY IS NORMAL?** NO.....1  
YES.....5  
PHONE...9

- |   |   |   |   |
|---|---|---|---|
| 1. Increased amount   | 3 | 4 | 9 |
| 2. Constantly fiddling, changing position, standing or sitting down | 3 | 4 | 9 |
| 3. Agitation  | 3 | 4 | 9 |
| 4. Tics   | 3 | 4 | 9 |
| 5. Tremor   | 3 | 4 | 9 |
| 6. Peculiar posturing   | 3 | 4 | 9 |
| 7. Unusual gait   | 3 | 4 | 9 |
| 8. Repetitive acts  | 3 | 4 | 9 |
| 9. Very slow to move; unusual for age & physical condition          | 3 | 4 | 9 |
| 10. Rigid posture   | 3 | 4 | 9 |

**D. FLOW OF THOUGHT IS NORMAL?** NO.....1  
YES.....5

- |                    |   |   |   |
|--------------------|---|---|---|
| 1. Blocking        | 3 | 4 | 9 |
| 2. Circumstantial  | 3 | 4 | 9 |
| 3. Tangential      | 3 | 4 | 9 |
| 4. Perseveration   | 3 | 4 | 9 |
| 5. Flight of ideas | 3 | 4 | 9 |
| 6. Indecisive      | 3 | 4 | 9 |
| 7. Illogical       | 3 | 4 | 9 |

**E. LEVEL OF CONSCIOUSNESS IS NORMAL?** NO.....1  
YES.....5

- |                  |   |   |   |
|------------------|---|---|---|
| 1. Hypervigilant | 3 | 4 | 9 |
| 2. Drowsy        | 3 | 4 | 9 |
| 3. Stupor        | 3 | 4 | 9 |

**F. SPEECH IS NORMAL?** NO.....1  
YES.....5

- |  |   |   |   |
|--|---|---|---|
| 1. Excessive amount                            | 3 | 4 | 9 |
| 2. Reduced amount                              | 3 | 4 | 9 |
| 3. Push of speech                              | 3 | 4 | 9 |
| 4. Slowed                                      | 3 | 4 | 9 |
| 5. Loud  | 3 | 4 | 9 |
| 6. Soft  | 3 | 4 | 9 |
| 7. Mute  | 3 | 4 | 9 |
| 8. Slurred                                     | 3 | 4 | 9 |
| 9. Stuttering                                  | 3 | 4 | 9 |
| 10. Neologisms                                 | 3 | 4 | 9 |
| 11. Gloomy, voice choking on distressing topic | 3 | 4 | 9 |
| 12. Fails to answer, questions need repeating  | 3 | 4 | 9 |
| 13. Monotonous voice                           | 3 | 4 | 9 |

**G. INTERVIEW BEHAVIOR IS NORMAL?** NO.....1  
YES.....5

- |                     |   |   |   |
|---------------------|---|---|---|
| 1. Angry outbursts  | 3 | 4 | 9 |
| 2. Irritable        | 3 | 4 | 9 |
| 3. Impulsive        | 3 | 4 | 9 |
| 4. Hostile          | 3 | 4 | 9 |
| 5. Silly            | 3 | 4 | 9 |
| 6. Sensitive        | 3 | 4 | 9 |
| 7. Apathetic        | 3 | 4 | 9 |
| 8. Withdrawn        | 3 | 4 | 9 |
| 9. Evasive          | 3 | 4 | 9 |
| 10. Passive         | 3 | 4 | 9 |
| 11. Aggressive      | 3 | 4 | 9 |
| 12. Naive           | 3 | 4 | 9 |
| 13. Overly dramatic | 3 | 4 | 9 |
| 14. Manipulative    | 3 | 4 | 9 |
| 15. Dependent       | 3 | 4 | 9 |
| 16. Uncooperative   | 3 | 4 | 9 |
| 17. Demanding       | 3 | 4 | 9 |
| 18. Negativistic    | 3 | 4 | 9 |
| 19. Callous         | 3 | 4 | 9 |

## INTERVIEWER OBSERVATIONS - CONTINUED

### H. MOOD AND AFFECT ARE NORMAL? NO.....1 YES.....5

- |    |                      |   |   |   |
|----|----------------------|---|---|---|
| 1. | Anxious              | 3 | 4 | 9 |
| 2. | Inappropriate affect | 3 | 4 | 9 |
| 3. | Flat affect          | 3 | 4 | 9 |
| 4. | Elated mood          | 3 | 4 | 9 |
| 5. | Depressed mood       | 3 | 4 | 9 |
| 6. | Labile mood          | 3 | 4 | 9 |

