27526

SEMI-STRUCTURED ASSESSMENT FOR DRUG DEPENDENCE AND ALCOHOLISM VERSION 11.2

October 3, 2013

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Center Family Ind

TIME STARTED: : (USE 24 HOUR CLOCK)

A1 RECORD SEX AS OBSERVED MALE ○ FEMALE ○

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 ○ YES ○

A7 Are you a twin or other multiple? NO ○ YES ○

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.

	I	II
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.

CODE KEY: IF > 100, CODE 98 OR 998. IF UNKNOWN, CODE 99 OR 999

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

RECORD: ☐

1. Does your religion have rules forbidding the use of any alcohol? NO ○ YES ○

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

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

☐☐☐☐ WIDOWED YEAR

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

1. MARRIED ○
2. WIDOWED ○
3. SEPARATED ○
4. DIVORCED ○
5. NEVER MARRIED ○

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 ○ YES ○

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

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=NO), SKIP TO A14. OTHERS CONTINUE.

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 T0 A14) ○
YES ○

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

B. How old were you the last time you separated? AGE REC: ☐☐

REC: 1 2 3 4 5 U

CODE KEY: IF > 100, CODE 98 OR 998. IF UNKNOWN, CODE 99 OR 999

BOX A14 IF R IS MALE, SKIP TO A14C.

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

A. Are you currently pregnant? NO ○ YES ○

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? **RECORD SEX AND DOB. NOTE: List in birth order.** CHILDREN ☐☐

CHILD	SEX	DATE OF BIRTH	CHILD	SEX	DATE OF BIRTH
1	M ○ F ○	☐☐ / ☐☐☐☐	5	M ○ F ○	☐☐ / ☐☐☐☐
2	M ○ F ○	☐☐ / ☐☐☐☐	6	M ○ F ○	☐☐ / ☐☐☐☐
3	M ○ F ○	☐☐ / ☐☐☐☐	7	M ○ F ○	☐☐ / ☐☐☐☐
4	M ○ F ○	☐☐ / ☐☐☐☐	8	M ○ F ○	☐☐ / ☐☐☐☐

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

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 ○ YES (SKIP TO C) ○

B. Did you pass a high school equivalency test NO ○ YES ○

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

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 ○ YES ○

CODE KEY: IF > 100, CODE 98 OR 998. IF UNKNOWN, CODE 99 OR 999

A16 Now I want to ask you about work for pay. In the 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.**

MONTHS ☐☐

A17 Are you employed now? NO (SKIP TO B) ○ YES ○

A. Do you work full-time? NO ○ YES ○

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 A19) ○ YES ○

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

STILL IN MILITARY ○
HONORABLE ○
GENERAL ○
MEDICAL ○
OTHER THAN HONORABLE ○
DISHONORABLE ○

B. What's the highest rank you achieved? CODE ☐☐☐

BRANCH OF MILITARY: CODE ☐☐

A19 Are you right or left handed? LEFT ○ RIGHT ○

A20 What is your eye color?

BROWN ○
BLUE ○
GREEN ○
GREY ○
BROWN CENTER ○
HAZEL ○

END OF SECTION A

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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 ○
- VERY GOOD ○
- GOOD ○
- FAIR ○
- POOR ○

B2 Has your health always been (ANSWER IN B1), or has it been better or worse?

- NO, WORSE ○
- NO, BETTER ○
- YES, SAME (SKIP TO B3) ○
- BOTH, BETTER & WORSE ○

A. PLEASE EXPLAIN:

B3 Has a doctor ever told you that you have (had):

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

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B4 **A.** How many times have you been in a hospital overnight (including surgery and pregnancy), excluding psychiatric or substance abuse treatment? TIMES ☐☐

Please tell me about your hospital stays, starting with the most recent one.

YEAR	LENGTH OF STAY (DAYS)	REASON FOR HOSPITALIZATION
☐☐☐☐	☐☐	
☐☐☐☐	☐☐	
☐☐☐☐	☐☐	
☐☐☐☐	☐☐	

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 ☐☐

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 ☐☐

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**.

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

IF ALL ARE CODED NO, SKIP TO B6B.8.
FOR EVERY YES CODED IN B6A.1-7, ASK B6B.1-7, AND ASK B6B.8.

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B6 **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**.

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

IF YES, SPECIFY REASON(S):

B6B.8 CODE CODE #5

If R has ever been prescribed methadone, answer B6.C. If .. , code B6.C. 000, if unknown code C 999.

9. Have you ever been prescribed methadone? **IF NO code B6.C. 000. If unknown code C 999.**	○ NO	○ YES				

mg

C. When you were taking methadone, what was your usual dosage?

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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 for at least 6 months in a row.*

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

(Circle up to 4 different routes of administration)

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

Code as above (A-M) or 00 for "no problem" ☐

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

DRUG ☐

CODE: ☐☐☐

CODE KEY: IF > 100, CODE 98 OR 998. IF UNKNOWN, CODE 99 OR 999

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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) ○
YES ○

IF YES: Would you tell me about this?

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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?

IF NEVER, SKIP TO B10.

TIMES ☐☐

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:

YEAR	LENGTH OF STAY (DAYS)	REASON FOR TREATMENT	CODE
☐☐☐☐	☐☐☐		☐
☐☐☐☐	☐☐☐		☐
☐☐☐☐	☐☐☐		☐
☐☐☐☐	☐☐☐		☐

CODE KEY: IF > 100, CODE 98 OR 998. IF UNKNOWN, CODE 99 OR 999

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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) ○
YES ○

A. Did you speak to a ...?

☐ 1. Psychiatrist
☐ 2. Psychologist
☐ 3. Social Worker
☐ 4. Counselor
☐ 5. Other Medical Doctor
☐ 6. Nurse Practitioner
☐ 7. Clergy
☐ 8. Other Please specify: _____

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:

YEAR	NUMBER OF VISITS	REASON FOR TREATMENT	REASON CODE

BOX B10

A. IS R CURRENTLY IN TREATMENT? NO ○ YES ○

B. DOES R VOLUNTEER MORE THAN 4 SEPARATE OUTPATIENT TREATMENT PROGRAMS? NO ○ YES ○

CODE KEY: IF > 100, CODE 98 OR 998. IF UNKNOWN, CODE 99 OR 999

END OF SECTION B

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...

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 empty?

NO ○
YES ○

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 ○
YES ○

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, clearly different from your normal self?

NO ○
YES ○

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 ○
YES ○

C5 Now I'm going to ask you about very unusual experiences you might have had.

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 ○
YES ○

C6 Did you ever see things that other people could not see or have visions when you were completely awake?

NO ○
YES ○

C7 Were you a very distractible child?

NO ○
YES ○

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

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 ○
YES ○

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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 ○
YES ○

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

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 ○
YES ○

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 ○
YES ○

END OF SECTION C

Now I'm going to ask you some questions about using tobacco.

D1 **A.** Have you ever tried any form of tobacco?

NO ○
YES (SKIP TO C) ○

B. So, you never have experimented with any form of tobacco (including cigarettes) even one time?

NEVER (SKIP TO E1) ○
YES, HAS USED ○

C. Have you ever:

1. smoked a cigarette? ○ NO ○ YES
2. smoked a cigar? ○ NO ○ YES
3. smoked a pipe? ○ NO ○ YES
4. used chewing tobacco or snuff? ○ NO ○ YES

D. How old were you the (first/last) time you used any form of tobacco?

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

D2 OMITTED

IF NEVER SMOKED CIGARETTES (D1C.1=NO), CODE D3 "NO" SILENTLY.

D3 Over your lifetime, have you smoked a total of 100 cigarettes?

NO (SKIP TO E1) ○
YES ○

BEGIN SCORING ASTERISKED ITEMS ON TALLY SHEET D.

D4 **A.** When you were smoking regularly, how many days per week did you usually smoke cigarettes? **IF NOT AS OFTEN AS ONCE A WEEK, CODE 0.**

☐☐ DAYS

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

☐☐ CIGS

C. For about how long did you smoke this many cigarettes at that rate?

☐☐☐ UNITS

CODE UNITS

DAYS ○ *MONTHS ○
*WEEKS ○ *YEARS ○

D. How old were you the (first/last) time you smoked cigarettes at that rate?

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

E. Have you ever smoked a pack a day for a month or more?

NO ○
*YES ○

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

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

☐☐☐ MINUTES

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

WITHIN 5 MINUTES ○
WITHIN 6-30 MINUTES ○
WITHIN 31-60 MINUTES ○
MORE THAN AN HOUR ○

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 ○
YES ○

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 ○
YES ○

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 ○
ANY OTHERS ○

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 ○
YES ○

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.)

D10 Did you ever chain smoke; that is, where you smoked several cigarettes, one right after another?

NO (SKIP TO D11) ○
YES ○

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

☐☐ HOURS

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

B. What is the longest period of time you have chain smoked every day or nearly every day? **IF 7 OR MORE DAYS, MARK TALLY SHEET D.**

☐☐☐ UNITS

CODE UNITS

DAYS ○ *MONTHS ○
*WEEKS ○ *YEARS ○

CODE KEY: IF > 100, CODE 98 OR 998. IF UNKNOWN, CODE 99 OR 999

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 ○
YES ○*

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 ○
YES ○*

A. Have you often found that you've run out of cigarettes sooner than you intended?

NO ○
YES ○*

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) ○
YES ○

A. Did this happen a total of 3 or more times?

NO (SKIP TO D14) ○
YES ○

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

NO ○
YES ○

D14 Have you <u>often</u> wanted to quit or cut down on smoking?

NO ○
YES ○*

A. Have you ever tried to quit smoking?

NO (SKIP TO D15) ○
YES ○

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) ○
YES ○

1. Was this for at least 1 month?

NO ○
YES (SKIP TO D15) ○

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 ○
YES ○*

CODE KEY: IF > 100, CODE 98 OR 998. IF UNKNOWN, CODE 99 OR 999

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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?
IF NEVER, CODE 000 DAYS. IF LESS THAN ONE DAY, CODE 001 DAY.

☐☐☐ UNITS

CODE UNITS:
DAYS ○
WEEKS ○
MONTHS ○
YEARS ○

BOX D15 **IF D15 = 000 DAYS, SKIP TO D17. OTHERS CONTINUE.**

A. Have you ever attended a class or group for people trying to quit or reduce their use of tobacco?
NO ○
YES ○

B. Have you ever tried nicotine gum or a nicotine patch (to quit or reduce your use of tobacco)?
NO ○
YES ○

C. Have you ever tried nicotine-free cigarettes (to quit or reduce your use of tobacco)?
NO ○
YES ○

D. Have you tried any other form of treatment or medicine to quit or reduce your use of tobacco?
NO ○
YES (SPECIFY) ○

SPECIFY: ☐

IF ANY YES 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 U

AGE REC: ☐☐
REC: 1 2 3 4 5 U

CODE KEY: IF > 100, CODE 98 OR 998. IF UNKNOWN, CODE 99 OR 999

27526

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.**

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

BOX D16 HOW MANY YES'S CODED IN COLUMN I?

NONE (SKIP TO D17) ○
1-3 (SKIP TO B) ○
4 OR MORE ○

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

NO (Skip to B) ○
YES* ○

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

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

AGE ONS: ☐☐ ONS: 1 2 3 4 5 U

AGE REC: ☐☐ REC: 1 2 3 4 5 U

FOR EACH YES 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 ○
YES ○

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

NO ○
YES* ○

CODE KEY: IF > 100, CODE 98 OR 998. IF UNKNOWN, CODE 99 OR 999

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

NO (SKIP TO D18) ○
YES ○

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

NO (SKIP TO D18) ○
YES (SPECIFY) ○

SPECIFY: _____

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

NO ○
YES ○*

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) ○
YES (SPECIFY) ○

SPECIFY: _____

CODE: ☐☐☐

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

NO ○
*YES ○

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 ○
YES (SPECIFY) ○*

SPECIFY: _____

CODE: ☐☐☐

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

NO ○
YES (SKIP TO C) ○

B. After you had been smoking regularly, did you come to need more cigarettes each day?

NO (SKIP TO D) ○
YES ○

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 ○
YES (SKIP TO BOX D21) ○*

D. After you had been smoking for some time, did you find that cigarettes had less effect on you than before?

NO ○
YES ○*

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

HAND R TOBACCO TALLY SHEET.

Tobacco Tally

D21 I'd like to review the experiences you've told me you had with smoking cigarettes. You've said that: **(READ SX MARKED ON TALLY SHEET D).**

Did you ever have experiences from 3 or more boxes in any 12-month period? **IF YES:** Which ones? **CIRCLE THE SYMPTOMS THAT CLUSTER. MUST BE FROM 3 DIFFERENT BOXES.**

NO (SKIP TO E1) ○
YES ○

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

AGE ONS: ☐☐
AGE REC: ☐☐

CODE KEY: IF > 100, CODE 98 OR 998. IF UNKNOWN, CODE 99 OR 999

END OF SECTION D

E1 Now I would like to ask you some questions about your use of alcoholic beverages, like beer, wine, wine coolers, champagne, or hard liquor like vodka, gin, or whiskey. Have you ever had a drink of alcohol?

NO (SKIP TO B) ○
YES ○

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) ○
YES, HAD A DRINK ○

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.

DO NOT COUNT IF ONLY ONE TYPE OF ALCOHOL CAUSED THE REACTION.	**COL A**		**COL B**	
1. flush or blush--that is, your face and hands felt hot and your face turned red?	NO ○	YES ○	NO ○	YES ○
a. IF E2A.1=YES, ASK: Did the flushing or blushing begin within the first few minutes after the first drink?	NO ○	YES ○		
2. break out into hives?	NO ○	YES ○	NO ○	YES ○
3. feel very sleepy (when you weren't already tired)?	NO ○	YES ○	NO ○	YES ○
4. have nausea?	NO ○	YES ○	NO ○	YES ○
5. have headaches, head pounding, or throbbing?	NO ○	YES ○	NO ○	YES ○
6. have heart palpitations, where your heart beat so hard you could feel it?	NO ○	YES ○	NO ○	YES ○

FOR EACH YES 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.

CODE KEY: IF > 100, CODE 98 OR 998. IF UNKNOWN, CODE 99 OR 999

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

AGE ☐☐

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.**

AGE ☐☐

IF NEVER, CODE 00 AND SKIP TO E4. IF DRUNK BEFORE AGE 15, SKIP TO B. OTHERS SKIP TO E4.

1. Was it before you were 15 years old?

NO (SKIP TO Box E4) ○
YES ○

B. Did you get drunk more than once before you were 15 years old?

NO ○
YES ○

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. OTHERS CONTINUE.

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 ○
YES ○

BEGIN SCORING ALCOHOL TALLY SHEET

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 E6D) ○
YES ○

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 ☐☐☐

B. WAS THE INCREASE IN A2 TO 5 DRINKS (WOMEN)/ 6 DRINKS (MEN) OR MORE?

NO (SKIP TO D) ○
YES ○

C. WAS INCREASE 50% OR MORE? CHECK CARD E2.

NO ○
YES (SKIP TO E7) ○ *

27526

D. Did you ever find you could drink a lot more before you got drunk?

NO (SKIP TO E7) ○
YES ○

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) ○
YES ○

G. WAS INCREASE 50% OR MORE? CHECK CARD E2.

NO ○
YES ○*

E7 Have you 3 or more times wanted to stop or cut down on drinking?
DO NOT COUNT DIETING OR PREGNANCY.

NO ○
YES ○*

A. Have you ever tried to stop or cut down on drinking?
COUNT ANY REASON.

NO (SKIP TO E8) ○
YES ○

B. Were you always able to stop or cut down when you tried to?

NO, UNABLE ○
YES (SKIP TO E8) ○

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

TIMES ☐☐ *

1. Was it 3 or more times?

NO ○
YES ○ *

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 ○
YES ○

A. Have you ever continued drinking for more days in a row than you intended?

NO ○
YES ○

IF BOTH E8 AND E8A ARE CODED NO, SKIP TO E9
OTHERWISE CONTINUE TO E8B

B. Did either happen 3 or more times?

NO ○
YES ○*

E9 Have you ever started drinking and become drunk when you didn't want to?

NO (SKIP TO E10) ○
YES ○

A. Did this happen 3 or more times?

NO ○
YES ○ *

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) ○
YES (SPECIFY) ○

SPECIFY: [ ]

A. Did this happen 3 or more times or for a month or more?

NO ○
YES ○ *

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) ○
YES ○

A. Did this period last for a month or more or did you have 3 or more periods like that?

NO ○
YES ○ *

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) ○
YES ○

A. Did you neglect some of your usual responsibilities then?

NO (SKIP TO E13) ○
YES ○

B. Did you go on binges 3 or more times?

NO ○
YES ○

IF FEWER THAN 3 BINGES, CODE "NO" SILENTLY.
C. Did this happen 3 or more times in any 12-month period?

NO ○
YES ○

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) ○
YES ○

A. How many blackouts have you had from drinking?
IF DK, ASK A1. OTHERS SKIP TO E14.

TIMES [ ][ ]

1. Did you have 3 or more blackouts?

NO ○
YES ○

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 ○
YES ○

A. Have you ever had a strong desire or craving for alcohol?

NO ○
YES ○ *

E15 Have you used alcohol 3 or more times while taking medications or drugs you knew were dangerous to mix with alcohol?

NO (SKIP TO E16) ○
YES (SPECIFY) ○

Number of drinks: [ ][ ]

Amount of (and which) drugs: [ ]

Reason to be dangerous: [ ]

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

CODE ☐☐☐

SPECIFY: ☐

CODE ☐☐☐

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

NO ○
YES ○

C. Did you have any harmful effects from mixing alcohol and (DRUG)?

NO ○
YES (SPECIFY) ○

SPECIFY: ☐

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) ○
YES ○

A. How many times has this happened? **IF 3 OR MORE, SKIP TO B. IF FEWER THAN 3, SKIP TO E17. IF DK, ASK A1.**

TIMES ☐☐

1. Did this happen 3 or more times?

NO (SKIP TO E17) ○
YES ○

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

NO (SKIP TO E17) ○
YES ○

E17 Have you ever been arrested for drunk driving?

NO (SKIP TO E18) ○
YES ○

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

AGE ONS: ☐☐

ONS: 1 2 3 4 5 U

AGE REC: ☐☐

REC: 1 2 3 4 5 U

B. How many times has this happened? **IF 3 OR MORE, SKIP TO C. IF FEWER THAN 3, SKIP TO E18. IF DK, ASK B1.**

TIMES ☐☐

1. Did this happen 3 or more times?

NO (SKIP TO E18) ○
YES ○

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

NO ○
YES ○

E18 Has your drinking and driving ever resulted in your damaging your car or having an accident? **COUNT ALL ACCIDENTS, EVEN IF NOT REPORTED TO THE POLICE.**

NO (SKIP TO E19) ○
YES ○

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

AGE ONS: ☐☐
ONS: 1 2 3 4 5 U

AGE REC: ☐☐
REC: 1 2 3 4 5 U

B. How many times has this happened? **IF 3 OR MORE, SKIP TO C. IF FEWER THAN 3, SKIP TO E19. IF DK, ASK B1.**

TIMES ☐☐

1. Did this happen 3 or more times?

NO (SKIP TO E19) ○
YES ○

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

NO ○
YES ○

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) ○
YES (SPECIFY) ○

SPECIFY: ☐

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

NO ○
YES ○

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

		COL I		COL II	
E20	**A1.** Did your drinking ever result in objections from or problems with your family, friends, doctors, clergy, or people at work or school?	NO ○	YES ○	NO ○	YES ○
	A2. Have you ever lost friends on account of your drinking?	NO ○	YES ○	NO ○	YES ○
	A3. Did your drinking ever cause you to have problems at work or school?	NO ○	YES ○	NO ○	YES ○
	A4. Did you ever get into arguments when you had been drinking?	NO ○	YES ○	NO ○	YES ○

IF ANY YES IS CODED IN COL. II, CONTINUE. OTHERS SKIP TO E21.

B. Did any of these experiences happen 3 or more separate times in any 12-month period?

NO ○ YES ○

CODE KEY: IF > 100, CODE 98 OR 998. IF UNKNOWN, CODE 99 OR 999

E21 Did your drinking cause serious or repeated problems in any marriage or love relationship?

NO (SKIP TO E22) ○
YES ○

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

NO ○
YES ○

B. Did you continue to drink knowing it caused these problems?

NO ○
YES ○

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) ○
YES ○

A. How many times has this happened? **IF 3 OR MORE, SKIP TO B. IF FEWER THAN 3, SKIP TO E23. IF DK, ASK A1**.

TIMES: ☐☐

1. Did this happen 3 or more times?

NO (SKIP TO E23) ○
YES ○

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

NO ○
YES ○

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) ○
YES ○

A. How many times has this happened? **IF 3 OR MORE, MARK TALLY A, AND SKIP TO B. IF FEWER THAN 3, SKIP TO E24. IF DK, ASK A1**.

TIMES: ☐☐

1. Did this happen 3 or more times?

NO (SKIP TO E24) ○
YES ○

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

NO ○
YES ○

E24 There are several health problems that can result from long stretches of drinking. Did drinking ever cause you to have any of the following or any other health problems:

NO ○
YES ○

- ☐ Pancreatitis
- ☐ Yellow jaundice
- ☐ Stomach Disease
- ☐ Liver Disease
- ☐ Memory problems even when you were not drinking (not counting blackouts)
- ☐ Make your feet tingle or feel numb for many hours
- ☐ Damage to your heart (cardiomyopathy)
- ☐ Make you vomit blood
- ☐ Other physical health problems

SPECIFY: ☐

IF CODED NO, SKIP TO E25. OTHERS CONTINUE.

NO ○
YES ○ *

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

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E25 Has drinking ever caused you emotional or psychological problems? like:

NO ○
YES ○

☐ Hearing things that weren't really there
☐ Seeing things that weren't really there
☐ Smelling things that weren't really there

Or caused any of the following for more than 24 hours and to the point that it interfered with functioning:

☐ Feeling depressed or uninterested in things
☐ Feeling jumpy or easily startled or nervous
☐ Having trouble thinking clearly
☐ Feeling paranoid or suspicious of people

IF CODED NO, SKIP TO BOX E25. OTHERS CONTINUE.

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

NO (SKIP TO BOX E25) ○
YES ○*

BOX E25 CHECK TALLY SHEET. IF NO MARKS, SKIP TO F1. 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.

	I	II	III
1. Did you have the shakes (hands trembling)?	NO ○ YES ○	NO ○ YES ○	NO ○ YES ○
2. Were you unable to sleep?	NO ○ YES ○	NO ○ YES ○	NO ○ YES ○
3. Did you feel anxious?	NO ○ YES ○	NO ○ YES ○	NO ○ YES ○
4. Did you feel depressed or irritable?	NO ○ YES ○	NO ○ YES ○	
5. Did your heart beat fast or did you sweat?	NO ○ YES ○	NO ○ YES ○	NO ○ YES ○
6. Did you have nausea or vomiting?	NO ○ YES ○	NO ○ YES ○	NO ○ YES ○
7. Did you feel physically weak?	NO ○ YES ○	NO ○ YES ○	
8. Did you have headaches?	NO ○ YES ○	NO ○ YES ○	
9. Did you see or hear things that weren't there?	NO ○ YES ○	NO ○ YES ○	NO ○ YES ○
10. Were you fidgety or restless?	NO ○ YES ○		NO ○ YES ○

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

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

DAYS ☐☐

IF ONLY ONE SX IS CODED YES 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) ○
YES ○

D. Which ones? **CODE IN COL. II & III.**

*

IF 2+ SX IN COL. III, MARK TALLY.

E. How old were you the first time these problems occurred together?

AGE ONS: ☐☐

ONS: 1 2 3 4 5 U

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

TIMES ☐☐

1. Did this occur 3 or more times?

NO ○

YES ○

IF NO YES'S IN COL. III, SKIP TO H. Others continue.

G. You said you **(REVIEW ALL YES'S CODED IN COL. III)**. Did (this/these) problem(s) interfere with your functioning at work, school, or home?

NO ○

YES ○

H. Have you ever taken a drink to keep from having any of these problems (or to make them go away) **(REVIEW ALL YES'S CODED IN COL. I)**?

NO (SKIP TO J) ○

YES ○

1. How old were you the first time?

AGE ONS: ☐☐ ONS: 1 2 3 4 5 U

I. Did this happen 3 or more times?

NO ○

YES ○*

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 (SKIP TO E27) ○

YES (SPECIFY) ○

SPECIFY: ☐ CODE: ☐☐☐ CODE: ☐☐☐

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) ○

YES ○*

A. How many times did this happen? **IF DK, ASK 1. OTHERS SKIP TO B.**

TIMES ☐☐

1. Did this occur 3 or more times?

NO ○

YES ○

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 ○

YES ○*

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

NO ○

YES (SPECIFY) ○

SPECIFY: ☐ CODE: ☐☐☐ CODE: ☐☐☐

CODE KEY: IF > 100, CODE 98 OR 998. IF UNKNOWN, CODE 99 OR 999

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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) ○
YES ○ *

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 ○
YES ○

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 ○
YES ○ *

C. Did you ever take any medication or drug to avoid DT's or to make them go away?

NO ○
YES (SPECIFY) ○

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

SPECIFY: ☐ CODE: ☐☐☐ CODE: ☐☐☐

Alcohol Tally A

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

HAND R ALCOHOL TALLY A

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 ○
YES (SKIP TO C) ○

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) ○
YES ○

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: ○ ○ ○ ○ ○ ○

AGE REC: ☐
REC: ○ ○ ○ ○ ○ ○

CODE KEY: IF > 100, CODE 98 OR 998. IF UNKNOWN, CODE 99 OR 999

27526

Alcohol Tally

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

HAND R ALCOHOL TALLY.

E30 **A.** I have checked 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 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) ○
YES ○

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: ☐☐
ONS: 1 2 3 4 5 U

AGE REC: ☐☐
REC: 1 2 3 4 5 U

E31 Have you ever brought up any problem you might have had with drinking with any professional?

NO (SKIP TO E32) ○
YES ○

A. Did you talk with:

☐ 1. a psychiatrist?
☐ 2. another medical doctor?
☐ 3. a psychologist?
☐ 4. another mental health professional?
☐ 5. a member of the clergy?
☐ 6. another professional? (IF YES, SPECIFY)

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 U

AGE REC: ☐☐
REC: 1 2 3 4 5 U

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

CODE: ☐

CODE KEY: IF > 100, CODE 98 OR 998. IF UNKNOWN, CODE 99 OR 999

E32 Have you ever attended a self-help group (like AA) for your drinking?

NO (SKIP TO E33) ○
YES ○

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

AGE ONS: ☐☐
ONS: 1 2 3 4 5 U

AGE REC: ☐☐
REC: 1 2 3 4 5 U

REFER TO B9 & B10 BEFORE ASKING

E33 Have you ever been in a treatment program for a drinking problem?

NO (SKIP TO F1) ○
YES ○

A. Were you treated:

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

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 U

AGE REC: ☐☐
REC: 1 2 3 4 5 U

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

CODE: ☐

END OF SECTION E

F1 Have you ever used cocaine or crack?

NO (SKIP TO G1) ○
YES ○

A. How many times in your life have you used cocaine?

TIMES ☐☐☐☐

1. **If DK, ASK:** would you say 11 or more times?

NO ○
YES ○

B. How old were you the last time you used cocaine? **IF REC CODE=5, SKIP TO D. OTHERS CONTINUE.**

AGE REC: ☐☐
REC: 1 2 3 4 5 U

C. How many times did you use cocaine in the last 12 months? **IF DK, ASK C1. OTHERS SKIP TO D.**

TIMES ☐☐☐☐

1. Did you use cocaine at least 11 times during the past 12 months?

NO ○
YES ○

D. Did you ever use cocaine at least once a week for a month or more?

NO (SKIP TO F2) ○
YES ○

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 U

AGE REC: ☐☐
REC: 1 2 3 4 5 U

F2 How old were you the first time you used cocaine?

AGE ONS: ☐☐
ONS: 1 2 3 4 5 U

IF AGE ONS 15 OR LATER, SKIP TO BOX F3. OTHERS CONTINUE.

A. Did you use cocaine more than once before you were 15?

NO ○
YES ○

BOX F3 **IF F1A<11 OR F1A1=1, SKIP TO G1.**

CODE KEY: IF > 100, CODE 98 OR 998. IF UNKNOWN, CODE 99 OR 999

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F3 Did you ever use cocaine daily or almost daily?

NO (SKIP TO F3B) ○
YES ○

A. What is the longest period of time you used cocaine daily or almost daily?

UNITS ☐☐☐☐

CODE UNITS:
○ DAYS ○ WEEKS
○ MONTHS ○ YEARS

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 9s 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? **IF GRAMS ARE CODED, CODE 999**

CODE IN ROCKS:
☐☐☐

D. How old were you when that period started?

AGE ☐☐

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

MONTHS ☐☐☐

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

NO ○
YES ○

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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 ○
ALCOHOL ONLY ○
YES ○

MEDICATIONS 1. ____ CODE: ___
2. ____ CODE: ___
3. ____ CODE: ___

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

NO ○
YES ○

1. How many times? TIMES: ___

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

AGE ONS: ___
ONS: 1 2 3 4 5 U

AGE REC: ___
REC: 1 2 3 4 5 U

I. Have you ever shared a needle?

NO (SKIP TO F4) ○
YES ○

1. How many times? TIMES: ___

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

AGE ONS: ___
ONS: 1 2 3 4 5 U

AGE REC: ___
REC: 1 2 3 4 5 U

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

NO (SKIP TO F5) ○
YES ○

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

NO (SKIP TO F5) ○
YES ○

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 U

AGE REC: ___
REC: 1 2 3 4 5 U

BEGIN SCORING COCAINE TALLY SHEET

CODE KEY: IF > 100, CODE 98 OR 998. IF UNKNOWN, CODE 99 OR 999

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

NO ○
YES ○

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

AGE ONS: ☐☐

ONS: 1 2 3 4 5 U

AGE REC: ☐☐

REC: 1 2 3 4 5 U

B. Have you ever had a strong desire or craving for cocaine?

NO ○
YES ○*

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 ○
YES ○*

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) ○
YES ○

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

NO ○
YES ○

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

NO ○
YES ○

IF F7.1 A = NO SKIP TO F8, OTHERS CONTINUE.

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

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F8 Because of your cocaine use, did you ever experience any of the following: CODE IN COLUMN I.

	COL. I		COL. II		
1. Feeling depressed or uninterested in things for more than 24 hours to the point that it interfered with your functioning?	NO ○	YES ○	NO ○	YES ○	*
2. Having trouble concentrating or having such trouble thinking clearly for more than 24 hours that it interfered with your functioning?	NO ○	YES ○	NO ○	YES ○	*
3. Feeling paranoid or suspicious of people for more than 24 hours to the point that it interfered with your relationships?	NO ○	YES ○	NO ○	YES ○	*
4. Hearing, seeing, feeling, or smelling things that weren't really there?	NO ○	YES ○	NO ○	YES ○	
5. Feeling jumpy or easily startled or nervous for more than 24 hours to the point that it interfered with your functioning	NO ○	YES ○	NO ○	YES ○	
6. Decreased contact with friends or family?	NO ○	YES ○	NO ○	YES ○	*

FOR EACH "YES" CODED IN COL. I, ASK F8A.

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

IF F8.6 IS CODED NO, SKIP TO F9. OTHERS CONTINUE.

B. Did you have decreased contact with friends or family 3 or more times in any 12-month period?

NO ○
YES ○

F9 Have you often wanted to stop or cut down on cocaine?

NO ○
YES ○*

A. Have you ever tried to stop or cut down on cocaine but found you couldn't? **IF NEVER TRIED TO STOP/CUT DOWN, CODE NO.**

NO, COULD STOP ○
YES, COULD NOT STOP ○

IF NO, COULD STOP (OR NEVER TRIED), SKIP TO F10. OTHERS CONTINUE.

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

NO ○
YES ○*

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F10 Have you <u>often</u> used cocaine on more days or in larger amounts than you intended to? NO ○ YES ○*

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 ○ YES ○*

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

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... **CODE IN COLUMN I.**

	COL. I		COL. II	
1. feel depressed?	NO ○	YES ○	NO ○	YES ○
2. feel restless?	NO ○	YES ○	NO ○	YES ○
3. feel tired, sleepy or weak?	NO ○	YES ○	NO ○	YES ○
4. have trouble sleeping?	NO ○	YES ○	NO ○	YES ○
5. sleep too much?	NO ○	YES ○	NO ○	YES ○
6. have a strong desire or craving for cocaine?	NO ○	YES ○	NO ○	YES ○
7. feel slowed down, like you could hardly move?	NO ○	YES ○	NO ○	YES ○
8. have an increase in appetite?	NO ○	YES ○	NO ○	YES ○
9. have nightmares?	NO ○	YES ○	NO ○	YES ○

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

A. Have you ever used cocaine to keep from having any these problems (or to make them go away)? NO (SKIP TO BOX F12B) ○ YES ○

B. Did this happen 3 or more times? NO ○ YES ○*

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

C. Did these problems ever occur together? NO (SKIP TO G) ○ YES ○*

D. Which ones? **CODE IN COL. II**

CODE KEY: IF > 100, CODE 98 OR 998. IF UNKNOWN, CODE 99 OR 999

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 ○ YES ○

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) ○ YES ○

A. Have you been in situations like this 3 or more times ? NO (SKIP TO B) ○ YES ○

1. Did this happen 3 or more times in any 12-month period? NO ○ YES ○

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) ○ YES ○

C. Did this happen 3 or more times? NO (SKIP TO F14) ○ YES ○

1. Did this happen 3 or more times in any 12-month period? NO ○ YES ○

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 ○
YES ○

B. Did you ever get into physical fights while using cocaine?

NO ○
YES ○

BOX F14 IF A AND B ARE BOTH CODED "NO"
SKIP TO F15. OTHERS, CONTINUE

C. Did (this/either of these experiences) happen 3 or more times in any 12-month period?

NO ○
YES ○

D. Did you continue to use cocaine after you realized it was causing these problems?

NO ○
YES ○

F15 Have you ever been arrested or had any other trouble with the police because of your cocaine use?

NO (SKIP TO F16) ○
YES ○

A. Did this happen 3 or more times?

NO (SKIP TO F16) ○
YES ○

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

NO ○
YES ○

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) ○
YES ○

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

NO ○
YES ○

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) ○
YES ○

A. Has this happened 3 or more times, or did it last a month or longer?

NO ○
YES ○ *

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F18 Did using cocaine cause you to have any other problems like :

A. An overdose ?

NO (SKIP TO B) ○
YES ○

1. **IF YES:** Did you require medical treatment afterwards?

NO (SKIP TO F18B) ○
YES ○

2. **IF YES:** Did this happen 3 or more times? (overdose that required treatment)

NO ○
YES ○*

B. Other serious health problems?

NO ○
YES ○

Specify:

1. **IF YES:** Did you continue to use cocaine knowing it caused health problems?

NO ○
YES ○*

---

(17) **F19** Have you ever used cocaine together with one or more other drugs, including alcohol?

NO (SKIP TO BOX F19) ○
ALCOHOL ONLY ○
YES (SPECIFY) ○

IF YES: which ones?

1. CODE: | | |
2. CODE: | | |
3. CODE: | | |
4. CODE: | | |

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

Cocaine Tally

HAND R cocaine TALLY.

F20 I have checked on this sheet the experiences with cocaine that you have told me about. You told me **(REVIEW SX).** When was the (first/last) time that you had any of these experiences?

AGE ONS: | |
ONS: 1 2 3 4 5 U

AGE REC: | |
REC: 1 2 3 4 5 U

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.**

CODE KEY: IF > 100, CODE 98 OR 998. IF UNKNOWN, CODE 99 OR 999.

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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 number of those experiences. CIRCLE SYMPTOMS THAT CLUSTER. NOTE: MUST BE 3 FROM DIFFERENT BOXES.

NO ○
YES (SKIP TO C) ●

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) ●
YES ●

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: [ ]
2 ● 3 ● 4 ● 5 ● U ● ● ●

AGE REC: [ ]
REC: ● ● ● ● ● ●

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

Cocaine Tally

HAND R Cocaine TALLY.

F22 **A.** Please review this list of experiences which are grouped into boxes. 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) ○
YES ○

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 U

AGE REC: [ ][ ]
REC: 1 2 3 4 5 U

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

CODE KEY: IF > 100, CODE 98 OR 998. IF UNKNOWN, CODE 99 OR 999

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) ○
YES ○

A. When did that/these occur?

RECORD IN ORDER OF LONGEST TO SHORTEST. IF R HAD MORE THAN 4 ABSTINENT PERIODS, RECORD THE 4 LONGEST.

FROM MO / YEAR **TO** MO / YEAR

FROM MO / YEAR **TO** MO / YEAR

FROM MO / YEAR **TO** MO / YEAR

FROM MO / YEAR **TO** MO / YEAR

F24 Did you ever bring up any problems you might have had with cocaine with any professional?

NO (SKIP TO F25) ○
YES ○

A. To whom did you speak first?

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

CODE: ☐

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 U

AGE REC: ☐☐
REC: 1 2 3 4 5 U

REFER TO B9 & B10 BEFORE ASKING

F25 Have you ever been treated for a problem with cocaine?

NO (SKIP TO D) ○
YES ○

A. Were you ever treated at:

☐ 1. outpatient drug program?
☐ 2. outpatient, other?
☐ 3. inpatient drug program?
☐ 4. inpatient for medical complications due to cocaine use?
☐ 5. at any other place or program? (IF YES, SPECIFY)

SPECIFY: ____

CODE KEY: IF > 100, CODE 98 OR 998. IF UNKNOWN, CODE 99 OR 999

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

AGE ONS: ☐☐
ONS: 1 2 3 4 5 U

AGE REC: ☐☐
REC: 1 2 3 4 5 U

C. Where were you <u>first</u> 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) ○
YES ○

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

AGE ONS: ☐☐
ONS: 1 2 3 4 5 U

AGE REC: ☐☐
REC: 1 2 3 4 5 U

CODE KEY: IF > 100, CODE 98 OR 998. IF UNKNOWN, CODE 99 OR 999

END OF SECTION F

G1 **Have you ever used any of the following opiate/drugs:**

NO (SKIP TO H1) ○
YES ○

☐ 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)
☐ Vicodin (270) ☐ Oxycontin (306)

IF OTHER, SPECIFY

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

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 ○
YES ○

B. How old were you the last time you used an opiate drug?
IF REC CODE=5, SKIP TO D. OTHERS CONTINUE.

AGE REC: ☐☐
REC: 1 2 3 4 5 U

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

TIMES ☐☐☐

1. Did you use an opiate drug at least 11 times during the past 12 months?

NO ○
YES ○

D. Did you ever use an opiate drug at least once a week for a month or more?

NO (SKIP TO G2) ○
YES ○

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 U

AGE REC: ☐☐
REC: 1 2 3 4 5 U

G2 **How old were you the first time you used an opiate drug?**
IF AGE ONS 15 OR LATER, SKIP TO BOX G2. OTHERS CONTINUE.

AGE ONS: ☐☐
ONS: 1 2 3 4 5 U

A. Did you use an opiate drug more than once before you were 15?

NO ○
YES ○

BOX G2 **IF G1A<11 or G1A1=1, SKIP TO H1**

CODE KEY: IF > 100, CODE 98 OR 998. IF UNKNOWN, CODE 99 OR 999

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

NO (SKIP TO G3B) ○
YES ○

A. What was the longest period of time you used (OPIATE) almost every day?

UNITS ☐☐☐☐

CODE UNITS

DAYS ○ MONTHS ○
WEEKS ○ YEARS ○

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?

$ ☐☐☐☐

D. How old were you when that period started?

AGE ☐☐

E. How long did that period last? (IF < 1 MONTH, CODE 01)

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 ○
YES ○

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

NO ○
YES ○

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 U

AGE REC: ☐☐

REC: 1 2 3 4 5 U

CODE KEY: IF > 100, CODE 98 OR 998. IF UNKNOWN, CODE 99 OR 999

H. Have you ever shared a needle?

NO (SKIP TO G4) ○
YES ○

1. How many times?

TIMES [ ][ ][ ]

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

AGE ONS: [ ][ ]
ONS: 1 2 3 4 5 U

AGE REC: [ ][ ]
REC: 1 2 3 4 5 U

G4 Have you ever stayed high from (OPIATE) for a whole day or more?

NO (SKIP TO G5) ○
YES ○

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

NO (SKIP TO G5) ○
YES ○

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 4 5 U

AGE REC: [ ][ ]
REC: 1 2 3 4 5 U

BEGIN SCORING OPIATES TALLY SHEET.

G5 Have you ever had such a strong desire for (OPIATE) that it was hard to think of anything else?

NO ○
YES ○

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

AGE ONS: [ ][ ]
ONS: 1 2 3 4 5 U

AGE REC: [ ][ ]
REC: 1 2 3 4 5 U

B. Have you ever had a strong desire or craving for opiates?

NO ○
YES ○ *

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 ○
YES ○ *

CODE KEY: IF > 100, CODE 98 OR 998. IF UNKNOWN, CODE 99 OR 999

G7 Because of your (OPIATE) use, did you ever experience any of the following: **CODE IN COLUMN I.**

		COL. I		COL. II		
1.	Feeling depressed or uninterested in things for more than 24 hours to the point that it interfered with your functioning?	NO ○	YES ○	NO ○	YES ○	*
2.	Having trouble concentrating or having such trouble thinking clearly for more than 24 hours that it interfered with your functioning?	NO ○	YES ○	NO ○	YES ○	*
3.	Feeling paranoid or suspicious of people for more than 24 hours to the point that it interfered with your relationships?	NO ○	YES ○	NO ○	YES ○	*
4.	Hearing, seeing, or smelling things that weren't really there?	NO ○	YES ○	NO ○	YES ○	
5.	Feeling jumpy or easily startled or nervous for more than 24 hours to the point that it interfered with your functioning?	NO ○	YES ○	NO ○	YES ○	
6.	Decreased contact with friends or family?	NO ○	YES ○	NO ○	YES ○	*

FOR EACH "YES" CODED IN COL. I, ASK G7A.

A. Did you continue to use (OPIATE) after you knew it caused this? **CODE IN COLUMN II.**

IF G7.6 Column I IS CODED "NO" SKIP TO G8, OTHERS CONTINUE.

B. Did you have decreased contact with friends or family 3 or more times in any 12-month period?

NO ○
YES ○

G8 Have you <u>often</u> wanted to stop or cut down on (OPIATE)?

NO ○
YES ○ *

A. Have you ever tried to stop or cut down on (OPIATE) but found you couldn't?

NO, COULD STOP ○
YES, COULD NOT STOP ○

IF NEVER TRIED TO STOP/CUT DOWN, CODE NO. IF NO, COULD STOP (OR NEVER TRIED), SKIP TO G9. OTHERS CONTINUE.

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

NO ○
YES ○ *

G9 Have you <u>often</u> used (OPIATE) on more days or in larger amounts than you intended to?

NO ○
YES ○ *

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 ○
YES ○ *

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

CODE KEY: IF > 100, CODE 98 OR 998. IF UNKNOWN, CODE 99 OR 999

G11 When you stopped, cut down, or went without (OPIATE), did you ever experience any of these following problems <u>for most of the day for 2 days or longer?</u>

CODE IN COLUMN I.

	COL. I		COL. II	
1. Did you feel depressed?	NO ○	YES ○	NO ○	YES ○
2. Did you have trouble sleeping?	NO ○	YES ○	NO ○	YES ○
3. Did you have a strong desire or craving for (OPIATE)?	NO ○	YES ○	NO ○	YES ○
4. Did you have diarrhea?	NO ○	YES ○	NO ○	YES ○
5. Did you have stomach aches or stomach cramps?	NO ○	YES ○	NO ○	YES ○
6. Did your eyes run?	NO ○	YES ○	NO ○	YES ○
7. Did your nose run?	NO ○	YES ○	NO ○	YES ○
8. Did you yawn?	NO ○	YES ○	NO ○	YES ○
9. Did you have muscle pains?	NO ○	YES ○	NO ○	YES ○
10. Were your pupils dilated or were your eyes sensitive to light?	NO ○	YES ○	NO ○	YES ○
11. Did you have gooseflesh, goose bumps, or did you get the chills?	NO ○	YES ○	NO ○	YES ○
12. Did your heart race?	NO ○	YES ○	NO ○	YES ○
13. Did you sweat?	NO ○	YES ○	NO ○	YES ○
14. Did you have a fever?	NO ○	YES ○	NO ○	YES ○
15. Did you have nausea, or did you vomit?	NO ○	YES ○	NO ○	YES ○

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) ○
YES ○

B. Did this happen 3 or more times?

NO ○
YES ○*

BOX G11B IF NO MARKS OR ONLY YES CODED IN COL. I, SKIP TO G12. OTHERS CONTINUE.