### I. CONTENT OF THOUGHT IS NORMAL? NO.....1 YES.....5

- |     |                            |   |   |   |
|-----|----------------------------|---|---|---|
| 1.  | Suicidal thoughts          | 3 | 4 | 9 |
| 2.  | Suicidal plans             | 3 | 4 | 9 |
| 3.  | Assaultive ideas           | 3 | 4 | 9 |
| 4.  | Homicidal thoughts         | 3 | 4 | 9 |
| 5.  | Homicidal plans            | 3 | 4 | 9 |
| 6.  | Antisocial attitudes       | 3 | 4 | 9 |
| 7.  | Suspiciousness             | 3 | 4 | 9 |
| 8.  | Poverty of content         | 3 | 4 | 9 |
| 9.  | Phobias                    | 3 | 4 | 9 |
| 10. | Obsessions                 | 3 | 4 | 9 |
| 11. | Compulsions                | 3 | 4 | 9 |
| 12. | Feelings of unreality      | 3 | 4 | 9 |
| 13. | Feels persecuted           | 3 | 4 | 9 |
| 14. | Thoughts of running away   | 3 | 4 | 9 |
| 15. | Somatic complaints         | 3 | 4 | 9 |
| 16. | Ideas of guilt             | 3 | 4 | 9 |
| 17. | Ideas of hopelessness      | 3 | 4 | 9 |
| 18. | Ideas of worthlessness     | 3 | 4 | 9 |
| 19. | Excessive religiosity      | 3 | 4 | 9 |
| 20. | Sexual preoccupation       | 3 | 4 | 9 |
| 21. | Blames others              | 3 | 4 | 9 |
| 22. | Illusions are present      | 3 | 4 | 9 |
| 23. | Auditory hallucination     | 3 | 4 | 9 |
| 24. | Visual hallucination       | 3 | 4 | 9 |
| 25. | Other hallucinations       | 3 | 4 | 9 |
| 26. | Delusion of persecution    | 3 | 4 | 9 |
| 27. | Delusion of grandeur       | 3 | 4 | 9 |
| 28. | Delusion of reference      | 3 | 4 | 9 |
| 29. | Delusion of influence      | 3 | 4 | 9 |
| 30. | Somatic delusion           | 3 | 4 | 9 |
| 31. | Other delusions            | 3 | 4 | 9 |
| 32. | Delusions are systematized | 3 | 4 | 9 |

### J. ORIENTATION IS NORMAL? NO.....1 YES.....5

- |    |        |   |   |   |
|----|--------|---|---|---|
| 1. | Time   | 3 | 4 | 9 |
| 2. | Place  | 3 | 4 | 9 |
| 3. | Person | 3 | 4 | 9 |

### K. MEMORY IS NORMAL? NO.....1 YES.....5

- |    |                           |   |   |   |
|----|---------------------------|---|---|---|
| 1. | Clouding of consciousness | 3 | 4 | 9 |
| 2. | Inability to concentrate  | 3 | 4 | 9 |
| 3. | Amnesia                   | 3 | 4 | 9 |
| 4. | Poor recent memory        | 3 | 4 | 9 |
| 5. | Poor remote memory        | 3 | 4 | 9 |
| 6. | Confabulation             | 3 | 4 | 9 |

### L. INTELLECT IS NORMAL? NO.....1 YES.....5

- |    |                      |   |   |   |
|----|----------------------|---|---|---|
| 1. | Above normal         | 3 | 4 | 9 |
| 2. | Below normal         | 3 | 4 | 9 |
| 3. | Paucity of knowledge | 3 | 4 | 9 |
| 4. | Vocabulary poor      | 3 | 4 | 9 |

### M. INSIGHT AND JUDGEMENT ARE NORMAL? NO.....1 YES.....5

- |    |   |   |   |   |
|----|---|---|---|---|
| 1. | Poor insight                            | 3 | 4 | 9 |
| 2. | Poor judgement                          | 3 | 4 | 9 |
| 3. | Unrealistic regarding degree of illness | 3 | 4 | 9 |
| 4. | Doesn't know why being treated          | 3 | 4 | 9 |
| 5. | Unmotivated for treatment               | 3 | 4 | 9 |

#### RATE ACCURACY OF CODES THROUGHOUT SSAGA-II:

- |   |   |
|---|---|
| NO DIFFICULTY                                       | 1 |
| SOME PROBLEMS, BUT MOST RATINGS REASONABLY ACCURATE | 2 |
| MAJOR DIFFICULTY IN CONDUCTING EXAM                 | 3 |
| IMPOSSIBLE TO RATE WITH ANY CONFIDENCE              | 4 |

[illegible]



CODE: \_\_ \_\_

## Global Assessment of Functioning Scale (GAF Scale)

Consider psychological, social, and occupational functioning on a hypothetical continuum of mental health-illness. Do not include impairment in functioning due to physical (or environmental) limitations.

### Code

- |    |  |
|----|--|
| 90 | Absent or minimal symptoms (e.g., mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g., an occasional argument with family members).  |
|    |  |
| 81 |  |
| 80 | If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g., difficulty concentrating after family argument); no more than slight impairment in social, occupational, or school functioning (e.g., temporarily falling behind in school work).  |
|    |  |
| 71 |  |
| 70 | Some mild symptoms (e.g., depressed mood and mild insomnia) OR some difficulty in social, occupational, or school functioning (e.g., occasional truancy, or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships.   |
|    |  |
| 61 |  |
| 60 | Moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with co-workers).  |
|    |  |
| 51 |  |
| 50 | Serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job).  |
|    |  |
| 41 |  |
| 40 | Some impairment in reality testing or communication (e.g., speech is at times illogical, obscure, or irrelevant) OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school). |
|    |  |
| 31 |  |
| 30 | Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) OR inability to function in almost all areas (e.g., stays in bed all day; no job, home, or friends).  |
|    |  |
| 21 |  |
| 20 | Some danger of hurting self or others (e.g., suicide attempts without clear expectation of death, frequently violent, manic excitement) OR occasionally fails to maintain minimal personal hygiene (e.g., smears feces) OR gross impairment in communication (e.g., largely incoherent or mute).   |
|    |  |
| 11 |  |
| 10 | Persistent danger of severely hurting self or others (e.g., recurrent violence) OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.  |
|    |  |
| 1  |  |