C. Did these problems ever occur together?

NO (SKIP TO G) ○
YES ○*

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 ○
YES ○

CODE KEY: IF > 100, CODE 98 OR 998. IF UNKNOWN, CODE 99 OR 999

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) ○
YES ○

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

NO (SKIP TO B) ○
YES ○

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

NO ○
YES ○

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) ○
YES ○

C. Did this happen 3 or more times?

NO (SKIP TO G13) ○
YES ○

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

NO ○
YES ○

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 ○
YES ○

B. Did you ever get into physical fights while using (OPIATE)?

NO ○
YES ○

BOX G13 IF A AND B ARE BOTH CODED "NO", SKIP TO G14. OTHERS, CONTINUE.

C. Did (this/either of these experiences) happen 3 or more times in any 12-month

NO ○
YES ○

D. Did you continue to use (OPIATE) after you realized it was causing these problems?

NO ○
YES ○

G14 Have you ever been arrested or had any other trouble with the police because of your (OPIATE) use?

NO (SKIP TO G15) ○
YES ○

SPECIFY:

A. Did this happen 3 or more times?

NO (SKIP TO G15) ○
YES ○

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

NO ○
YES ○

G15 Has your being high on (OPIATE) or experiencing its after-effects often interfered with your work, school, household, or child care responsibilities?

NO (SKIP TO G16) ○
YES ○

A. Did this happen 3 or more times in a 12-month period?

NO ○
YES ○

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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 G17) ○
YES ○

A. Has this happened 3 or more times, or did it last a month or longer?

NO ○
YES ○*

G17 Did using (OPIATE) cause you to have any other problems like:

A. An overdose?

NO (SKIP TO G17B) ○
YES ○

1. IF YES: Did you require medical treatment

NO (SKIP TO G17B) ○
YES ○

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

NO ○
YES ○*

B. Other serious health problems?

NO (SKIP TO G18) ○
YES ○

SPECIFY: _____

1. IF YES: Did you continue to use (OPIATE) knowing it caused health problems?

NO ○
YES ○*

G18 Have you ever used (OPIATE) together with one or more other drugs, including alcohol?

NO (SKIP TO BOX G18) ○
ALCOHOL ONLY ○
YES (SPECIFY) ○

IF YES: Which ones?

1. _____ CODE: ___
2. _____ CODE: ___
3. _____ CODE: ___
4. _____ CODE: ___

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

Opiate Tally

HAND R Opiates TALLY.

G19 I have checked on this sheet the experiences with (OPIATE) that you have told me about. You told me **(REVIEW SX)**. When was the (first/last) time that you had any of these experiences?

AGE ONS: ___
ONS: 1 2 3 4 5 U

AGE REC: ___
REC: 1 2 3 4 5 U

CODE KEY: IF > 100, CODE 98 OR 998. IF UNKNOWN, CODE 99 OR 999

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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 ○
YES (SKIP TO C) ○

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) ○
YES ○

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: ____
1 ○ 2 ○ 3 ○ 4 ○ 5 ○ U ○ ○

AGE REC: ____
REC: ○ ○ ○ ○ ○ ○

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

HAND R Opiates TALLY.

Opiate Tally

G20 **A.** Please review this list of experiences which are grouped into boxes. 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) ○
YES ○

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 U

AGE REC: ____
REC: 1 2 3 4 5 U

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

CODE KEY: IF > 100, CODE 98 OR 998. IF UNKNOWN, CODE 99 OR 999

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) ○
YES ○

A. When did that/these occur? **RECORD IN ORDER OF LONGEST TO SHORTEST. IF R HAD MORE THAN 4 ABSTINENT PERIODS RECORD THE 4 LONGEST.**

FROM	MO / YEAR		TO	MO / YEAR			
FROM	MO / YEAR		TO	MO / YEAR			
FROM	MO / YEAR		TO	MO / YEAR			
FROM	MO / YEAR		TO	MO / YEAR			

G22 Did you ever bring up any problems you might have had with (OPIATE) with any professional?

NO (SKIP TO G23) ○
YES ○

A. To whom did you speak first?

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

CODE ☐

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 U

AGE REC: ☐☐
REC: 1 2 3 4 5 U

REFER TO B9 & B10 BEFORE ASKING

G23 Have you ever been treated for a problem with (OPIATE)?

NO (SKIP TO G23D) ○
YES ○

A. Were you ever treated at:

☐ 1. outpatient drug program?
☐ 2. outpatient, other?
☐ 3. inpatient drug program?
☐ 4. inpatient for medical complications due to (OPIATE) use?
☐ 5. other? (IF YES, SPECIFY)

☐

CODE KEY: IF > 100, CODE 98 OR 998. IF UNKNOWN, CODE 99 OR 999

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

AGE ONS: ☐☐

ONS: 1 2 3 4 5 U

AGE REC: ☐☐

REC: 1 2 3 4 5 U

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 H) ○

YES ○

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 U

AGE REC: ☐☐

REC: 1 2 3 4 5 U

CODE KEY: IF > 100, CODE 98 OR 998. IF UNKNOWN, CODE 99 OR 999

END OF SECTION G

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H1 **HAND R CARD H.**

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?

MJ	STIM	SED	PCP	HAL	SOL	COM	OTH
N ○	N ○	N ○	N ○	N ○	N ○	N ○	N ○
Y ○	Y ○	Y ○	Y ○	Y ○	Y ○	Y ○	Y ○

BOX H1 **IF NONE SELECTED, SKIP TO I1. OTHERS CONTINUE FOR EACH DRUG CHOSEN.**

A. How many times in your life have you used (DRUG)? **(IF > 100, CODE 98. IF UKNOWN, CODE 99)**

1. **IF DK, ASK:** Would you say 11 or more times?

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

FOR EACH AGE ONS BEFORE 15, ASK C. OTHERS SKIP TO D.

	MJ	STIM	SED	PCP	HAL	SOL	COM	OTH
TIMES:								
	N ○	N ○	N ○	N ○	N ○	N ○	N ○	N ○
	Y ○	Y ○	Y ○	Y ○	Y ○	Y ○	Y ○	Y ○
AGE ONS:								
ONS:								
AGE REC:								
REC:								

C. Did you use (DRUG) more than once before you were 15?

MJ	STIM	SED	PCP	HAL	SOL	COM	OTH
N ○	N ○	N ○	N ○	N ○	N ○	N ○	N ○
Y ○	Y ○	Y ○	Y ○	Y ○	Y ○	Y ○	Y ○

D. Have you ever injected any drugs? **IF YES:** Which ones? **IF NO, SKIP TO F.**

	STIM	SED	COM	OTH
	N ○	N ○	N ○	N ○
	Y ○	Y ○	Y ○	Y ○
TIMES:				
AGE ONS:				
ONS:				
AGE REC:				
REC:				

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

CODE KEY: IF > 100, CODE 98 OR 998. IF UNKNOWN, CODE 9, 99 OR 999

E. Have you ever shared a needle?

NO (SKIP TO F) ○
YES ○

1. How many times?

TIMES: ___

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

AGE ONS: ___
ONS: 1 2 3 4 5 U

AGE REC: ___
REC: 1 2 3 4 5 U

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

DRUG: _____ **CODE:** ___

BOX H2 **CHECK H1A & H1A1. IF NO DRUG USED 11 OR MORE TIMES, SKIP TO I1. 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: ___

H2 **ASK ONE COLUMN AT A TIME.**
Have you ever used (drug) daily or almost daily? IF NO, SKIP TO H2. What is the longest period you used (DRUG) almost every day? **IF NEVER ALMOST EVERY DAY, CODE 0 DAYS. IF > 100 CODE 98, IF UNKNOWN CODE 99. IF USED DAILY FOR 1 MONTH OR LONGER, CODE H2A "YES" SILENTLY.**

	MJ	STIM	SED	OTH
DAYS				
WEEKS				
MONTHS				
YEARS				

A. Did you ever use (DRUG) at least once a week for one month or more?

	MJ	STIM	SED	OTH
	N ○ Y ○	N ○ Y ○	N ○ Y ○	N ○ Y ○

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

CODE KEY: IF > 100, CODE 98 OR 998. IF UNKNOWN, CODE 9, 99 OR 999

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		MJ	STIM	SED	OTH
H3	Have you ever stayed high from (DRUG) for a whole day or more?	N● Y●	N● Y●	N● Y●	N● Y●
A.	Did this happen 3 or more times?	N● Y●	N● Y●	N● Y●	N● Y●

BEGIN SCORING DRUG TALLY SHEET

		MJ	STIM	SED	OTH
H4	Have you ever had such a strong desire for (DRUG) that it was hard to think of anything else?	N● Y●	N● Y●	N● Y●	N● Y●
A.	**IF YES:** How old were you the (first/last) time?	AGE ONS:			
		ONS:			
		AGE REC:			
		REC:			
B.	Have you ever had a strong desire or craving for (DRUG)?	N○ Y○	N○ Y○	N○ Y○	N○ Y○ *
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?	N● Y●	N● Y●	N● Y●	N● Y● *
H6	Have you often wanted to stop or cut down on (DRUG)?	N● Y●	N● Y●	N● Y●	N● Y● *
A.	Have you ever tried to stop or cut down on (DRUG) but found that you couldn't? **NO, COULD STOP** / **YES, COULDN'T STOP**	N● Y●	N● Y●	N● Y●	N● Y●
	IF NO (COULD STOP), SKIP TO H7. OTHERS CONTINUE.				
B.	Were you unable to stop or cut down 3 or more times?	N● Y●	N● Y●	N● Y●	N● Y● *
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? **(CODE "YES" IF R. INCREASED HIS USUAL DOSE 50% OR MORE OVER A PREVIOUS HABITUAL LEVEL OF USE)**	N● Y●	N● Y●	N● Y●	N● Y● *

CODE KEY: IF > 100, CODE 98 OR 998. IF UNKNOWN, CODE 9, 99 OR 999

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	MJ	STIM	SED	OTH
H8 Have you ever given up or greatly reduced important activities while using (DRUG), like sports, work, or associating with friends or relatives?	N Y	N Y	N Y	N Y

SPECIFY:

	MJ	STIM	SED	OTH
A. IF YES: Did this happen 3 or more times or for a month or more?	N Y	N Y	N Y	N Y *

	MJ	STIM	SED	OTH
H9 Have you <u>often</u> used (DRUG) more days or in larger amounts than you intended to?	N Y	N Y	N Y	N Y *

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=N, YES=Y)**
ASK H10 A1-24 ONE COLUMN AT A TIME.

REPEAT STEM OFTEN.	**MJ**	**STIM**	**SED**	**OTH**
A. 1. Did you feel depressed?		N Y	N Y	N Y
2. Did you feel restless?	N Y	N Y	N Y	N Y
3. Did you feel tired, sleepy, or weak?		N Y	N Y	N Y
4. Did you have trouble sleeping?	N Y	N Y	N Y	N Y
5. Did you sleep too much?		N Y		N Y
6. Did you have a strong desire or craving for (DRUG)?	N Y	N Y		N Y
7. Did you feel slowed down, like you could hardly move?		N Y		N Y
8. Did you have an increase or decrease in appetite?	N Y	N Y		N Y
9. Did you have nightmares?		N Y		N Y
10. Did you think that people were plotting to harm you (i.e., were you paranoid?)	N Y	N Y		N Y
11. Did you have diarrhea?	N Y			N Y
12. Did you have stomach aches or stomach cramps?	N Y			N Y
13. Were your pupils dilated or were your eyes sensitive to light?				N Y
14. Did your heart race?			N Y	N Y
15. Did you sweat?	N Y		N Y	
16. Did you have a fever?	N Y		N Y	N Y
17. Did you have nausea, or did you vomit?	N Y		N Y	N Y
18. Did you have headaches?			N Y	N Y
19. Did you feel nervous, tense, or irritable?	N Y		N Y	N Y
20. Did your hands shake?			N Y	
21. Did you tremble or twitch?	N Y		N Y	N Y
22. Did you experience dizziness?			N Y	N Y
23. Did you have seizures?			N Y	N Y
24. Did you see, hear, or feel things that weren't really there?			N Y	N Y

CONTINUE ASKING ONE COLUMN AT A TIME.
FOR EACH DRUG COLUMN:
IF ALL CODED N, GO TO NEXT DRUG COLUMN.
IF ONLY ONE CODED Y, SKIP TO E.
IF TWO OR MORE Y'S CODED, CONTINUE.

	MJ	STIM	SED	OTH	
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.**	N○ Y○	N● Y●	N● Y●	N○ Y○	*
1. **IF YES:** Did these problems occur together for 2 days or longer? **IF NO, SKIP TO C.**	N○ Y○	N● Y●	N● Y●	N○ Y○	
2. **IF YES:** How old were you the (first/last) time?	AGE ONS:	ONS:	AGE REC:	REC:	
C. Did you have any of these problems 3 or more times?	N○ Y○	N● Y●	N● Y●	N○ Y○	
D. Did these problems interfere with your functioning at work, school, or home?	N○ Y○	N● Y●	N● Y●	N○ Y○	
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.	N○ Y○	N● Y●	N● Y●	N○ Y○	
1. IF YES: How old were you the (first/last) time?	AGE ONS:	ONS:	AGE REC:	REC:	
2. Did you do that 3 or more times?	N○ Y○	N● Y●	N● Y●	N○ Y○	*

CODE KEY: IF > 100, CODE 98 OR 998. IF UNKNOWN, CODE 9, 99 OR 999

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		MJ	STIM	SED	OTH
H11	Did using (DRUG) cause you to have any other problems like:	N○	N●	N●	N○
A.	an overdose?	Y○	Y●	Y●	Y○
1.	**IF YES:** Did you require medical treatment afterwards? **IF NO, SKIP TO B**	N○	N●	N●	N○
		Y○	Y●	Y●	Y○
2.	IF YES: Did this happen 3 or more times? (overdose that required medical treatment)	N○	N●	N●	N○
		Y○	Y●	Y●	Y○*
B.	hepatitis?	N○	N●	N●	N○
		Y○	Y●	Y●	Y○
1.	**IF YES:** Did you continue to use (DRUG) knowing it caused hepatitis?	N○	N●	N●	N○
		Y○	Y●	Y●	Y○*
C.	Other serious health problems?	N○	N●	N●	N○
		Y○	Y●	Y●	Y○
SPECIFY:					
1.	**IF YES:** Did you continue to use (DRUG) knowing it caused health problems?	N○	N●	N●	N○
		Y○	Y●	Y●	Y○*

		MJ	STIM	SED	OTH
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?	N○	N●	N●	N○
		Y○	Y●	Y●	Y○
B.	Did you ever get into any physical fights while using (DRUG)?	N○	N●	N●	N○
		Y○	Y●	Y●	Y○

BOX H12 IF A AND B ARE BOTH CODED NO, SKIP TO H13. OTHERS CONTINUE.

C.	Did (this/either of these experiences) happen 3 or more times in any 12-month period?	N○	N●	N●	N○
		Y○	Y●	Y●	Y○
D.	Did you continue to use (DRUG) after you realized it was causing you any problem?	N○	N●	N●	N○
		Y○	Y●	Y●	Y○A

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		MJ	STIM	SED	OTH
H13	Did you ever have trouble with the police because of (DRUG)? **IF NO, SKIP TO H14**	N ○ Y ○	N ● Y ●	N ● Y ●	N ○ Y ○
A.	**IF YES:** Did this happen 3 or more times in any 12-month period?	N ○ Y ○	N ● Y ●	N ● Y ●	N ○ Y ○
B.	Did you continue to use (DRUG) after you realized it was causing you trouble with the police?	N ○ Y ○	N ● Y ●	N ● Y ●	N ○ Y ○

		MJ	STIM	SED	OTH
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? **IF NO, SKIP TO H15.**	N ○ Y ○	N ● Y ●	N ● Y ●	N ○ Y ○
A.	**IF YES**: Did this happen 3 or more times? **IF NO, SKIP TO H15.**	N ○ Y ○	N ● Y ●	N ● Y ●	N ○ Y ○
B.	**IF YES:** Did this happen 3 or more times in any 12-month period?	N ○ Y ○	N ● Y ●	N ● Y ●	N ○ Y ○

		MJ	STIM	SED	OTH
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? **IF NO, SKIP TO H16.**	N ○ Y ○	N ● Y ●	N ● Y ●	N ○ Y ○
	IF YES, SPECIFY:				
A.	**IF YES:** Did this happen 3 or more times in any 12-month period?	N ○ Y ○	N ● Y ●	N ● Y ●	N ○ Y ○

		MJ	STIM	SED	OTH
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? **IF NO, SKIP TO H17**	N ○ Y ○	N ● Y ●	N ● Y ●	N ○ Y ○
A.	**IF YES:** Did this happen 3 or more times in any 12-month period?	N ○ Y ○	N ● Y ●	N ● Y ●	N ○ Y ○

CODE KEY: IF > 100, CODE 98 OR 998. IF UNKNOWN, CODE 9, 99 OR 999

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H17 Has your use of (DRUG) ever caused you emotional or psychological problems like:

	MJ	STIM	SED	OTH
1. Feeling depressed or uninterested in things for more than 24 hours to the point that it interfered with your functioning?	N○ Y○	N● Y●	N● Y●	N○ Y○
2. Feeling paranoid or suspicious of people for more than 24 hours to the point that it interfered with your relationships?	N○ Y○	N● Y●	N● Y●	N○ Y○
3. Having trouble concentrating or thinking clearly for more than 24 hours to the point that it interfered with your functioning?	N○ Y○	N● Y●	N● Y●	N○ Y○
4. Hearing, seeing, or smelling things that weren't really there?	N○ Y○	N● Y●	N● Y●	N○ Y○
5. Feeling jumpy or easily startled or nervous for more than 24 hours to the point that it interfered with your functioning?	N○ Y○	N● Y●	N● Y●	N○ Y○

IF ALL ARE CODED NO, SKIP TO BOX H17. OTHERS CONTINUE.

A. Did you continue to use (DRUG) after you knew it caused any of these problems? **REVIEW SX AS NEEDED.**	N○ Y○	N● Y●	N● Y●	N○ Y○*

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

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HAND R DRUG TALLY.

H18 Please review these experiences that you told me about. **(REVIEW SX.)** When was the (first/last) time you had any of these experiences?

Drug Tally

	MJ	STIM	SED	OTH
AGE ONS:				
ONS:				
AGE REC:				
REC:				

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

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

MJ	STIM	SED	OTH
N○	N●	N●	N○
Y○	Y●	Y●	Y○

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?

N○	N●	N●	N○
Y○	Y●	Y●	Y○

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 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?

	MJ	STIM	SED	OTH
AGE ONS:				
ONS:				
AGE REC:				
REC:				

BOX H18B IF 3 OR MORE BOXES MARKED ON TALLY, CONTINUE. OTHERS SKIP TO BOX H19B.

CODE KEY: IF > 100, CODE 98 OR 998. IF UNKNOWN, CODE 9, 99 OR 999

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Drug Tally

MJ	STIM	SED	OTH
N ○	N ●	N ●	N ○
Y ○	Y ●	Y ●	Y ○

HAND R DRUG TALLY.

H19 **A.** Was there ever a 12-month period in which you had experiences from 3 or more boxes?

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.

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

IF YES, CIRCLE SX THAT CLUSTER AND ASK B.

IF NO, SKIP TO BOX H19.

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?

	MJ	STIM	SED	OTH
AGE ONS:				
ONS:				
AGE REC:				
REC:				

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

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.**

MJ	STIM	SED	OTH
N ○	N ●	N ●	N ○
Y ○	Y ●	Y ●	Y ○

A. When did (that/these) occur?

MJ

	MO	YEAR	MO	YEAR
FROM	/		TO	/
FROM	/		TO	/
FROM	/		TO	/
FROM	/		TO	/

STIM

	MO	YEAR	MO	YEAR
FROM	/		TO	/
FROM	/		TO	/
FROM	/		TO	/
FROM	/		TO	/

SED

	MO	YEAR	MO	YEAR
FROM	/		TO	/
FROM	/		TO	/
FROM	/		TO	/
FROM	/		TO	/

OTH

	MO	YEAR	MO	YEAR
FROM	/		TO	/
FROM	/		TO	/
FROM	/		TO	/
FROM	/		TO	/

CODE KEY: IF > 100, CODE 98 OR 998. IF UNKNOWN, CODE 9, 99 OR 999

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

NO (SKIP TO H22) ○
YES ○

A. Did you speak with:

☐ 1. A psychiatrist?
☐ 2. Another medical doctor?
☐ 3. A psychologist?
☐ 4. Another mental health professional?
☐ 5. A member of the clergy?
☐ 6. Anyone else?

SPECIFY: ☐☐☐☐☐☐☐☐☐☐

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 U

AGE REC: ☐☐
REC: 1 2 3 4 5 U

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

CODE: ☐

CODE KEY: IF > 100, CODE 98 OR 998. IF UNKNOWN, CODE 9, 99 OR 999

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

NO (SKIP TO D) ○
YES ○

A. Were you treated:

☐ 1. at an outpatient drug-free program?
☐ 2. at an outpatient program for something other than drugs?
☐ 3. at an inpatient drug-free program?
☐ 4. when inpatient for medical complications due to drug use?
☐ 5. at any other place or program? (IF YES, SPECIFY)

IF YES, 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 U

AGE REC: ☐☐
REC: 1 2 3 4 5 U

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

CODE: ☐

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

NO (SKIP TO I1) ○
YES ○

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 U

AGE REC: ☐☐
REC: 1 2 3 4 5 U

CODE KEY: IF > 100, CODE 98 OR 998. IF UNKNOWN, CODE 9, 99 OR 999

END OF SECTION H

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BEGIN SCORING TALLY SHEET FOR SECTION

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 91
13-14.....RECORD 92
15-17.....RECORD 93
18 OR OLDER..RECORD 94

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) ○
YES ○

A. Did this ever happen twice in 1 year?

NO (SKIP TO I2) ○
YES ○

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) ○
YES ○

A. How old were you the first time?

AGE ONS: ☐☐

I3 Did you ever run away from home overnight?

NO (SKIP TO I4) ○
YES ○

A. Why did you run away?

☐

CODE SILENTLY:
Avoid physical abuse ○
Avoid sexual abuse ○
Other ○

B. Did you run away overnight more than once?

NO (SKIP TO C) ○
YES ○ A

1. How old were you the (first/last) time you ran away from home overnight?

AGE ONS: ☐☐
AGE REC: ☐☐

IF I3B = YES, CODE AGES AND THEN SKIP TO I4

C. After you ran away, did you return home?

NO (SKIP TO 2) ○ A
YES ○

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: ☐☐

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) ○
YES ○

A. Did this happen 3 or more times?

NO (SKIP TO I5) ○
YES ○

B. How old were you the first time?
MARK TALLY IF AGE ONS LESS THAN 13.

AGE ONS: ☐☐ A

I5 Did you ever sneak out of the house at night after your parents thought you had gone to bed?

NO (SKIP TO I6) ○
YES ○

A. Did this happen 3 or more times?

NO (SKIP TO I6) ○
YES ○

B. How old were you the first time?
MARK TALLY IF AGE ONS LESS THAN 13.

AGE ONS: ☐☐ A

I6 Did you 3 or more times start physical fights with your brothers or sisters?

NO (SKIP TO B) ○
ALC/DRUGS ONLY ○
YES, CLEAN ○ A,B
BOTH A/D & CLEAN ○ A,B

A. At what age did you (first/last) start fights with your siblings?

A1. UNRELATED TO ALC/DRUGS.

AGE ONS: ☐☐

A2. IN CONTEXT OF ALC/DRUGS.

AGE ONS A/D: ☐☐

A3. RECENCY.

AGE REC: ☐☐

B. Did you 3 or more times start physical fights with persons other than your brothers and sisters?

NO (SKIP TO D) ○
ALC/DRUGS ONLY ○
YES, CLEAN ○A,B
BOTH A/D & CLEAN ○A,B

C. At what age did you (first/last) start fights with persons other than siblings?

C1. UNRELATED TO ALC/DRUGS. AGE ONS: ☐☐

C2. IN CONTEXT OF ALC/DRUGS. AGE ONS A/D: ☐☐

C3. RECENCY. AGE REC: ☐☐

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 a part of your job)?

DO NOT COUNT FIGHTS WITH SIBLINGS UNLESS SOMEONE WAS HURT.

NO (SKIP TO I7) ○
ALC/DRUGS ONLY ○
YES, CLEAN ○B
BOTH A/D & CLEAN ○B

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

E1. UNRELATED TO ALC/DRUGS. AGE ONS: ☐☐

E2. IN CONTEXT OF ALC/DRUGS. AGE ONS A/D: ☐☐

E3. RECENCY. AGE REC: ☐☐

I7 When you were younger did you often 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 errands, refusing to participate in class, or not behaving well?

NO (SKIP TO I8) ○
YES ○

A. How old were you the first time? AGE ONS: ☐☐

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) ○
YES ○

A. How old were you the first time?

AGE ONS: ☐☐

I9 Did people complain that you were often a bully, deliberately hurting, threatening, or being mean to other children?

NO (SKIP TO I10) ○
YES ○ A,B

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

AGE ONS: ☐☐
AGE REC: ☐☐

I10 Did you ever hurt or injure a pet or any other animal on purpose?

NO (SKIP TO I11) ○
YES (SPECIFY) ○ A,B

SPECIFY: ☐

A. How many times?

TIMES: ☐☐

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

AGE ONS: ☐☐
AGE REC: ☐☐

I11 Throughout your life have you told <u>a lot</u> of lies?

NO ○
ALC/DRUGS ONLY ○
YES, CLEAN ○ A
BOTH A/D & CLEAN ○ A

A. Did you often lie to get your own way, or to get out of trouble?

NO ○
ALC/DRUGS ONLY ○
YES, CLEAN ○ A
BOTH A/D & CLEAN ○ A

B. Have you ever used an alias or a false name?
EXCLUDE MINORS USING FALSE ID TO BUY ALCOHOL OR ENTER A BAR

NO ○
ALC/DRUGS ONLY ○
YES, CLEAN ○
BOTH A/D & CLEAN ○

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B1. Did you ever do this to take advantage of a person or a situation?

NO ○
YES ○ A

BOX I11 IF I11, I11A, AND I11B ARE ALL CODED NO, SKIP TO I12. OTHERS CONTINUE.

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. AGE ONS: ☐☐

C2. IN CONTEXT OF ALC/DRUGS. AGE ONS A/D: ☐☐

C3. RECENCY. AGE REC: ☐☐

I12 When something went wrong that was your fault, did you usually try to get out of it by blaming others?

NO (SKIP TO I13) ○
ALC/DRUGS ONLY ○
YES, CLEAN ○
BOTH A/D & CLEAN ○

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: ☐☐

I13 Did you often cheat on schoolwork, on exams, in games, or anything like that?

NO ○
YES ○ A

A. Have you often cheated on things as an adult? Examples include cheating at work or on taxes.

NO ○
ALC/DRUGS ONLY ○
YES, CLEAN ○ A
BOTH A/D & CLEAN ○ A

IF I13 AND I13A ARE BOTH CODED NO, SKIP TO I14. 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: ☐☐

I14 Did you more than once steal money or things from your family, friends, or relatives? **COUNT ONLY IF MORE THAN A FEW DOLLARS.**

NO (SKIP TO B) ○
ALC/DRUGS ONLY ○
YES, CLEAN ○ A,B
BOTH A/D & CLEAN ○ 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: ☐☐

B. Did you more than once steal or shoplift from stores or from other people? (NO CONFRONTATION)

NO (SKIP TO D) ○
ALC/DRUGS ONLY ○
YES, CLEAN ○ A,B
BOTH A/D & CLEAN ○ A,B

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: ☐☐

D. Did you more than once forge anyone's signature on a check or credit card without permission?

NO (SKIP TO BOX I14) ○
ALC/DRUGS ONLY ○
YES, CLEAN ○ A,B
BOTH A/D & CLEAN ○ A,B

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

E1. UNRELATED TO ALC/DRUGS. AGE ONS: ☐☐

E2. IN CONTEXT OF ALC/DRUGS. AGE ONS A/D: ☐☐

E3. RECENCY. AGE REC: ☐☐

BOX I14, I14B, AND I14D ARE ALL CODED NO, SKIP TO I15. OTHERS CONTINUE.

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F. Since your 15th birthday, have you stolen things (or forged a signature without permission) 3 or more times?

NO ○
YES ○

I15 Did you ever break into someone else's home, car, or building (not because you were locked out)?

NO (SKIP TO I16) ○
ALC/DRUGS ONLY ○
YES, CLEAN ○ A,B
BOTH A/D & CLEAN ○ 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: ☐☐

B. Has this happened 3 or more times since you were 15?

NO ○
YES ○

I16 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) ○
ALC/DRUGS ONLY ○
YES, CLEAN ○ A,B
BOTH A/D & CLEAN ○ 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: ☐☐

B. Has this happened 3 or more times since you were 15?

NO ○
YES ○

I17 Did you ever deliberately set fires you were not supposed to?

NO (SKIP TO I18) ○
ALC/DRUGS ONLY ○
YES, CLEAN ○
BOTH A/D & CLEAN ○

A. Did you do this with the intention to damage property

NO ○
YES ○ A,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: ☐☐

C. Has this happened 3 or more times since you were 15?

NO ○
YES ○

I18 Have you ever damaged someone's property on purpose (other than by fire setting)?

NO (SKIP TO I19) ○
ALC/DRUGS ONLY ○
YES, CLEAN ○ A,B
BOTH A/D & CLEAN ○ A,B

SPECIFY:

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: ☐☐

IF AGE ONS IS LESS THAN 15, ASK B.
OTHERS SKIP TO D.

B. Did you more than once damage someone's property before you turned 15?

NO ○
YES ○

C. Since your 15th birthday, have you damaged someone else's property on purpose?

NO (SKIP TO I19) ○
YES ○

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

NO ○
YES ○

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

NO (SKIP TO I20) ○
ALC/DRUGS ONLY ○
YES, CLEAN ○ A,B
BOTH A/D & CLEAN ○ A,B

SPECIFY:

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: ☐☐

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

NO (SKIP TO I21) ○
ALC/DRUGS ONLY ○
YES, CLEAN ○ A,B
BOTH A/D & CLEAN ○ 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: ☐☐

I21 Have you ever forced anyone into any sexual activity?

NO (SKIP TO BOX I22) ○
ALC/DRUGS ONLY ○
YES, CLEAN ○ A,B
BOTH A/D & CLEAN ○ 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**

Section I Tally A

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I22 You mentioned that you (**LIST SX 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) ○
YES ○

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

AGE ONS: ☐☐
AGE REC: ☐☐

Section I Tally A

REC: 1 2 3 4 5 U

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

	NO	ALC DRUGS ONLY	YES CLEAN	BOTH A/D & CLEAN
1. Deliberately written bad checks?.....	○	○	○	○
2. Received, sold, or bought stolen goods (fenced), sold drugs, or "run numbers" (illegally gambled)?.....	○	○	○	○
3. Been paid for having sex with someone?.....	○	○	○	○
a. IF YES (YES CLEAN, ALC/DRUGS ONLY, or BOTH A/D & CLEAN): were you ever paid with drugs?	N ○ Y ○			
4. Found customers for male or female prostitutes or "call girls".....	○	○	○	○

IF ALL CODED NO, CONTINUE. OTHERS SKIP TO B.

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) ○
ALC/DRUGS ONLY ○
YES, CLEAN ○
BOTH A/D & CLEAN ○

SPECIFY:

B. Since your 15th birthday, have you done any of these things (I231-4 or I23A) 3 or more times?

NO ○
YES ○

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: ☐☐

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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) ○
ALC/DRUGS ONLY ○
YES, CLEAN ○
BOTH A/D & CLEAN ○

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: ☐☐

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) ○
YES ○

	NO	ALC DRUGS ONLY	YES CLEAN	BOTH A/D & CLEAN
A. Have you often not provided financial support for your family when you were supposed to?.....	○	○	○ B	○ B
B. Have you often left young children under 6 at home alone while you were out shopping or doing anything else?.....	○	○	○ B	○ B
C. Has a neighbor fed or taken care of a child yours because no one was taking care of the child at home?.....	○	○	○ B	○ B
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?.....	○	○	○ B	○ B
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 going out?.....	○	○	○ B	○ B

IF ALL CODED NO, 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 OF ALC/DRUGS. AGE ONS A/D: ☐☐

F3. RECENCY. AGE REC: ☐☐

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

NO (SKIP TO I27) ○
ALC/DRUGS ONLY ○
YES, CLEAN ○
BOTH A/D & CLEAN ○

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: ☐☐

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) ○
ALC/DRUGS ONLY ○
YES, CLEAN ○B
BOTH A/D & CLEAN ○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: ☐☐

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) ○
ALC/DRUGS ONLY ○
YES, CLEAN ○
BOTH A/D & CLEAN ○

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

TICKETS: ☐☐

1. Was it at least 4?

NO ○
YES ○

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: ☐☐

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

NO (SKIP TO I30) ○
ALC/DRUGS ONLY ○
YES, CLEAN ○
BOTH A/D & CLEAN ○

REASON(S):

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: ☐☐

B. How many times have you been arrested (other than for moving violations)? ☐☐

C. Have you been convicted of a felony?

NO ○
YES (SPECIFY) ○

SPECIFY:

D. Have you ever spent time in jail for something other than using drugs or alcohol?

NO (SKIP TO I30) ○
YES (SPECIFY) ○

SPECIFY:

E. Since you got out of jail have you ever been arrested for things other than using drugs or alcohol?

NO ○
YES (SPECIFY) ○

SPECIFY:

I30 Since you were 15, have you quit 3 or more jobs before having another job lined up?

IF YES CLEAN OR BOTH A/D & CLEAN, SKIP TO I 31. OTHERS CONTINUE.

NO ○
ALC/DRUGS ONLY ○
YES, CLEAN ○
BOTH A/D & CLEAN ○

A. Since you were 15, have you dropped out of 3 or more academic programs?
INCLUDE GED AND TECHNICAL TRAINING PROGRAMS.

NO ○
ALC/DRUGS ONLY ○
YES, CLEAN ○
BOTH A/D & CLEAN ○

I31 On any job you have had since you were 15, have you frequently been late or absent?

NO (SKIP TO I 32) ○
ALC/DRUGS ONLY ○
YES, CLEAN ○
BOTH A/D & CLEAN ○

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 ○
YES ○

I32 In the last 5 years, have you been without a job for 6 months or more?

NO (SKIP TO I33) ○
YES ○

A. Was this when you were in school, laid off, sick, on strike, a full-time homemaker, retired, or in jail?

NO (ANOTHER REASON) ○
YES (SKIP TO I33) ○

B. Were you **always** having problems with alcohol or drugs at that time?

NO ○
YES ○

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? **DO NOT COUNT VACATIONS.**

NO (SKIP TO I34) ○
YES ○

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

AGE ONS: ☐☐
AGE REC: ☐☐

B. Were you **always** having problems with alcohol or drugs at that time?

NO ○
YES ○

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

I34 Since you were 18, have you ever had a close personal friendship or love relationship that lasted continuously for more than one year?

NO ○
YES ○
N/A (CURRENTLY 18) ○

I35 How old were you when you first had sexual intercourse (voluntarily)?

AGE ONS: ☐☐

BOX I35 IF NEVER CODE 00 AND SKIP TO I38

A. How many sexual partners have you had in your life?

NUMBERS ☐☐☐

IF 1, SKIP TO I37. IF 2-9, SKIP TO I36. OTHERS CONTINUE.

B. Have you ever had sex with 10 different people within a single year?

NO ○
YES ○

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) ○
ALC/DRUGS ONLY ○
YES, CLEAN ○
BOTH A/D & CLEAN ○

A. Did this happen 3 or more times?

NO ○
YES ○

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)? **IF NEVER HAD A 1-YEAR RELATIONSHIP, CODE N/A.**

NO, NEVER FAITHFUL ○ B
YES, WAS FAITHFUL ○
N/A ○

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 ○
- ALC/DRUGS ONLY ○
- YES, CLEAN ○
- BOTH A/D & CLEAN ○

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?

SPECIFY:

- NO ○
- ALC/DRUGS ONLY ○
- YES, CLEAN ○
- BOTH A/D & CLEAN ○

A. Have you often taken chances when driving--like racing a train to a crossing, or drag racing?

SPECIFY:

- NO ○
- ALC/DRUGS ONLY ○
- YES, CLEAN ○
- BOTH A/D & CLEAN ○

BOX I38 IF I38 AND I38A ARE BOTH CODED NO, 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: ☐☐

I39 Was there ever a time when you really enjoyed conning people to the point that would often go out of your way to put something over on them?

- NO (SKIP TO I40) ○
- ALC/DRUGS ONLY ○
- YES, CLEAN ○
- BOTH A/D & CLEAN ○

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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: ☐☐

B. Did this happen 3 or more times since your 15th birthday?

NO ○
YES ○

I40 Have you <u>often</u> ignored the feelings of others in order to do what <u>you</u> wanted?

NO ○
ALC/DRUGS ONLY ○
YES, CLEAN ○
BOTH A/D & CLEAN ○

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 ○
ALC/DRUGS ONLY ○
YES, CLEAN ○
BOTH A/D & CLEAN ○

I42 Have you <u>often</u> felt that others were to blame for your troubles or mistakes?

NO ○
ALC/DRUGS ONLY ○
YES, CLEAN ○
BOTH A/D & CLEAN ○

I Tally Part B

BOX I43 REVIEW PART B OF TALLY SHEET I. IF 2 OR MORE ITEMS MARKED, CONTINUE. OTHERS SKIP TO I44.

I43 Now I'd like you 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 U

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 ○
YES (SKIP TO I44) ○

B. Was that because you felt the person(s) (or animals) involved deserved it more times than not?

NO ○
YES ○

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I44 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? **IF > 100, CODE 98. IF UNKNOWN, CODE 99.**

NO (SKIP TO C) ○
YES (CONTINUE) ○

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. Burglary, larceny, B & E..... ☐☐

A7. Robbery..... ☐☐

A8. Assault..... ☐☐

A9. Arson..... ☐☐

A10. Rape..... ☐☐

A11. Homicide, manslaughter..... ☐☐

A12. Prostitution..... ☐☐

A13. Contempt of court..... ☐☐

A14. Other..... ☐☐

If Other, specify: ☐

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?..... ☐☐

NOTE: CODE ONLY SENTENCED JAIL TIME, IF < 1 MONTH, CODE 01

END OF SECTION I

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C1 C2

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

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 empty?

NO ○
YES ○

J2 Have you ever had a period of time lasting at least one week when you lost interest or enjoyment in most things, even things you usually liked to do?

NO ○
YES ○

BOX J2 IF J1 AND J2 BOTH CODED NO, SKIP TO K1. OTHERS CONTINUE.

J3 Please tell me about the time in your life that stands out as the most severe period of feeling depressed, uninterested in things or empty 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: | | |

During this most severe episode when you were____ years old....	**MOST SEVERE EPISODE**

BEGIN SCORING ASTERISKED ITEMS ON TALLY SHEET J

J4 Were you feeling depressed, sad, empty, or blue most of the day, nearly every day, for at least 2 weeks during this episode?

NO ○
YES ○*

A. Had you lost interest or enjoyment in most things for most of the day, nearly every day, for at least 2 weeks during this episode?

NO ○
YES ○*

IF EPISODE BEGAN BEFORE AGE 18, CONTINUE. OTHERS SKIP TO J5.

B. Did you feel irritable most of the day, nearly every day, for at least 2 weeks during this episode?

NO ○
YES ○*

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Now I would like to ask you about other experiences you may have had during this episode of feeling (depressed/uninterested/empty/irritable).

During this most severe episode when you were____ years old....	MOST SEVERE EPISODE
J5 **A.** Did you have a change in appetite (that was not due to pregnancy, a physical condition, or dieting)?	NO (SKIP TO B) ○ YES ○*
1. Increase or decrease?	INCREASE ○ DECREASE ○ BOTH ○
IF DECREASE ASK: **2.** Did you have to force yourself to eat?	NO ○ YES ○
B. Did you gain or lose weight when you were not trying to (that was NOT due to pregnancy, a physical condition, or dieting)?	NO (SKIP TO J6) ○ YES ○*
1. Gained or lost weight?	GAINED ○ LOST ○ BOTH ○
C. What was your weight before the (gain/loss)? **IF BOTH, CODE THE MORE SIGNIFICANT CHANGE.**	LBS: ☐☐☐
D. What was your weight after the (gain/loss)? **IF C or D=999 ASK D1.**	LBS: ☐☐☐
1. **IF DK, ASK:** How much weight did you gain/lose?	LBS: ☐☐☐
E. Over what period of time did you (gain/lose) this amount of weight?	WEEKS: ☐☐☐

During this most severe episode when you were___years old?	MOST SEVERE EPISODE
J6 Did you have more trouble sleeping than usual?	NO (SKIP TO F) ○ YES ○
A. Were you unable to fall asleep?	NO (SKIP TO C) ○ YES ○
B. Was this for at least one hour?	NO ○ YES ○ *
C. Did you wake up in the middle of the night and have trouble going back to sleep?	NO ○ YES ○ *
D. Did you wake up too early in the morning?	NO (SKIP TO F) ○ YES ○
E. Was this at least one hour earlier than usual?	NO ○ YES ○ *
F. Did you sleep much more than usual?	NO ○ YES ○ *
J7 Were you so fidgety or restless that you had a hard time sitting still?	NO (SKIP TO J8) ○ YES ○
A. Was it so bad that other people noticed?	NO ○ YES ○ *
J8 Were you talking or moving much more slowly than is normal for you?	NO (SKIP TO J9) ○ YES ○
A. Was it so bad that other people noticed?	NO ○ YES ○ *
J9 Were you much less interested in things or less able to enjoy sex or other pleasurable activities?	NO ○ YES ○ *

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J10	Were you feeling a loss of energy or were you more tired than usual?	NO ○ YES ○ *
J11	Were you feeling excessively guilty, that everything was your fault, or that you were a bad person?	NO ○ YES ○*
	During this most severe episode when you were ____ years old?	**MOST SEVERE EPISODE**
J12	Were you feeling that you were a failure or worthless?	NO ○ YES ○*
J13	Did you feel particularly bad when you first woke up, but better later in the day?	NO ○ YES ○
J14	Were you having more difficulty than usual thinking, concentrating, or making decisions?	NO ○ YES ○*
J15	Did your thoughts come much slower than usual or seem mixed up almost every day?	NO ○ YES ○*
J16	Did you have thoughts of dying, taking your life, or wishing you were dead? **DO NOT COUNT THINKING ABOUT THE DEATH OF A RECENTLY DECEASED OR DYING LOVED ONE.**	NO ○ YES ○*
	A. Did you make a plan for committing suicide?	NO ○ YES ○*
	B. Did you try to kill yourself?	NO ○ YES ○ *

BOX J17 COUNT THE BOXES MARKED ON TALLY SHEET J

OF BOXES: ☐☐

IF LESS THAN 5 BOXES: SKIP TO J20

IF 5 OR MORE BOXES: CONTINUE TO BOX J18

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MOST SEVERE EPISODE

BOX J18 IF R DENIES LOW MOOD, LOSS OF INTEREST, AND IRRITABILITY (J4=NO, J4A=NO AND J4B=NO, OR IS NULL), SKIP TO J19B. OTHERS CONTINUE.

HAND R TALLY J. Tally J

J19 **A.** You told me you experienced the following **(REVIEW SYMPTOMS ENDORSED)**. Did you feel (depressed/uninterested/empty/irritable) and have experiences from 4 or more other groups of problems nearly every day, for at least 2 weeks?

NO (SKIP TO B) ○
YES ○

IF YES: Which ones?

CIRCLE MOOD AND SX THAT CLUSTER. NOTE: BOX A OR BOX B MUST BE INCLUDED.

SKIP TO D.

B. You told me that during this episode you experienced **(REVIEW SYMPTOMS ENDORSED).** 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 J20) ○
YES ○

IF YES: Which ones?

CIRCLE SX THAT CLUSTER.

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 J20) ○
YES ○

D. When did this episode begin (when you had these experiences nearly every day)?

☐☐ / ☐☐☐☐
MO YEAR

E. For how long did you feel (depressed/uninterested/empty/irritable) and have experiences from at least 4 other groups of problems nearly every day?

WEEKS: ☐☐☐

MOST SEVERE EPISODE

J20 During this episode, did you see or hear things that other people could not see or hear, that is, did you have hallucinations?

SPECIFY:

WHOM SAW:

WHAT TOLD:

CODE: 1 2 3 4 5 U

A. During this episode, did you have beliefs or ideas that you later found out were not true?

SPECIFY:

WHOM SAW:

WHAT TOLD:

CODE: 1 2 3 4 5 U

IF ANY 5's IN J20 OR J20A, CONTINUE. OTHERS SKIP TO J21.

B. Did these (beliefs/ideas/hallucinations) occur before your (depressed mood/loss of interest/irritability)?

NO (SKIP TO D) ○
YES ○

C. How long before your depressed mood/loss of interest/ irritability) began did you have these (beliefs/ideas/ hallucinations)?

DAYS: ☐☐☐

D. Did you keep having these (beliefs/ideas/hallucinations) after your mood came back to normal?

NO (SKIP TO BOX J20) ○
YES ○
EPISODE ONGOING ○

IF ONGOING, SKIP TO BOX J20

E. How long did they last after your mood came back to normal?

DAYS: ☐☐☐

BOX J20 **WERE SYMPTOMS MOOD CONGRUENT? DID EXAMPLES IN J20 AND J20A HAVE CONTENT THAT WAS ENTIRELY CONSISTENT WITH THEMES OF PERSONAL INADEQUACY, GUILT, POVERTY, PUNISHMENT, ILLNESS, OR CATASTROPHE?**

NO ○
YES ○

Sometimes people have episodes of depression that follow the death of a loved one, heavy drinking or drug use, a change in medication, or serious illness (or childbirth).

MOST SEVERE EPISODE

J21 During the 6 weeks before this episode of feeling (depressed/uninterested/empty/irritable) began, how many days a week did you typically drink alcohol?

DAYS: ☐☐☐

IF 0 OR 1, SKIP TO J22. OTHERS CONTINUE.

A. On the days you drank, how many drinks would you typically have in a day?

DRINKS: ☐☐

CODE SILENTLY:
B. TYPICALLY 3+(WOMAN) OR 5+ (MAN) DRINKS FOR 4+ DAYS/WEEK?

NO ○
YES (SKIP TO J22) ○

C. During the 6 weeks before this episode began, what was the largest number of drinks you had in one day?

DRINKS: ☐☐

IF 4 OR FEWER, SKIP TO J22

D. Did you drink at least 5 drinks 2 or more times a week during the 6 weeks before this episode began?

NO ○
YES ○

HAND R CARD J.

J22 During the 6 weeks before this episode of feeling (depressed/uninterested/ empty/irritable) began, did you use any of these street drugs or abuse any prescription drugs?

IF YES: Which ones? **CIRCLE ON CARD J. CODE THE THREE USED MOST.**

NO (SKIP TO J23) ○
YES (SPECIFY) ○

1. ____ ____
2. ____ ____
3. ____ ____

A. Did you take any of these drugs for a high or intoxication daily or almost daily? **IF YES:** Which ones?

NO (SKIP TO D) ○
YES (SPECIFY) ○

CIRCLE DRUG: 1 2 3

B. During that time, on average, how many days per week did you take (DRUG)?

DRUG 1. DAYS: ____
DRUG 2. DAYS: ____
DRUG 3. DAYS: ____

C. What is the average number of times you used (DRUG) on those days you used?

DRUG 1. AVG: ____
DRUG 2. AVG: ____
DRUG 3. AVG: ____

D. During the 6 weeks before this episode began, what was the largest number of times you used (DRUG) in one day?

DRUG 1. MAX: ____
DRUG 2. MAX: ____
DRUG 3. MAX: ____

E. On how many days during that 6-week period you use (DRUG) that much (#IN D) in a day?

DRUG 1. DAYS: ____
DRUG 2. DAYS: ____
DRUG 3. DAYS: ____

J23 Did this episode of feeling (depressed/uninterested/empty/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?

NO (SKIP TO J24) ○
YES (SPECIFY) ○

1. ☐☐☐
2. ☐☐☐

J24 Did this episode of feeling(depressed/uninterested/empty/irritable) begin within 6 months after learning about the death of someone close to you?

NO (SKIP TO J25) ○
YES (SPECIFY) ○

RELATIONSHIP:

DATE OF DEATH:

☐☐ / ☐☐☐☐
MO YEAR

J25 Did this episode of feeling (depressed/uninterested/empty/irritable) begin within the 6 weeks that followed an episode of a serious physical illness, like thyroid disease, a stroke, multiple sclerosis, a brain tumor, or AIDS?

NO (SKIP TO BOX J26) ○
YES (SPECIFY) ○

SPECIFY:

CODE: ☐☐☐

BOX J26 IF R IS MALE OR HAS NEVER BEEN PREGNANT, SKIP TO J28. OTHERS CONTINUE.

J27 Did this episode of feeling (depressed/uninterested/empty/irritable) begin around the time of a childbirth, miscarriage, or abortion?

NO (SKIP TO J28) ○
YES ○

A. Did it begin between the 2 weeks before to 6 weeks after the (birth/miscarriage/abortion)?

NO ○
YES ○

J28 During this episode, were you seen by a doctor, or other professional?

NO (SKIP TO J32) ○
YES (SPECIFY) ○

SPECIFY:

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J29 During this episode, were you prescribed medicine for depression (or were you already taking medicine for depression)?

NO ○
YES (SPECIFY) ○
1. ____ ____
2. ____ ____

J30 During this episode, did you receive ECT (shock treatments)?

NO ○
YES ○

J31 During this episode, were you hospitalized for depression?

NO (SKIP TO J32) ○
YES ○

A. For how long?

DAYS: ____

J32 During this episode, were you (working/going to school) full time?

NO ○
YES (SKIP TO J33) ○

A. What was your major responsibility during this episode?

PART-TIME JOB ○
HOME ○
PART-TIME SCHOOL ○
OTHER (SPECIFY) ○

SPECIFY: ____

J33 Did you have trouble functioning in this role?

NO (SKIP TO D) ○
YES ○

A. Did something happen as a result of poor functioning?

NO ○
YES (SPECIFY) ○

SPECIFY: ____

B. Did anyone notice you had trouble functioning? (If no one was around, could someone have noticed this)?

NO ○
YES ○

C. Were you completely unable to function in this role for at least 2 days in a row?

NO ○
YES ○

D. Was your functioning in any other area of your life affected? (MINOR ROLE DYSFUNCTION)

NO ○
YES (SPECIFY) ○

SPECIFY: ____

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BOX J33 RATE FUNCTIONING:

INCAPACITATED--
(J33C=YES) COMPLETELY UNABLE TO FUNCTION IN PRINCIPAL ROLE FOR 2+DAYS, OR
(J31A=2+) HOSPITALIZED 2+ DAYS, OR (J30=YES) ECT, OR
(J20 OR J20A=5) PSYCHOTIC SYMPTOMS.

IMPAIRED--
(J33B=YES AND J33C=NO) A DECREASE, NOTICEABLE TO OTHERS, IN QUALITY OF THE MOST IMPORTANT ROLE PERFORMANCE. THIS USUALLY REQUIRES A DECREASE IN THE AMOUNT OF PERFORMANCE.

INCAPACITATED ○
IMPAIRED ○
NEITHER ○

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) ○
YES ○

A. How old were you then?

AGE: ☐☐

B. During this episode:
COUNT ONLY IF MORE THAN USUAL:

1. Were you depressed (**IF AGE IN A<18:** or irritable)?	NO ○	YES ○
2. Did you lose interest in pleasurable activities?	NO ○	YES ○
3. Did you have an increase or decrease in your appetite or weight?	NO ○	YES ○
4. Did you have any sleep difficulty or did you sleep too much?	NO ○	YES ○
5. Were you either more restless or more slowed down than usual?	NO ○	YES ○
6. Did you have a loss of energy or were you more tired than usual?	NO ○	YES ○
7. Did you feel excessively guilty or bad about yourself?	NO ○	YES ○
8. Did you have difficulty thinking or concentrating?	NO ○	YES ○
9. Did you have thoughts of dying or committing suicide, or did you make a suicide plan, or did you attempt suicide?	NO ○	YES ○

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IF FIVE OR MORE CODED YES 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)?

WEEKS: ☐☐

1. Was it 2 or more weeks?

NO ○
YES ○

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 ○
YES (SPECIFY) ○

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) ○
YES (SPECIFY) ○

☐ Received professional help
☐ Medications (specify) 1. ☐☐☐ 2. ☐☐☐
☐ ECT (shock treatment)
☐ Hospitalized

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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 was around the time of childbirth, miscarriage, or abortion)? **IF MORE THAN ONE ADDITIONAL DIRTY EPISODE, HAVE R PICK THE MOST SEVERE ONE.**

NO (SKIP TO J36) ○
YES ○

A. How old were you then?

AGE: ☐☐

B. During this episode:
COUNT ONLY IF MORE THAN USUAL:

1. Were you depressed (**IF AGE IN A<18:** or irritable)?	NO ○	YES ○
2. Did you lose interest in pleasurable activities?	NO ○	YES ○
3. Did you have an increase or decrease in your appetite or weight?	NO ○	YES ○
4. Did you have any sleep difficulty or did you sleep too much?	NO ○	YES ○
5. Were you either more restless or more slowed down than usual?	NO ○	YES ○
6. Did you have a loss of energy or were you more tired than usual?	NO ○	YES ○
7. Did you feel excessively guilty or bad about yourself?	NO ○	YES ○
8. Did you have difficulty thinking or concentrating?	NO ○	YES ○
9. Did you have thoughts of dying or committing suicide, or did you make a suicide plan, or did you attempt suicide	NO ○	YES ○

IF FIVE OR MORE CODED YES 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 ○
YES (SPECIFY) ○

SPECIFY:

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F. Did you seek help, receive any treatment (such as medications or ECT), or were you hospitalized during this episode?

NO (SKIP TO J36) ○
YES (SPECIFY) ○

☐ Received professional help
☐ Medications (specify) 1. ☐☐☐ 2. ☐☐☐
☐ ECT (shock treatment)
☐ Hospitalized

J36 How many episodes of depression Lasting 2 weeks or longer (such as the one(s) we have been talking about) have you had over your lifetime, including the one(s) we already talked about? **Only count episodes that lasted at least 2 weeks, cluster 5 boxes on the tally, and interfere with functioning.**

NUMBERS: ☐☐

A. How old were you the (first/last)time you had an episode of depression lasting a week or longer?

AGE ONS: ☐☐
ONS: 1 2 3 4 5 U

AGE REC: ☐☐
REC: 1 2 3 4 5 U

J37 Were you ever treated for depression with medication or ECT (shock treatment)?

NO (SKIP TO BOX J38) ○
YES ○

A. Did you ever feel high or were you overactive following treatment for depression with medication or ECT?

NO ○
YES ○

BOX J38 **IF R HAD 1+ BOX MARKED ON ALC, COC, OPI, OR DRUG TALLY SHEET, AND J36 IS AT LEAST 01, CONTINUE, OTHERS SKIP TO K1.**

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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 CLUSTERING ENDORSED ON ALC/COC/OPI/DRUG TALLY SHEET, HAND TALLY(IES) TO R AND ASK 1. OTHERS SKIP TO 2.

1. When this episode of feeling (depressed/sad/down/blue/irritable) began, were you having experiences from 3 or more boxes found on this (ALC/MJ/DRUG) sheet?

IF NO, CONTINUE TO 2. IF YES, RECORD ON TIME LINE AND RETURN TO J38A FOR NEXT EPISODE OF DEPRESSION. IF NO OTHER EPISODES, SKIP TO J38B

2. When this episode of feeling (depressed/sad/down/blue/irritable) began, were you (drinking heavily/using DRUGS) daily or almost daily?

IF NO, RETURN TO J38A FOR NEXT EPISODE OF DEPRESSION. IF NO OTHERS, SKIP TO J38B. IF YES, RECORD ON TIME LINE AND RETURN TO J38A FOR NEXT EPISODE OR DEPRESSION. IF NO OTHERS, SKIP TO J38B

B. So, according to the information on this time line,

1. ...your episodes of feeling depressed/sad/down/blue/irritable) (NEVER/SOMETIMES/ALWAYS) started when you were experiencing some problems with alcohol, marijuana, or drugs?

NEVER ○
SOMETIMES ○
ALWAYS (SKIP TO K1) ○

2. ...your episodes (that did <u>not</u> start when you were having problems with alcohol or drugs) (NEVER/SOMETIMES/ ALWAYS) started when you were drinking heavily or using drugs daily (or almost daily)?

NEVER ○
SOMETIMES ○
ALWAYS ○

END OF SECTION J

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C3 C4

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

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 ○
ALC/DRUGS ONLY ○
YES ○

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 ○
ALC/DRUGS ONLY ○
YES ○

BOX K1 DOES R ENDORSE MOOD? (A OR B CODED YES) **DENIES MOOD (READ a)** ○
ENDORSES MOOD (READ 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).**

1. much more active than usual?	NO ○	YES ○
2. much more talkative than usual?	NO ○	YES ○
3. talking unusually fast or were your thoughts racing?	NO ○	YES ○
4. feeling very special, gifted with special powers?	NO ○	YES ○
5. needing much less sleep than usual?	NO ○	YES ○
6. more easily distracted than usual?	NO ○	YES ○
7. doing reckless or foolish things (spending sprees, reckless driving, affairs)?	NO ○	YES ○

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 YES'S ARE CODED IN K1C.1-7, CONTINUE TO BOX KIB. OTHERS SKIP TO K31.**

BOX K1B **IF R ENDORSES MOOD IN BOX K1, SKIP TO K2. OTHERS CONTINUE.**

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) ○
YES ○

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

IF NEVER USED DRUGS (F1=NO, G1=NO & H1=NO) OR ALCOHOL (E1B=NEVER), SKIP TO K5. OTHERS CONTINUE.

HAND R CARD K.

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 or use alcohol?
IF YES: Which ones? **CIRCLE DRUGS USED ON CARD K. CODE THE TWO USED MOST.**

NO (SKIP TO K5) ○
YES (SPECIFY) ○

DRUG 1: ☐☐☐☐

DRUG 2: ☐☐☐☐

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 daily or almost daily? **IF YES: Which ones? CIRCLE DRUGS OR ALCOHOL.**

NO (SKIP TO D) ○
YES (SPECIFY) ○*

CIRCLE:
DRUG 1 | DRUG 2 | ALCOHOL

B. During that time, on average, how many days per week did you take (DRUGS) or drink?

DRUG 1. DAYS ☐
DRUG 2. DAYS ☐
ALCOHOL DAYS ☐

C. What is the average number of times you used (DRUGS) or drank on those days you were using?

DRUG 1. AVG ☐☐
DRUG 2. AVG ☐☐
ALCOHOL AVG ☐☐

D. During the 2 weeks before this episode began, what was the largest number of times you used (DRUG) or drank in one day?

DRUG 1. MAX ☐☐
DRUG 2. MAX ☐☐
ALCOHOL MAX ☐☐

E. On how many days during that 2-week period did you use (DRUG) or drink that much in a day?

DRUG 1. DAYS ☐☐
DRUG 2. DAYS ☐☐
ALCOHOL DAYS ☐☐

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REMIND R WHICH EPISODE AS NEEDED.	MOST SEVERE EPISODE

BOX K4 IF K4A=NO, SKIP TO K5. OTHERS CONTINUE.

F. Did you have another episode of feeling (hyper/elated/ irritable) for 2 days or longer that was not after a time when you had been drinking or using drugs daily or almost daily?

NO (SKIP TO BOX K8) ○
YES ○*

G. When did this episode begin?

☐☐ / ☐☐☐☐
MO YEAR

1. How old were you?

AGE: ☐☐

K5 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?

NO (SKIP TO K6) ○
YES (SPECIFY) ○

1. ☐☐☐
2. ☐☐☐

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?

NO (SKIP TO BOX K8) ○*
YES ○

B. When did this episode begin?

☐☐ / ☐☐☐☐
MO YEAR

1. How old were you?

AGE: ☐☐

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REMIND R WHICH EPISODE AS NEEDED.	MOST SEVERE EPISODE
K6 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?	NO (SKIP TO K7) ○ YES ○ **SPECIFY:** [ ] [ ][ ][ ]
A. Did you have another episode of feeling (hyper/elated/ irritable) for 2 days or longer that did not follow a serious physical illness and was not after the daily or almost daily use of alcohol or drugs?	NO (SKIP TO BOX K8) ○* YES ○
B. When did this episode begin?	[ ][ ] / [ ][ ][ ][ ] MO YEAR
1. How old were you?	AGE: [ ][ ]
K7 Did this episode of feeling (hyper/elated/irritable) begin shortly after receiving ECT (shock therapy) or bright light therapy?	NO (SKIP TO BOX K8) ○ YES ○
A. Did you have another episode of feeling (hyper/elated/ irritable) for 2 days or longer that did not follow shock or bright light therapy, did not follow change in prescription medication, did not follow a serious physical illness, and was not after the daily or almost daily use of alcohol or drugs?	NO (SKIP TO BOX K8) ○* YES ○
B. When did this episode begin?	[ ][ ] / [ ][ ][ ][ ] MO YEAR
1. How old were you?	AGE: [ ][ ]

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.**

BOX K8 **A. IS EPISODE CLEAN?** **(DIRTY = ANY * ITEM)**
NO, DIRTY ○
YES, CLEAN ○

REMIND R WHICH EPISODE AS NEEDED.	**MOST SEVERE EPISODE**
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 . . .	
K9 Were you much more active than usual, either socially, at work, at home, sexually, or were you physically restless?	NO ○ YES (SPECIFY) ○ **SPECIFY:**
K10 Were you much more talkative than usual, or did you feel pressure to keep talking?	NO ○ YES ○
K11 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 ○ YES ○
K12 Did you feel you were a very important person, or that you had special powers, plans, talents, or abilities?	NO ○ YES (SPECIFY) ○ **SPECIFY:**

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 . . .	MOST SEVERE EPISODE
K13 Did you need much less sleep than usual for several days in a row?	NO (SKIP TO K14) ○ YES ○
A. How many hours of sleep did you get per night during this episode?	HOURS: ☐☐
B. How many hours do you usually get per night?	HOURS: ☐☐
K14 Did your attention keep jumping from one thing to another much more than is usual for you?	NO ○ YES ○
During this most severe episode, when you were __ years old . . .	**MOST SEVERE EPISODE**
K15 Did you do anything that could have gotten you into trouble -- like spending sprees, foolish business investments, reckless driving, or sexual indiscretions?	NO ○ YES (SPECIFY) ○ **SPECIFY:** ☐
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?	NO ○ YES ○
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?	NO ○ YES ○

BOX K15 **COUNT THE BOXES CODED YES IN K9-15.**

IF 0 OR 1 BOX(ES) CODED YES, SKIP TO K25.

IF 2 OR MORE BOXES CODED YES, RECORD EPISODE ON TIMELINE AND CONTINUE.

BOXES CODED YES: ☐

K16 You told me that while you were feeling (hyper/elated/irritable), you also experienced **(LIST SX CODED YES)**. When did you start experiencing these together? **(DATE CLUSTERING OF MOOD AND SX TOGETHER)**	☐☐ / ☐☐☐☐ MO YEAR
A. For how long did you experience these together?	DAYS: ☐☐☐

K17 During this episode, were you so excited that it was almost impossible to hold a conversation with you?

NO ○
YES (SPECIFY) ○
SPECIFY:

A. Would you say your behavior was provocative, obnoxious, or manipulative enough to cause problems for your family, friends, or your co-workers?

NO ○
YES (SPECIFY) ○
SPECIFY:

K18 During this episode did you see or hear things that other people could not see or hear, that is, did you have hallucinations?

CODE: 1 2 3 4 5 U
SPECIFY:
WHOM SAW:
WHAT TOLD:

A. During this episode, did you have beliefs or ideas that you later found out were not true?

CODE: 1 2 3 4 5 U
SPECIFY:
WHOM SAW:
WHAT TOLD:

BOX K18A IF ANY 5 IN K18 OR K18A, CONTINUE. OTHERS SKIP TO K19.

B. Did these (beliefs/ideas/hallucinations) occur before you felt (hyper/elated/irritable)?

NO (SKIP TO D) ○
YES ○

C. How long before you felt (hyper/elated/irritable) did you have these (beliefs/ideas/hallucinations?

DAYS: | | |

D. Did these (beliefs/ideas/hallucinations) persist after your mood came back to normal?

NO (SKIP TO BOX K18B) ○
YES ○
EPISODE ONGOING ○

IF ONGOING, SKIP TO BOX K18B.

E. How long did they last after your mood came back to normal?

DAYS: | | |

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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?**

NO ○
YES ○

During this most severe episode, when you were __ years old . . .	**MOST SEVERE EPISODE**
K19 Were you seen by a doctor or other professional? **SPECIFY:**	NO (SKIP TO K23) ○ YES (SPECIFY) ○
K20 Did you receive medication?	NO ○ YES (SPECIFY) ○ 1. ☐☐☐ 2. ☐☐☐
K21 Did you receive ECT (shock treatments)?	NO ○ YES ○
K22 Were you hospitalized during this episode for these experiences? **A.** For how long?	NO (SKIP TO K23) ○ YES ○ DAYS: ☐☐☐
K23 During this episode, were you (working/going to school) full-time?	NO ○ YES (SKIP TO K24) ○
A. What was your major responsibility at that time?	PART-TIME JOB ○ HOME ○ PART-TIME SCHOOL ○ OTHER (SPECIFY) ○ **SPECIFY:**

During this most severe episode, when you were __ years old . . .	MOST SEVERE EPISODE
K24 Was your functioning in this role affected?	NO (SKIP TO D) ○ YES ○
A. Did something happen as a result of this change in functioning?	NO ○ YES (SPECIFY) ○ **SPECIFY:**
B. Did anyone notice that your functioning was affected? (If no one was around, could someone have noticed this?)	NO ○ YES ○
C. Were you completely unable to function in this role for at least 2 days in a row?	NO ○ YES ○
D. Was your functioning in any other area of your life affected, or did you get into trouble in any way?	NO ○ YES (SPECIFY) ○ **SPECIFY:**

BOX K24 RATE FUNCTIONING

INCAPACITATED --
(K24C=YES) COMPLETELY UNABLE TO FUNCTION IN PRINCIPAL ROLE FOR 2+ DAYS , OR
(K22A=2+) HOSPITALIZED 2+ DAYS , OR
(K21=YES) ECT, OR
(K18 OR K18A=5) DELUSIONS OR HALLUCINATIONS PRESENT,
OR (K17=YES) INABILITY TO CARRY ON A CONVERSATION.

IMPAIRED --
(K24B=YES AND K24C=NO) A DECREASE, NOTICEABLE TO OTHERS, IN QUALITY OF THE MOST IMPORTANT ROLE PERFORMANCE. THIS USUALLY REQUIRES A DECREASE IN THE AMOUNT OF PERFORMANCE.

IMPROVED --
(CHECK EXAMPLE IN K24A) IMPROVEMENT IN FUNCTION.

INCAPACITATED ○
IMPAIRED ○
IMPROVED ○
NEITHER ○

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) ○
YES ○

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:

1. More active than usual?	NO ○	YES ○
2. More talkative than usual?	NO ○	YES ○
3. Having racing thoughts or talking too fast?	NO ○	YES ○
4. Feeling you were an especially important person?	NO ○	YES ○
5. Needing less sleep than usual?	NO ○	YES ○
6. Easily distracted?	NO ○	YES ○
7. Going on spending sprees or having sexual indiscretions?	NO ○	YES ○

IF 2 OR MORE ARE CODED YES, 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 ○
YES (SPECIFY) ○

SPECIFY: ☐

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F. Did you seek help, receive any treatment (such as medications or ECT), or were you hospitalized during this episode?

NO ○
YES (SPECIFY) ○

☐ Sought professional help
☐ Medications (specify)
☐ ECT (shock treatment)
☐ Hospitalized

1. ☐☐☐☐☐☐☐☐☐☐ ☐☐☐ 2. ☐☐☐☐☐☐☐☐☐☐ ☐☐☐

K26 How old were you the (first/last) time you had an episode like this?

AGE ONS: ☐☐
ONS: 1 2 3 4 5 U

AGE REC: ☐☐
REC: 1 2 3 4 5 U

K27 How many episodes have you had over your lifetime, including the one(s) we have already talked about?

NUMBER: ☐☐☐

K28 **MIXED AFFECTIVE STATES:** During any of these episodes of feeling (hyper/elated/irritable), did you also experience:

1. Depressed mood? ..... NO ○ YES ○

2. Loss of interest or pleasure?..... NO ○ YES ○

BOX K28 **IF K28.1 AND K28.2 BOTH CODED NO, SKIP TO K29. OTHERS CONTINUE.**

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3. Sleep difficulty?	NO ○	YES ○
4. A change in activity level? (PSYCHOMOTOR)	NO ○	YES ○
5. Fatigue or loss of energy?	NO ○	YES ○
6. A change in appetite or weight?	NO ○	YES ○
7. Low self-esteem or guilt?	NO ○	YES ○
8. Decreased concentration?	NO ○	YES ○
9. Thoughts of dying or suicide?	NO ○	YES ○

IF FEWER THAN FIVE ARE CODED YES, 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: ☐☐☐

K29 Have you ever switched back and forth quickly between feeling (hyper/elated/irritable) and feeling depressed?

NO (SKIP TO BOX K29) ○
YES ○

A. Did that happen every few hours, every few days, or every few weeks?
IF MORE THAN ONE, CODE THE MOST RAPID CYCLE.

HOURS ○
DAYS ○
WEEKS ○

B. Did you ever have 4 or more episodes like this within a 12-month period?

NO ○
YES ○

BOX K29 IF R HAD 1+ BOX MARKED ON ALCOHOL, COCAINE, OPIATE, OR DRUG TALLY SHEET A, CONTINUE. OTHERS SKIP TO L1.

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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 CLUSTERING ON ALC/COCAINE/OPIATE/DRUG TALLY SHEET, HAND TALLY(IES) TO R AND ASK 1. OTHERS SKIP TO 2.

1. When 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.

2. When 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,

1. . . . your episodes of feeling (unrealistically happy/elated/ hyper/irritable) (NEVER / SOMETIMES / ALWAYS) started when you were experiencing some problems with alcohol, cocaine, opiates, or other drugs?

   NEVER ○
   SOMETIMES ○
   ALWAYS (SKIP TO L1) ○

2. . . . your episodes (that did <u>not</u> start when you were having problems with alcohol or drugs) (NEVER / SOMETIMES / ALWAYS) started when you were drinking heavily or using drugs daily (or almost daily)?

   NEVER ○
   SOMETIMES ○
   ALWAYS ○

BOX K30 **SKIP TO L1.**

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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 unusually cheerful, energetic, hyper, or irritable?

NO (SKIP TO L1) ○
ALC/DRUG ONLY ○
YES ○

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 YES, CONTINUE. OTHERS SKIP TO L1.

A. During this period were you:

1. much more active than usual?	NO ○	YES ○
2. much more talkative than usual?	NO ○	YES ○
3. experiencing racing thoughts?	NO ○	YES ○
4. feeling you were a very important person or had special powers, or talents?	NO ○	YES ○
5. needing less sleep than usual?	NO ○	YES ○
6. much more distractible than usual, when your attention kept jumping from one thing to another?	NO ○	YES ○
7. doing anything that could have gotten you into trouble, like spending sprees, or sexual indiscretions?	NO ○	YES ○
8. very friendly with people you normally would not be friendly with?	NO ○	YES ○

IF ALL ARE CODED NO, SKIP TO L1. OTHERS CONTINUE.

B. How long did this period last, when these experiences occurred together with your unusually (cheerful / energetic / hyper / irritable) mood?

DAYS: ☐☐☐

K32 How many episodes like this have you had?

NUMBER: ☐☐

K33 How old were you the (first/last) time?

AGE ONS: ☐☐
ONS: 1 2 3 4 5 U

AGE REC: ☐☐
REC: 1 2 3 4 5 U

END OF SECTION K

BEFORE CODING L1-L12, ASK FOR EXAMPLES.

Now I'm going to ask you about very unusual experiences that some people have.

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) ○
YES ○

A. What did you hear?

EXAMPLES:

B. For how long did you hear these things?

DAYS ○ MONTHS ○

CODE UNITS: WEEKS ○ YEARS ○

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 thinking?

NO ○
YES ○

E. How many voices did you hear?

NUMBER:

IF ONLY 1 VOICE, CODE "NO" SILENTLY.

F. Were they talking to each other?

NO ○
YES ○

G. BEGIN PROBING.

CODE: 1 2 3 4 5 U

WHOM SAW:

WHAT TOLD:

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 U

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.**

L3 What about strange sensations in your body or on your skin?

CODE: 1 2 3 4 5 U

EXAMPLES:

WHOM SAW:

WHAT TOLD:

L4 What about smelling things that other people could not smell?

CODE: 1 2 3 4 5 U

EXAMPLES:

WHOM SAW:

WHAT TOLD:

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 U

EXAMPLES:

WHOM SAW:

WHAT TOLD:

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 U

EXAMPLES:

WHOM SAW:

WHAT TOLD:

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 U

EXAMPLES:

WHOM SAW:

WHAT TOLD:

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 U

EXAMPLES:

WHOM SAW:

WHAT TOLD:

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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 U

EXAMPLES:

WHOM SAW:

WHAT TOLD:

A. Did you ever feel that certain thoughts, that were not your own, were put into your head?

CODE: 1 2 3 4 5 U

EXAMPLES:

WHOM SAW:

WHAT TOLD:

B. What about thoughts taken out of your head?

CODE: 1 2 3 4 5 U

EXAMPLES:

WHOM SAW:

WHAT TOLD:

BOX L9 IF NO 5'S IN L5-L9, SKIP TO BOX L13. OTHERS CONTINUE.

L10 Did it ever seem that people were talking about you or taking special notice of you?

CODE: 1 2 3 4 5 U

EXAMPLES:

WHOM SAW:

WHAT TOLD:

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 U

EXAMPLES:

WHOM SAW:

WHAT TOLD:

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 U

EXAMPLES:

WHOM SAW:

WHAT TOLD:

BOX L13 IF ANY 5 CODED IN L1G-L8 AND L9-L12, CONTINUE. OTHERS SKIP TO M1.

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L13 What is your understanding of why you (CONTENT IN L1-L12)?

RECORD:

EDITOR/CLINICIAN CODE:
Systematized delusions ○
Bizarre delusions ○
Other ○

L14 Did (EXPERIENCES CODED 5 IN L1-L12) last for 6 months or longer?

NO ○
YES ○

A. Did (this experience/any of these experiences) cause you to miss work or school, or affect your ability to function at home?

NO ○
YES (SPECIFY) ○

SPECIFY:

BOX L14 IF L14=NO AND L14A=NO, SKIP TO M1. OTHERS CONTINUE.

L15 How old were you the (first/last) time you had any of these experiences?

AGE ONS: ☐☐
ONS: 1 2 3 4 5 U

AGE REC: ☐☐
REC: 1 2 3 4 5 U

BOX L16 CHECK J1, J2 AND K1A, K1B. IF ANY ARE CODED YES, CONTINUE. OTHERS SKIP TO BOX L17.

L16 Were you having (beliefs/experiences) such as (SX CODED 5 IN L1-L12) only when you were having an episode of feeling (depressed/elated/irritable)?

NO ○
YES ○

BOX L17 RESPONDENT'S PRESENT STATE:

☐ **A. CATATONIC BEHAVIOR?**
☐ **B. FLAT AFFECT?**
☐ **C. GROSSLY INAPPROPRIATE AFFECT?**
☐ **D. INCOHERENCE?**
☐ **E. MARKED LOOSENING OF ASSOCIATION?**
☐ **F. EMOTIONAL TURMOIL?**
☐ **G. NONE OF THE ABOVE OBSERVED?**
☐ **H. NOT APPLICABLE**

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BOX L18 **IF R HAD 1+ BOX MARKED ON ALC, COCAINE, OPIATE, OR OTHER DRUG TALLY SHEET A, CONTINUE. OTHERS SKIP TO M1.**

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 CLUSTERING ON ALC/COCAINE/OPIATE/OTHER DRUG TALLY SHEET, HAND TALLY(IES) TO R AND ASK 1. OTHERS SKIP TO 2.

1. 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.

2. 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,

1. . . . the time(s) when (NAME SX/your mind was playing tricks on you) (NEVER/ SOMETIMES / ALWAYS) started when you were experiencing some problems with alcohol, cocaine, opiates, or other drugs?

NEVER ○
SOMETIMES ○
ALWAYS (SKIP TO M1) ○

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 when you were drinking heavily or using drugs daily (or almost daily)?

NEVER ○
SOMETIMES ○
ALWAYS ○

END OF SECTION L

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 has been like for you.

C7

A1. Were you a very distractible child?
NO ○
YES ○

A2. As an adult, are you easily distracted?
NO ○
YES ○

B. Did you used to have a really hard time doing your schoolwork, because you had trouble paying attention to details?
NO ○
YES ○

C. Did you make a lot of careless mistakes in your schoolwork or homework?
NO ○
YES ○

IF ALL RESPONSES ARE CODED "NO," SKIP TO M10.

M2 **A.** As a child, did you have difficulty keeping your mind on schoolwork, homework, or anything you were supposed to be doing?
NO ○
YES ○

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 ○
YES ○

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 ○
YES ○

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 ○
YES ○

M4 As a child, did you often fail to follow through on instructions, or fail to finish schoolwork, chores, or duties?
NO (SKIP TO M4B) ○
YES ○

A. Was this because you just didn't want to finish your work or chores?
NO ○
YES ○

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 ○
YES ○

M5 As a child, did you have a lot of difficulty getting organized for tasks and activities?
NO ○
YES ○

M6 Did you dislike or avoid doing school work or homework, or other activities that you had to think hard about? NO ○ YES ○

M7 Did you lose things a lot, like toys, books, or things you needed for school? NO ○ YES ○

M8 Were you often distracted from schoolwork or other things that required concentration when something else was going on around you? NO ○ YES ○

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 ○ YES ○

IF M9=NO, SKIP TO M10.

A. Have these problems continued into adulthood? NO ○ YES ○

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 ○ YES ○

2. Did you often leave your seat in class, or at other times when you were expected to stay seated? NO ○ YES ○

3. Did you often run or climb when you knew you weren't supposed to? NO ○ YES ○

4. Did you have difficulty playing or resting quietly? NO ○ YES ○

5. Were you often "on the go," as if you were "driven by a motor"? NO ○ YES ○

6. Did people say that you used to talk too much? NO ○ YES ○

7. Did you used to start answering questions before they were completed? NO ○ YES ○

8. Was it very hard for you to wait your turn, for example when standing in line or when playing a game? NO ○ YES ○

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 ○ YES ○

IF 6 OR MORE RESPONSES IN THIS SECTION *OR* 6 OR MORE RESPONSES FROM M2 TO M9 ARE CODED YES, CONTINUE. OTHERS SKIP TO SECTION N.

M11 **A.** How old were you when these things started happening?

AGE ONS: ☐☐

ONS: 1 2 3 4 5 U

(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.

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 U

C. Did you have problems or get into trouble because of some of these things in school? at work? at home? (CODE YES ONLY IF SYMPTOMS WERE PRESENT IN TWO OR MORE SETTINGS)

NO ○

YES (TWO OR MORE) ○

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 ○

YES ○

2. Were your parents very worried about you?

NO ○

YES ○

3. Did other kids not want you around?

NO ○

YES ○

4. Did the teacher tell your parent(s) you were having problems in school?

NO ○

YES ○

5. Did you get low grades in school?

NO ○

YES ○

6. Did you have other big problems?

NO ○

YES, SPECIFY ○

SPECIFY:

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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) ○
YES ○

A. Did you see:

☐ 1. A psychiatrist or psychologist?
☐ 2. Another medical doctor?
☐ 3. A school counselor or social worker?
☐ 4. Another professional?
☐ 5. Unknown

B. Did you ever recieve any medicine for the problems you were having?

NO (SKIP TO N1) ○
YES, RITALIN ○
YES, OTHER ○

SPECIFY, IF OTHER THAN RITALIN:

CODE: ☐☐☐

C. Are you still taking medicine for similar problems?

NO ○
YES, RITALIN ○
YES, OTHER ○

SPECIFY, IF OTHER THAN RITALIN:

CODE: ☐☐☐

D. (IF R IS NO LONGER TAKING MEDICATION, ASK) How old were you when you stopped taking the medicine?

AGE: ☐☐

END OF SECTION M

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Now I am going to ask you some (further) questions about suicide.

N1 Have you ever thought about killing yourself?

NO (SKIP TO N2) ○
YES ○

A. Did those thoughts persist for at least 7 days in a row?

NO ○
YES ○

B. Did you have a plan?
(Did you actually consider a way to take your life?)

NO (SKIP TO D) ○
YES ○

C. What were you going to do?

SPECIFY:

D. How old were you when you (first/last) had these thoughts?

AGE ONS: ☐☐
ONS: 1 2 3 4 5 U

AGE REC: ☐☐
REC: 1 2 3 4 5 U

N2 Have you ever tried to kill yourself?

NO (SKIP TO N12) ○
YES ○

A. How many times?

TIMES: ☐☐

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

AGE ONS: ☐☐
ONS: 1 2 3 4 5 U

AGE REC: ☐☐
REC: 1 2 3 4 5 U

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: ☐☐

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N5 Did you require medical treatment after you tried to kill yourself? NO ○ YES (SPECIFY) ○

SPECIFY:

N6 Were you admitted to a hospital after the attempt (for medical reasons)? NO ○ YES (SPECIFY) ○

SPECIFY:

N7 Did you really want to die? NO ○ YES ○

A. Afterwards, were you sorry that you didn't die? NO ○ YES ○

N8 Did you think you would die from what you had done? NO ○ YES ○ MAYBE ○

N9 Did you try to kill yourself:

1. While feeling depressed?	NO ○	YES ○
2. While feeling extremely good or high?	NO ○	YES ○
3. After you had been drinking?	NO ○	YES ○
4. After using drugs?	NO ○	YES ○
5. While having strange thoughts or experiences, or while seeing visions?	NO ○	YES ○
6. Other: IF YES, SPECIFY:	NO ○	YES ○

N10 CODE SILENTLY: TYPE OF METHOD INTENDED (SEE N3). **CODE:**

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 combination**

N10B CODE SILENTLY: DEGREE OF **CODE:**

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).**

N11 CODE SILENTLY: INTENT. **CODE:**

1. **Unclear (no information or not sure)**
2. **Denies intent**
3. **Reports minimal intent**
4. **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) ○
YES ○

A. How many times?

TIMES: ☐☐

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

AGE ONS: ☐☐
ONS: 1 2 3 4 5 U

AGE REC: ☐☐
REC: 1 2 3 4 5 U

END OF SECTION N

HAND R CARD O.

O1 Please look at this list. Have you ever experienced something that is so horrible that it would be distressing or upsetting to almost anyone? OR have you ever experienced or witnessed a situation where you feared there was a serious threat to your life or the life of another person? 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 the life of another person? **IF YES, RECORD EVENT AND CODE.**

NO (SKIP TO P1) ○
YES ○

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

1. Did R report more than 3 events?

NO ○
YES ○

B. When this most disturbing event occurred, did you feel intense fear, helplessness, or horror?

NO ○
YES ○

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) ○
YES ○

1. When did this start?

☐☐ / ☐☐☐☐
MO YEAR

2. So, that was when you were__years old?

AGE: ☐☐

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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).....

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 ○
YES (SPECIFY) ○

IF YES: Can you give me some examples?

O3 Did you have unpleasant dreams again and again about (EVENT)?

NO ○
YES ○

Still focusing on the period that started (DATE IN O1D.1).. (that is, the period of the month or longer when you were having the most, or most intense, feelings or experiences about (EVENT).

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 ○
YES (SPECIFY) ○

IF YES: Can you give me some examples?

O5 Did you feel very upset when you were reminded of (EVENT)? For example, on the anniversary of (EVENT).

NO ○
YES ○

O6 Did things that reminded you of (EVENT) make you sweat, tense up, breathe hard, tremble, or respond in some other physical way?

NO ○
YES ○

BOX O7 IF O2-O6 ALL CODED NO, SKIP TO P1.
OTHERS CONTINUE

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)..

O8 Did you ever try to avoid thinking or having feelings about (EVENT) and find that you couldn't?

NO ○
YES ○

O9 Did you avoid activities, places, or people that reminded you of (EVENT)?

NO ○
YES (SPECIFY) ○

IF YES: Can you give me some examples?

O10 Did you find that you sometimes could not remember important things about (EVENT)?

NO ○
YES ○

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 ○
YES ○

O12 During that period of time, did you feel more cut off, distant, or separated from people than before (EVENT) happened?

NO ○
YES (SPECIFY) ○

IF YES: Can you give me some examples?

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 ○
YES ○

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 ○
YES ○

BOX O15 REVIEW O8 -O14. IF 3 OR MORE CODED YES, CONTINUE. OTHERS, SKIP TO P1.

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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)...**

O16 Did you have more trouble falling or staying asleep than before (EVENT)? NO ○ YES ○

O17 Did you find that you got irritated or lost your temper more easily than before (EVENT)? NO ○ YES ○

O18 Were there times when you had more trouble concentrating than before (EVENT)? NO ○ YES ○

O19 Were there times when unexpected noise, movement, or touch startled you more than before (EVENT)? NO ○ YES ○

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 ○ YES ○

BOX O21 REVIEW O16-O20. IF 2 OR MORE CODED YES, CONTINUE. OTHERS, SKIP TO P1.

O21 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) ○
ALC/DRUG ONLY ○
YES, CLEAN ○
BOTH A/D & CLEAN ○

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 ○ Months ○ Weeks ○ Years ○

C. How old were you the last time you had a period of time like this?

AGE REC: ☐☐

REC: 1 2 3 4 5 U

D. Did these experiences interfere with your work, school, household activities, or how you got along with other people?

NO ○
YES (SPECIFY) ○

SPECIFY:

O23 Did you ever talk to a doctor or other professionals about the problems you had after the (EVENT)?

NO ○
YES ○

SPECIFY:

BOX O24 IF R HAD 1+ BOX MARKED ON ALCOHOL, COCAINE, OPIATE OR OTHER DRUG TALLY SHEET, CONTINUE. OTHERS SKIP TO P1.

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 CLUSTERING ON ALCOHOL/COCAINE/OPIATES/OTHER DRUG TALLY SHEET, HAND TALLY (IES) TO R AND ASK A. OTHERS SKIP TO B.

CLUSTERING AT ONSET

A. When 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 ○
YES (SKIP TO P1) ○

HEAVY USE WHEN NOT CLUSTERING

B. When you first had these very intense feelings, were you (drinking heavily/using DRUGS) daily or almost daily?

NO ○
YES ○

END OF SECTION O

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

C8

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) ○
YES ○

A. Please describe the diffrent things you worried about

EXAMPLES:

CIRCLE NUMBER

1 _____
2 _____
3 _____
4 _____
5 _____

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.

B. ARE THERE 2 OR MORE WORRIES CIRCLED?

NO (SKIP TO Q1) ○
YES ○

C. BEGIN PROBING

CODE: 2 3 4 5

WHOM SAW: _____

WHAT TOLD: _____

IF CODED 2, SKIP TO Q1.

D. Did people around you, such as family and friends, tell you that you worried far too much about these problems?

NO ○
YES ○

1. Have you ever thought that you worried far too much about these problems?

NO (SKIP TO Q1) ○
YES ○

2. Did this anxiety or worry occur for more days than not for a period of at least 6 months?

NO ○
YES ○

E. Did you find it difficult to control your worry?

NO (SKIP TO Q1) ○
YES ○

27526

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....

1. Trembling, twitching, or feeling shaky?	NO ○	YES ○
2. Sore, aching, or tense muscles?	NO ○	YES ○
3. Restlessness?	NO ○	YES ○
4. Feeling easily tired or fatigued?	NO ○	YES ○
5. Shortness of breath or feeling like you were smothering?	NO ○	YES ○
6. Heart palpitations or a racing heart?	NO ○	YES ○
7. Sweating? Or cold, clammy hands?	NO ○	YES ○
8. Dry mouth?	NO ○	YES ○
9. Dizziness or lightheadedness?	NO ○	YES ○
10. Nausea, diarrhea, or stomach problems?	NO ○	YES ○
11. Flushes, hot flashes, or chills?	NO ○	YES ○
12. Frequent urination?	NO ○	YES ○
13. Trouble swallowing, or feeling a "lump" in your throat?	NO ○	YES ○
14. Feeling "keyed up" or on edge?	NO ○	YES ○
15. Being easily startled?	NO ○	YES ○
16. Difficulty concentrating or having your mind go blank?	NO ○	YES ○
17. Difficulty falling asleep or staying asleep, or having restless, unsatisfying sleep so that when you woke up did not feel rested?	NO ○	YES ○
18. Irritability?	NO ○	YES ○

IF 3 OR MORE ARE CODED YES, CONTINUE. OTHERS SKIP TO Q1.

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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) ○
YES ○

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 ○
TEA ○
SOFT DRINKS ○

B. Did your anxiousness, worry, or feeling "on edge" usually occur soon after you drank caffeinated beverages (like coffee, tea, or soft drinks)?

NO ○
YES ○

C. During that period, were you drinking heavily or using drugs, or had you recently cut down?

NO ○
YES ○

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 ○
YES (SPECIFY) ○

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) ○
YES (SPECIFY) ○

SPECIFY 1. **CODE:** ☐☐☐

SPECIFY 2. **CODE:** ☐☐☐

A. Did (drinking/using drugs) help?

NO ○
YES ○

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 U

AGE REC: ☐☐
REC: 1 2 3 4 5 U

BOX P7 IF J19E, J34C, OR J35C=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 ○
YES ○

BOX P8 IF R HAD 1+ BOX MARKED ON ALC, COC, OP, OR DRUG TALLY SHEET, CONTINUE.
OTHERS SKIP TO Q1.

P8 We talked about the long period of time when you felt anxious or worried, which started at (AGE).

IF CLUSTERING ON ALC/COC/OP/DRUG TALLY SHEET, HAND TALLIES TO R AND ASK A. OTHERS SKIP TO B.

CLUSTERING AT ONSET

A. When you first felt anxious or worried, were you having experiences from 3 or more boxes found on this (ALC/COC/OP/DRUG) sheet?

NO ○
YES (SKIP TO Q1) ○

HEAVY USE WHEN NOT CLUSTERING

B. When you first felt anxious or worried, were you (drinking heavily/using DRUGS) daily or almost daily?

NO ○
YES ○

END OF SECTION P

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) ○
YES ○

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) ○
YES ○

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 ○
YES (SKIP TO Q9) ○

C. What other kinds of thoughts or ideas bothered you?

EXAMPLES:

D. BEGIN PROBING

WHOM SAW:

WHAT TOLD:

CODE: 2 3 4 5 U

IF CODED 2, SKIP TO Q9. OTHERS CONTINUE.

Q2 Did you try to block these thoughts by doing something or thinking about something else?

NO (SKIP TO Q9) ○
YES ○

Q3 Were these your own thoughts or were they put in your head by someone else?

SOMEONE ELSE ○
OWN THOUGHTS ○

IF CODED "SOMEONE ELSE", SKIP TO Q9. OTHERS CONTINUE.

Q4 Did you think that these (thoughts/images/impulses) were unreasonable or excessive?

NO (SKIP TO Q9) ○
YES ○

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BOX Q5 IF J19A=YES OR J19C=YES, CONTINUE. OTHERS SKIP TO Q6.

Q5 Did these thoughts only occur when you were feeling sad, blue, or depressed, like the times we talked about earlier?

NO ○
YES ○

Q6 Did these thoughts only occur when you were using alcohol or drugs or had recently cut down?

NO ○
YES ○

Q7 Did these thoughts really upset you or interfere with your normal routine?

NO ○
YES (SPECIFY) ○

SPECIFY:

A. Did you find yourself having these thoughts or impulses for at least an hour a day?

NO ○
YES ○

BOX Q7 IF Q7 AND Q7A ARE BOTH CODED NO, 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 U

AGE REC: ☐☐
REC: 1 2 3 4 5 U

Q9 Have you found that you had 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 your clothes on in a certain order, counting repeatedly, saying words to yourself over and over, or other rituals like that?

NO (SKIP TO R1) ○
YES (SPECIFY) ○

SPECIFY:

A. Did you do those things to keep something bad from happening?

NO ○
YES (SPECIFY) ○

SPECIFY:

B. BEGIN PROBING.

CODE: 2 3 4 5 U

IF CODED 2, SKIP TO R1. OTHERS CONTINUE

WHOM SAW:

WHAT TOLD:

Q10 If you tried to stop doing (BEHAVIOR), did you become anxious or very nervous?

NO ○
YES (SPECIFY) ○

SPECIFY:

Q11 Did you think that these activities were unreasonable or excessive?

NO ○
YES ○

Q12 Were these activities <u>always</u> related to feelings about your body size or weight?

NO ○
YES (SPECIFY) ○

SPECIFY:

BOX Q13 IF J19A=YES OR J19C=YES, CONTINUE. OTHERS SKIP TO Q14.

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 ○
YES ○

Q14 Did these behaviors <u>only</u> occur when you were using alcohol or drugs or had recently cut down?

NO ○
YES ○

Q15 Did those activities really upset you or interfere with your normal routine?

NO ○
YES (SPECIFY) ○

SPECIFY:

A. Did you find yourself performing these behaviors at least an hour at a time each day?

NO ○
YES ○

BOX Q15 IF Q15 AND Q15A ARE BOTH CODED NO, SKIP TO R1. OTHERS CONTINUE.

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 U

AGE REC: ☐☐
REC: 1 2 3 4 5 U

BOX Q17 IF R HAD 1+BOX MARKED ON ALCOHOL, COCAINE, OPIATE, OR OTHER DRUG TALLY SHEET, CONTINUE. OTHERS SKIP TO R1.

Q17 You told me about the (thoughts/behaviors) that occurred over and over, which first started at(AGE).

IF CLUSTERING ON ALC/COCAINE/OPIATE/OTHER DRUG TALLY SHEET, HAND TALLY(IES) TO R AND ASK A OTHERS SKIP TO B.

CLUSTERING AT ONSET

A. When 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 ○
YES (SKIP TO R1) ○

HEAVY USE WHEN NOT CLUSTERING

B. When you first had (thoughts/behaviors), were you (drinking heavily/ using DRUGS) daily or almost daily?

NO ○
YES ○

END OF SECTION C

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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:

1. Starting or keeping up conversations or talking to people you don't know well?.... NO ○ YES ○

2. Speaking to your teachers, boss or other people in authority?..... NO ○ YES ○

3. Speaking in public or answering questions in a meeting or a class?..... NO ○ YES ○

4. Eating or drinking in public?..... NO ○ YES ○

5. Writing while someone watches?..... NO ○ YES ○

6. Using public restrooms (other than worrying about germs)?..... NO ○ YES ○

IF R1.1-6 ARE ALL NO, CODE 1 AND SKIP TO S1.
OTHERS BEGIN PROBING.

CODE: 1 2 3 4 5 U

IF CODED 1 OR 2, SKIP TO S1.

SPECIFY:

WHOM SAW:

WHAT TOLD:

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 ○ **YES** ○

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) ○
YES ○

A. Did you try avoid that situation?

NO ○
YES ○

B. When you had to be in that situation, did you almost always feel extremely nervous or panicky?

NO (SKIP TO S1) ○
YES ○

R3 Do you think that your fear was excessive or unreasonable?

NO (SKIP TO S1) ○
YES ○

R4 Did this fear or avoiding the situation ever interfere with your job, school, social functioning, or normal routine?

NO ○
YES (SPECIFY) ○

SPECIFY:

A. Have you been very upset with yourself for having any of these fears?

NO ○
YES ○

BOX R4 IF R4 AND R4A ARE BOTH CODED NO, SKIP TO S1. OTHERS CONTINUE

R5 Would you say that these problems occurred in most social situations?

NO ○
YES ○

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 U

AGE REC: ___
REC: 1 2 3 4 5 U

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) ○
YES (SPECIFY) ○

SPECIFY 1. ___ CODE: ___

SPECIFY 2. ___ CODE: ___

A. Did (taking medicine/drinking alcohol/using drugs) help?

NO ○
YES ○

BOX R9 IF R1.4=YES CONTINUE. Others skip to Box R9A

R9 **A.** Did any of these fears occur because you were afraid people would notice you had an eating problem?

NO ○
YES ○

BOX R9A IF R1.1, R1.2, OR R1.3 = YES, ASK R9B. OTHERS SKIP TO BOX R10.

B. Did any of these fears occur because you were afraid people would notice you have a stuttering problem or another problem speaking?

NO ○
YES ○

IF B IS CODED YES, NOTE IF YOU OBSERVED SUCH A PROBLEM (SPECIFY):

BOX R10 IF R HAD 1 +BOX MARKED ON ALCOHOL, COCAINE, OPIATE, OR DRUG TALLY SHEET, CONTINUE. OTHERS SKIP TO S1.

R10 You told me about feeling very concerned about (SITUATIONS) in public and that first started at (AGE).

IF CLUSTERING ON ALC/COC/OP/DRUG TALLY SHEET, HAND TALLIES TO R AND ASK A. OTHERS SKIP TO B.

CLUSTERING AT ONSET

A. When you first felt concerned about (SITUATIONS), were you having experiences from 3 or more boxes found on this (ALC/COC/OP/DRUG) SHEET?

NO ○
YES (SKIP TO S1) ○

HEAVY USE WHEN NOT CLUSTERING

B. When you first felt concerned about (SITUATIONS), were you (drinking heavily/ using DRUGS) daily or almost daily?

NO ○
YES ○

END OF SECTION R

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C11

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; travelling 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) ○
YES ○

S2 Did you feel this way about:

1. going outside of the house alone?	NO ○	YES ○
2. being in a crowd or standing in a line?	NO ○	YES ○
3. being on a bridge or in a tunnel?	NO ○	YES ○
4. traveling in a bus, train, or car?	NO ○	YES ○
5. being in an elevator?	NO ○	YES ○

IF ALL ARE ANSWERED "NO", CONTINUE.
OTHERWISE SKIP TO B.

A. What situation did you have in mind when you said some situations made you unreasonably afraid?

NONE (SKIP TO T1) ○
YES ○

EXAMPLES:

B. Did more than one situation make you feel this way?

NO ○
YES ○

C. BEGIN PROBING. SPECIFY FEAR AND RECORD EXAMPLES.

CODE: 2 3 4 5 U

IF CODED 2, SKIP TO T1.
OTHERWISE CONTINUE.

What was it about (SITUATIONS) that was frightening to you?

EXAMPLES:

WHOM SAW:

WHAT TOLD:

S2 D. EDITOR'S CODE CAN SX BE EXPLAINED BY ANOTHER

NO ○ YES ○

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S3 **A.** When you were in those situations, did you usually:

1. get sweaty?	NO ○	YES ○
2. tremble?	NO ○	YES ○
3. have a dry mouth?	NO ○	YES ○
4. feel dizzy?	NO ○	YES ○
5. feel your heart pound?	NO ○	YES ○
6. get nauseated or vomit?	NO ○	YES ○
7. feel like you couldn't control your bodily functions?	NO ○	YES ○
8. feel tightness or pain in your chest or stomach?	NO ○	YES ○
9. feel that you, or things around you, seemed unreal?	NO ○	YES ○

B. When you were in situations like (SITUATIONS IN S2), were you afraid that any of these things might happen? NO ○ YES ○

S4 Did you almost always avoid these situation(s) or stop going places because of your fear that you would feel sick or be embarassed? NO ○ YES (SPECIFY) ○

SPECIFY:

A. Has your fear kept you from going somewhere you wanted to go 3 or more times? NO ○ YES (SPECIFY) ○

SPECIFY:

B. When you had to be in one of these situations, did it almost always make you extremely nervous or panicky? NO ○ YES (SPECIFY) ○

SPECIFY:

C. When you had to be in one of these situations, did you begin to need someone to be with you? NO ○ YES (SPECIFY) ○

SPECIFY:

BOX S4 **IF S4, S4A, S4B, AND S4C ARE ALL ANSWERED "NO", SKIP TO T1. 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 U

AGE REC: ☐☐
REC: 1 2 3 4 5 U

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) ○
YES (SPECIFY) ○

SPECIFY: ☐

CODE: ☐☐☐

SPECIFY: ☐

CODE: ☐☐☐

A. Did (taking medicine/drinking alcohol/using drugs) help?

NO ○
YES ○

BOX S7 **IF R HAD 1+ BOX MARKED ON ALC, COC, OP, OR DRUG TALLY SHEET, CONTINUE. OTHERS SKIP TO T1.**

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 CLUSTERING ON ALC/COC/OP/DRUG TALLY SHEET, HAND TALLIES TO R AND ASK A. OTHERS SKIP TO B.

CLUSTERING AT ONSET

A. When 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 ○
YES (SKIP TO T1) ○

HEAVY USE WHEN NOT CLUSTERING

B. When you first started feeling concerned about not being able to escape if needed, were you (drinking heavily/ using DRUGS) daily or almost daily?

NO ○
YES ○

END OF SECTION S

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 U

IF CODED 1 OR 2, SKIP TO U1. OTHERS CONTINUE.

EXAMPLES:

WHOM SAW:

WHAT TOLD:

T2 Have you ever had...

A. 3 attacks within a three-week period? NO ○ YES ○

B. 4 attacks within a four-week period? NO ○ YES ○

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 ○ YES ○

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) ○ YES ○

1. Did you think that for a month or longer? NO ○ YES ○

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) ○ YES ○

1. Did you stop doing things or going places for a month or longer? NO ○ YES ○

C. After having an attack like this, did you begin to need someone to go with you? NO (SKIP TO T4) ○ YES ○

1. Did that last for a month or longer? NO ○ YES ○

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T4 During one of your worst attacks, did you have...

1. Shortness of breath or feeling that you were smothering?	NO ○	YES ○
2. Palpitations or a pounding heart?	NO ○	YES ○
3. Dizziness, light-headedness, unsteadiness, or feeling faint?	NO ○	YES ○
4. Chest tightness or chest pain?	NO ○	YES ○
5. Numbness or tingling in your face, feet, or fingers?	NO ○	YES ○
6. Choking sensation?	NO ○	YES ○
7. Sweating?	NO ○	YES ○
8. Shaking or trembling?	NO ○	YES ○
9. Flushing, hot flashes, or chills?	NO ○	YES ○
10. A feeling that things were unreal?	NO ○	YES ○
11. A fear that you might die?	NO ○	YES ○
12. A fear that you were going crazy or losing control?	NO ○	YES ○
13. Nausea or discomfort in your stomach or abdomen?	NO ○	YES ○

BOX T4 IF 4 OR MORE ARE ANSWERED "YES" IN T4 1-13, CONTINUE. OTHERS SKIP TO U1.

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. OTHERS CONTINUE.

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 ○
YES ○

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T7 **A. IF ANY "YES" ANSWERS IN R1.1-6 (SOCPHOB), ASK:** Did you have attacks like that when you were (SOCPHOB SITUATIONS ANSWERED "YES" IN R1.1-6)?

NO ○
YES ○

B. IF ANY "YES" ANSWERS IN S2.1-5 (AGPHOB), ASK: Did you have attacks like that when you were (AGPHOB SITUATIONS ANSWERED "YES" IN S2.1-5)?

NO ○
YES ○

C. Did being in any (other) particular situations make it likely that you would have an attack like this?

NO (SKIP TO D) ○
YES (SPECIFY) ○

SPECIFY:

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 ○
YES ○

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 ANSWERED "YES" IN T4.1-13)?

AGE ONS: ☐☐
ONS: 1 2 3 4 5 U

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.

AGE REC: ☐☐
REC: 1 2 3 4 5 U

A. IF DK: Would you say that the first time was before you were 40?

NO ○
YES ○

T9 Have you ever been nervous or anxious much of the time between attacks?

NO ○
YES ○

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?

NO ○
YES (SPECIFY) ○

SPECIFY:

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 T12) ○
YES (SPECIFY) ○

SPECIFY:

1. _____ CODE: ___

2. _____ CODE: ___

A. Did (drinking/using drugs) help?

NO ○
YES ○

BOX T12 IF R HAD 1+ BOX MARKED ON ALC, COC, OP, OR DRUG TALLY SHEET, CONTINUE. OTHERS SKIP TO U1.

T12 We talked about sudden attacks of feeling panicky, frightened, or nervous. You said that first happened at (AGE).

IF CLUSTERING ON ALC/COC/OP/DRUG TALLY SHEET, HAND TALLIES TO R AND ASK A. OTHERS SKIP TO B.

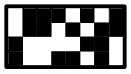
A. When the attacks first started, were you having experiences from 3 or more boxes found on this (ALC/COC/OP/DRUG) sheet?

NO ○
YES (SKIP TO U1) ○

B. When the attacks first started, were you (drinking heavily/ using DRUGS) daily or almost daily?

NO ○
YES ○

END OF SECTION T



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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 Z1) ○
YES ○

A. When you were gambling the most, how often did you gamble? **CONTINUE ONLY IF YOU CODED, Daily +, Daily, Weekly, OR Monthly; IF YOU CODED Less than monthly, SKIP TO Z1.**

CODE:
1. More than once a day ○
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 per month? **CONTINUE ONLY IF MONTHLY AMOUNT EXCEEDS $10; IF NOT, GO TO Z1**

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? (Code in months.)

☐☐☐

B. During the period when you were gambling the most, how often did you do each of the following kinds of gambling?

CODE: 1 - Daily + 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 ○
YES ○

U4. During that time, did anyone object to your gambling?

NO ○
YES ○

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BOX U4 **IF ALL ITEMS ARE SCORED 5, AND BOTH U3 AND U4 ARE SCORED "NO", THEN SKIP TO Z1. OTHERS CONTINUE.**

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 daily
2- Daily
3- Weekly (1-6 times/wk)
4- Monthly (1-3 times/mo)
5- Less than monthly
(code "5" for *Never)*

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 responsibilties?..... NO ○ YES ○

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 ○ YES ○

2. Relieve uncomfortable or bad feelings or moods? NO ○ YES ○

IF BOTH A1 AND A2 ARE CODED NO, 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 daily ○
2. Daily ○
3. Weekly (1-6 times/wk) ○
4. Monthly (1-3 times/mo) ○
5. Less than monthly ○

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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) ○
YES ○

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 ○
YES ○

U8 When you have lost money gambling, have you ever chased after your losses? In otherwords, have you often returned to try and get even?

NO ○
YES ○

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 U10) ○
YES ○

A. To whom did you lie?

1. Spouse or significant other.....NO ○ YES ○

2. Work supervisor or co-workers.....NO ○ YES ○

3. Friends.....NO ○ YES ○

4. Others.....NO ○ YES ○

B. About how many times have you lied to others about how much you were gambling?

TIMES: ☐☐☐☐

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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 ○
YES ○

U11 Has gambling ever resulted in any other losses such as damage or risk to your reputation or your mental or physical health?

NO ○
YES ○

U12 Have you ever attempted to control your gambling by repeated unsuccessful efforts at cutting back or stopping?

NO ○
YES ○

A. How many times?

TIMES: ☐☐☐

U13 Did you ever stop gambling entirely?

NO (SKIP TO U14) ○
YES ○

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 ○
YES ○

C. Is this something you have been worrying about?

NO ○
YES ○

U14 Did you ever experience restlessness or irritability when you tried to cut back or stop gambling?

NO ○
YES ○

A. Did you ever experience discomfort or feel upset when cutting back or stopping gambling, such as, trouble sleeping, sweating, handshaking, or anxiety?

NO ○
YES (SKIP TO U16) ○

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 ○
YES ○

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 ○ YES ○

B. Borrowed money against a credit card or from a bank or other lender? NO ○ YES ○

C. Cashed in bonds, stocks, or retirement accounts? NO ○ YES ○

D. Sold personal property or family property? NO ○ YES ○

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 ○ YES ○

B. Have you written checks to accounts in different banks to keep bad checks afloat ("kiting" checks)?..... NO ○ YES ○

C. Have you passed a check after signing or forging someone else's name on it?..... NO ○ YES ○

D. Have you lied about the facts when submitting an insurance claim?..... NO ○ YES ○

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 ○ YES ○

F. Other..... NO ○ YES ○

END OF SECTION U

Z1. In this section, I'll ask you some questions about what things were like for you when you were growing up.

A. Who was the main person taking care of you when you were growing up (before age 18)? Was it a mother, father, grandmother, older brother or sister, another relative, or a foster or adoptive parent?

(Select)

NOTE: If more than one, select the person R considers subjectively his "main" caregiver or caregiver for the greatest length of time.

A1. Was it always the same person?
(Code "Yes" if parents split and R stayed with one parent.)

NO ○
YES (Skip to B) ○

A2. Was it the same person through age 13?

NO ○
YES (Skip to A4) ○

A3. Was it the same person through age 5?

NO ○
YES ○

A4. How many different people had the main responsibility for taking care of you, up to age 18?

☐☐

B. Did either of your parents die before you were age 6?

NO ○
YES ○

Z2. How many times did you move by age 13?
Note: Moving between foster homes counts as a move.

☐

enter 0-9; code 9 for 9 or more

Z3. Did you ever witness or experience a violent crime, like a shooting or a rape, by age 13?

NO (Skip to Z4) ○
YES ○
REFUSAL ○

A. Did this happen more than once by age 13?

NO ○
YES ○
REFUSAL ○

B. Were you ever the victim?

NO ○
YES ○
REFUSAL ○

Z4. By the time you were age 13...

A. Were you ever sexually abused?

NO ○
YES ○
REFUSAL ○

B. Were you ever beaten by an adult so badly that you needed medical care, or had marks on you body that lasted for more than 30 days?

NO ○
YES ○
REFUSAL ○

Z5. Now I'm going to ask about use of drugs or alcohol in the household where you grew up, by the time you were 13 years old. Were you ever aware of adults in your household drinking enough to get drunk, or using drugs or alcohol, by the time you were 13?

NO (Skip to Z6) ○
YES ○

A. Were you aware of adults in your household, or your older siblings, drinking enough to get drunk by the time you were 13?

NO (Skip to B) ○
YES ○

A1. Did this happen more than ten times?

NO ○
YES ○

A2. What was the earliest age when you had access to alcohol yourself?

code age or "0" for never had access

B. Were you aware of adults in your household, or your older siblings, using cocaine by the time you were 13?

NO (Skip to C) ○
YES ○

B1. Did this happen more than ten times?

NO ○
YES ○

B2. What was the earliest age when you had access to cocaine yourself?

code age or "0" for never had access

C. Were you aware of adults in your household, or your older siblings, using heroin by the time you were 13?

NO (Skip to D) ○
YES ○

C1. Did this happen more than ten times?

NO ○
YES ○

C2. What was the earliest age when you had access to heroin yourself?

☐☐

code age or "0" for never had access

D. Were you aware of the adults in your household, or your older siblings, using other illegal drugs by the time you were age 13?

NO ○
YES ○

E. Were you aware of the adults in your household, or your older siblings, abusing prescription drugs by the time you were age 13?

NO ○
YES ○

Z6. Were any members of your household regular cigarette smokers by the time you were 13?

NO ○
YES ○

Z7. How often did you attend religious services as a child, up to and including age 13? Was it never, several times yearly, monthly, weekly or almost weekly, or more frequently than weekly? *NOTE: Code the highest frequency that lasted for more than a year.*

One or twice a year

Z8. Were you ever in full-time day care (other than with a relative) prior to kindergarten?

NO ○
YES ○

Z9. How would you describe the quality of your relationship with your main caregiver up to age 13... Was it excellent, very good, good, fair or poor?

(Select)

A. Was the person you were closest to usually available when you needed him or her?

NO ○
YES ○

B. Do you feel you could confide in this person when necessary?

NO ○
YES ○

C. Was this person aware of who your friends were?

NO ○
SOMETIMES ○
YES ○

Z10. How often did you see or have contact with your grandparents or other relatives when you were younger (before age 13)? Was it never, weekly (or more) to more than monthly, monthly to more than yearly, yearly or less frequently? *(Do not include a relative who was also the primary caregiver.)*

(Select)

Z11. What was your favorite cartoon character - from television, movies, comics, or even advertisements - when you were growing up?

Z12. Do you have perfect pitch or absolute pitch? (That is, the ability to identify the pitch of a musical tone without an external reference pitch)

NO ○
YES ○

Z13. Sometimes people have experiences where one kind of sense can "leak" into another kind of sense. Do you commonly have any of the following experiences (when you are not intoxicated):

A. Do numbers or letters cause you to have a color experience? (Example: Does the letter "J" mean yellow to you? or does "5" make you perceive purple?)

NO ○
YES ○

B. Do weekdays and months have specific colors? (Example: Does July always mean Navy Blue to you? Is Wednesday always orange?)

NO ○
YES ○

C. Do you imagine or visualize weekday, months and/or years as having a particular location in space around you? (Example: Is September always located two feet in front of you to the left)?

NO ○
YES ○

D. Does hearing a sound make you perceive a color? (Example: Does a shrill car horn cause you to see the color green? Does C Sharp make you see pink?)

NO ○
YES ○

E. Do certain words trigger a taste in your mouth? (Example: Does the name Derek taste like earwax?)

NO ○
YES ○

F. Do you feel a sense of touch when you smell things? (Example: Does the smell of coffee make you feel as though you are touching a cold glass surface?)

NO ○
YES ○

END OF SECTION Z

SORT SCORE

List P:	
List 1:	
List 2:	
List 3:	
List 4:	
List 5:	
List 6:	
List 7:	
List 8:	
List 9 - 12:	
Total Raw Score:	

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 DATE ENDED:

☐☐ / ☐☐ / ☐☐☐☐
MO DAY YEAR

RECORD TIME ENDED:

: ☐☐
(USE 24 HOUR CLOCK)

END OF SECTION V

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W: INTERVIEWER OBSERVATIONS

BORDERLINE	**=3**
DEFINITE	**=4**
DOES NOT APPLY	**=9**

TYPE OF INTERVIEW (CHOOSE 1):

PERSONAL INTERVIEW ○
TELEPHONE INTERVIEW ○
PROXY INTERVIEW ○

IF CODED YES OR PHONE, SKIP TO NEXT QUESTION.

A. FACIAL EXPRESSION IS NORMAL?

NO ○ **YES** ○ **PHONE** ○

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 ○ **YES** ○ **PHONE** ○

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 ○ **YES** ○ **PHONE** ○

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 ○ **YES** ○

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** ○ **YES** ○

1. Hypervigilant	**3**	○	**4**	○	**9**	○
2. Drowsy	**3**	○	**4**	○	**9**	○
3. Stupor	**3**	○	**4**	○	**9**	○

F. SPEECH IS NORMAL? **NO** ○ **YES** ○

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**	○

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BORDERLINE	**=3**
DEFINITE	**=4**
DOES NOT APPLY	**=9**

G. INTERVIEW BEHAVIOR IS NORMAL? NO ○ YES ○

1. Angry outburst	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 ○

H. MOOD AND AFFECT ARE NORMAL ? NO ○ YES ○

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 ○ YES ○

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. Delusions 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 delusion	3 ○	4 ○	9 ○
32. Delusions are systematized	3 ○	4 ○	9 ○

INTERVIEWER OBSERVATIONS-CONTINUED

J. ORIENTATION IS NORMAL? NO ○ YES ○

1. Time.....	3	○	4	○	9	○
2. Place.....	3	○	4	○	9	○
3. Person.....	3	○	4	○	9	○

K. MEMORY IS NORMAL? NO ○ YES ○

1.Clouding of conscious.....	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 ○ YES ○

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 ○ YES ○

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 SSADDA:

NO DIFFICULTY ○

SOME PROBLEMS, BUT MOST RATINGS REASONABLY ACCURATE ○

MAJOR DIFFICULTY IN CONDUCTING EXAM ○

IMPOSSIBLE TO RATE WITH ANY CONFIDENCE ○

QR form completed? NO ○ YES ○

INTERVIEWER NARRATIVE ABOUT THE RESPONDENT

GLOBAL ASSESSMENT OF FUNCTIONING
SCALE ON NEXT PAGE

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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 | 81 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).

80 | 71 If symptoms are present, they are transient and expectable reactions to psychological 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).

70 | 61 Some mild symptoms (e.g., depressed mood and mild insominia) 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.

60 | 51 Moderate symptoms (e.g., flat effect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with co-workers).

50 | 41 Serious symptoms (e.g., suicidal ideation, severe obsessive rituals, frequent shoplifting) OR any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job).

40 | 31 Some impairment in reality testing or communication (e.g., speech is at times illogical, obscure, or irrelevant) OR major problems 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).

30 | 21 Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communications 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).

20 | 11 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).

10 | 1 Persistent danger of severely hurting self or others (e.g., recurrent violence) OR persistent inability it maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.

Quality Control Checks

	Interviewer ID	Month	Day	Year
Self-Edit	☐☐☐☐	☐☐ /	☐☐ /	☐☐☐☐
Cross-Edit	☐☐☐☐	☐☐ /	☐☐ /	☐☐☐☐

Submit Type

- Computer Interview Complete ○
- Computer Interview Edit ○
- Verify Paper Interview ○
- Replace/Update ○

Study: **Cocaine** ○ **Opioid** ○ **Both (C&O)** ○ **Alcohol** ○

END OF SECTION W

38660

RELIABILITY STUDY QUESTIONS

Case Control Type

- ○ Drug Dependent
- ○ Community Sample
- ○ Psychiatric

Test Type

- ○ First Interview
- ○ Test-Retest
- ○ InterRater
- ○ Cross-Site

33905

Tally Sheets

TOBACCO TALLY SHEET

ALCOHOL TALLY SHEET

COCAINE TALLY SHEET

OPIATES TALLY SHEET

DRUG TALLY SHEET A

DRUG TALLY SHEET B

TALLY SHEET FOR SECTION I - PART A

TALLY SHEET FOR SECTION I - PART B

TALLY SHEET FOR SECTION J

33905

TOBACCO TALLY SHEET

CLSTR

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

Return to D

33905

ALCOHOL TALLY SHEET

CLSTR

__	__ E6C Needed 50% more alcohol to get an effect	
__	__ E6G Could drink 50% more alcohol before getting drunk	Box 1 __
__	__ E7 Wanted to stop or cut down 3+ times	
__	__ E7C Tried but was unable to stop or cut down 3+ times	Box 2 __
__	__ E8B Drank more than intended, more days in a row than intended, or when promised self wouldn't 3+ times	
__	__ E9A Became drunk when didn't want to 3+ times	Box 3 __
__	__ E10A Gave up or greatly reduced important activities to drink 3+ times or for 1+ month	Box 4 __
__	__ E11A Drinking or recovering from effects left little time for anything else for 1+ month or 3+ times	Box 5 __
__	__ E24A Continued to drink knowing alcohol caused health problems	
__	__ E25A Continued to drink knowing alcohol caused emotional problems	Box 6 __
__	__ E26D Experienced withdrawal symptoms	
__	__ E26I Drank to relieve or avoid withdrawal symptoms 3+ occasions	
__	__ E27 Had fits or seizures from drinking	
__	__ E27B Drank to relieve or avoid fits or seizures 3+ times	
__	__ E28 Had the DTs from drinking	
__	__ E28B Drank to relieve or avoid the DTs 3+ times	Box 7 __
__	__ E14 Had a strong desire or craving for alcohol	
__	__ E14A Had a strong desire or craving for alcohol that it was hard to think of anything else	Box 8 __

Return to E

33905

COCAINE TALLY SHEET

CLSTR

__	__ F6 Great deal of time spent using cocaine, getting it, or getting over its effects for 1 month or longer	Box 1 __
__	__ F8A.1,2,3, or 6 Continued to use cocaine knowing it caused emotional or psychological problems or decreased contact with family/friends (COL II = 5)	
__	__ F18A.2 Cocaine caused an overdose 3+ times	
__	__ F18B.1 Continued to use cocaine knowing it caused other health problems	Box 2 __
__	__ F9 Often wanted to stop or cut down on cocaine	
__	__ F9B Tried but was unable to stop or cut down on cocaine 3+ times	Box 3 __
__	__ F10 Often used cocaine more frequently or in larger amounts than intended	Box 4 __
__	__ F11 Needed larger amounts of cocaine to get same effect or couldn't get high on amount used to use	Box 5 __
__	__ F12B Used cocaine to relieve or avoid withdrawal symptoms 3+ times	
__	__ F12C Experienced 2+ withdrawal symptoms	Box 6 __
__	__ F17A Gave up or greatly reduced important activities to use cocaine 3+ times or for 1 month	Box 7 __
__	__ F5 Had a strong desire or craving for cocaine that it was hard to think of anything else	
__	__ F5B Had a strong desire or craving for cocaine	Box 8 __

Return to F

33905

OPIATES TALLY SHEET

CLSTR

__ __ G6 Great deal of time spent using opiates, getting them, or getting over their effects for 1 month or more — Box 1 __

__ __ G7A.1,2,3, or 6 Continued to use opiates knowing it caused emotional/psychological problems or decreased contact with family/friends (COL II = 5)

__ __ G17A.2 Opiates caused an overdose 3+ times

__ __ G17B.1 Continued to use opiates knowing they caused other health problems — Box 2 __

__ __ G8 Often wanted to stop or cut down on opiates

__ __ G8B Tried but was unable to stop or cut down on opiates 3+ times — Box 3 __

__ __ G9 Often used opiates more frequently or in larger amounts than intended — Box 4 __

__ __ G10 Needed larger amounts of opiates to get same effect or couldn't get high on amount used to use — Box 5 __

__ __ G11B Used opiates to relieve or avoid withdrawal symptoms 3+ times

__ __ G11C Experienced 2+ withdrawal symptoms — Box 6 __

__ __ G16A Gave up or greatly reduced important activities to use opiates 3+ times or for 1 month — Box 7 __

__ __ G5 Had a strong desire or craving for opiates that it was hard to think of anything else

__ __ G5B Had a strong desire or craving for opiates — Box 8 __

Return to G

33905

DRUG TALLY SHEET

		MJ CLSTR	STIM CLSTR	SED CLSTR	OTH CLSTR
H5	Much time spent using, getting, or getting over effects of (DRUG)	__ __	__ __	__ __	__ __
H6	Often wanted to stop or cut down on (DRUG)	__ __	__ __	__ __	__ __
H6B	Tried to stop or cut down on (DRUG) but couldn't 3+ times	__ __	__ __	__ __	__ __
H7	Needed larger amounts of (DRUG) to get effect or couldn't get high on same amount	__ __	__ __	__ __	__ __
H8A	Gave up or reduced important activities to use (DRUG) 3+ times or for 1 month	__ __	__ __	__ __	__ __
H9	Often used (DRUG) more days or in larger amounts than intended	__ __	__ __	__ __	__ __
H10B	Experienced withdrawal from (DRUG)	__ __	__ __	__ __	__ __
H10E.2	Used (DRUG) to relieve or avoid withdrawal symptoms 3+ times	__ __	__ __	__ __	__ __
H11A.2	(DRUG) caused and overdose 3+ times	__ __	__ __	__ __	__ __
H11B.1	Continued to use (DRUG) knowing it caused hepatitis	__ __	__ __	__ __	__ __
H11C.1	Continued to use (DRUG) knowing it caused other health problems	__ __	__ __	__ __	__ __
H17A	Continued to use (DRUG) knowing it caused emotional or psychological problems	__ __	__ __	__ __	__ __
H4	Had a strong desire or craving for (DRUG) that it was hard to think of anything else	__ __	__ __	__ __	__ __
H4B	Had a strong desire or craving for opiates	__ __	__ __	__ __	__ __

Clear Drug Tally B Return to H

TALLY SHEET FOR SECTION I

PART A ONLY COUNT ITEMS CODED 5 OR 6

CLSTR

__	__	I1B Truant from school twice in one year (ONSET BEFORE AGE 13)
__	__	I3B Ran away from home more than once
__	__	I3C (=1) Ran away and did not return home
__	__	I3C1 Ran away for 7 or more days
__	__	I4B Stayed out later than supposed to (ONSET BEFORE AGE 13)
__	__	I5B Sneaked out of the house (ONSET BEFORE AGE 13)
__	__	I6, 6B Started fights 3+ times
__	__	I9 Was a bully
__	__	I10 Hurt animals on purpose
__	__	I11,I11A/B1 Told a lot of lies, lied to get out of trouble, or used an alias
__	__	I13,I13A Cheated often
__	__	I14 Stole money or things from family or friends
__	__	I14B Shoplifted or stole from others without their knowing it
__	__	I14D Forged a signature on check or credit card
__	__	I15 Broke into someone's home, car, or building
__	__	I16 Stole money or property by using force or threatening
__	__	I17A Set fires on purpose (in order to cause damage)
__	__	I18 Damaged property on purpose
__	__	I19 Injured someone on purpose
__	__	I20 Used a weapon
__	__	I21 Forced someone into sexual activity

Return to I

PART B ONLY COUNT ITEMS CODED 5 OR 6 AND ONLY IF BEHAVIOR OCCURRED AFTER 15th BIRTHDAY

__ I6, 6B Started fights 3+ times

__ I6D Has been in 3+ physical fights

__ I9 Was a bully

__ I10 Hurt animals on purpose

__ I14 Stole money or things from family or friends

__ I14B Shoplifted or stole from others without their knowing it

__ I14D Forged a signature on check or credit card

__ I15 Broke into someone's home, car, or building

__ I16 Stole money or property by using force or threatening

__ I17A Set fires on purpose (in order to cause damage)

__ I18 Damaged property on purpose

__ I19 Injured someone on purpose

__ I20 Used a weapon

__ I21 Forced someone into sexual activity

__ I25A-E Did not provide for child/family when supposed to

__ I27 Often hit or assaulted others

__ I36B Never faithful for 1 year

Return to I

33905

TALLY SHEET FOR SECTION J

				CLSTR
BOX A: DEPRESSED	**J4**	Felt depressed for 2+ weeks	__	__
	J4B	Felt irritable for 2+ weeks	__	__
BOXB: LOSS OF INTEREST	**J4A**	Lost interest in most things for 2+ weeks	__	__
	J9	Less able to enjoy sex or other pleasurable activities	__	__
BOX C: APPETITE/WEIGHT	**J5A**	Had a change in appetite	__	__
	J5B	Gained or lost weight	__	__
BOX D: SLEEPING	**J6B**	Unable to fall asleep for more than 1 hour	__	__
	J6C	Trouble sleeping through the night	__	__
	J6E	Waking up an hour earlier than usual	__	__
	J6F	Slept more than usual	__	__
BOX E: RESTLESS/SLOWED DOWN	**J7A**	Was fidgety or restless, others noticed	__	__
	J8A	Moved or talked slower, others noticed	__	__
BOX F: TIRED	**J10**	Felt a loss of energy or more tired than usual	__	__
BOX G: GUILT	**J11**	Felt excessively guilty or bad about self	__	__
	J12	Felt was a failure or worthless	__	__
BOX H: THINKING	**J14**	Had more difficulty than usual thinking, concentrating, or making decisions	__	__
	J15	Thoughts were slower than usual/mixed up	__	__
BOX I: THOUGHTS OF DYING	**J16**	Thought about dying/wishing was dead	__	__
	J16A	Made a suicide plan	__	__
	J16B	Attempted suicide	__	__

Return to J

Section	Question	NO	YES
A	**Demographic information** is confirmed on review, but individual item-level responses should be discarded as potentially unreliable.	☐	☐
B	**Medical History** is confirmed on review, but individual item-level responses should be discarded as potentially unreliable.	☐	☐
C	**Section C** is confirmed on review, but individual item-level responses should be discarded as potentially unreliable.	☐	☐
D	**Tobacco Dependence** is confirmed on review, but individual item-level responses should be discarded as potentially unreliable.	☐	☐
E	**Alcohol Dependence** is confirmed on review, but individual item-level responses should be discarded as potentially unreliable.	☐	☐
F	**Cocaine Dependence** is confirmed on review, but individual item-level responses should be discarded as potentially unreliable.	☐	☐
G	**Opiate Dependence** is confirmed on review, but individual item-level responses should be discarded as potentially unreliable.	☐	☐
H (MJ)	**Marijuana Dependence** is confirmed on review, but individual item-level responses should be discarded as potentially unreliable.	☐	☐
H (STIM)	**Stimulant Dependence** is confirmed on review, but individual item-level responses should be discarded as potentially unreliable.	☐	☐
H (SED)	**Sedative Dependence** is confirmed on review, but individual item-level responses should be discarded as potentially unreliable.	☐	☐
H (OTH)	**Other Drug Dependence** is confirmed on review, but individual item-level responses should be discarded as potentially unreliable.	☐	☐
I	**ASP** is confirmed on review, but individual item-level responses should be discarded as potentially unreliable.	☐	☐
J	**Depression** is confirmed on review, but individual item-level responses should be discarded as potentially unreliable.	☐	☐
K	**Mania** is confirmed on review, but individual item-level responses should be discarded as potentially unreliable.	☐	☐
L	**Psychosis** is confirmed on review, but individual item-level responses should be discarded as potentially unreliable.	☐	☐
M	**ADHD** is confirmed on review, but individual item-level responses should be discarded as potentially unreliable.	☐	☐
N	**Suicide** is confirmed on review, but individual item-level responses should be discarded as potentially unreliable.	☐	☐
O	**PTSD** is confirmed on review, but individual item-level responses should be discarded as potentially unreliable.	☐	☐
P	**Generalized Anxiety Disorder** is confirmed on review, but individual item-level responses should be discarded as potentially unreliable.	☐	☐
Q	**OCD** is confirmed on review, but individual item-level responses should be discarded as potentially unreliable.	☐	☐
R	**Social Phobia** is confirmed on review, but individual item-level responses should be discarded as potentially unreliable.	☐	☐
S	**Agoraphobia** is confirmed on review, but individual item-level responses should be discarded as potentially unreliable.	☐	☐
T	**Panic Disorder** is confirmed on review, but individual item-level responses should be discarded as potentially unreliable.	☐	☐
U	**Gambling** is confirmed on review, but individual item-level responses should be discarded as potentially unreliable.	☐	☐
Z	**Environment** is confirmed on review, but individual item-level responses should be discarded as potentially unreliable.	☐	☐

APPENDIX

CARD A1

	CODE
Native American/American Indian	01
Asian	02
Pacific Islander	03
African-American/Black, not of Hispanic origin	04
African-American/Black, of Hispanic origin	05
Caucasian/White, not of Hispanic origin	06
Caucasian/White, of Hispanic origin	07
Other (Specify)	08

CARD A2

Code	Nationality	Code	Nationality
01	Afghanistani	34	Italian
02	African (e.g., Egyptian, Nigerian, Algerian)	35	Japanese
03	African-American (Black, Negro, or Afro-American)	36	Jordanian
69	Aleutian Islander	37	Korean
04	American Indian/Native American	38	Lebanese
67	American, NOS	39	Malaysian
05	Australian	40	Mexican
06	Australian(Aboriginal)	41	Mexican-American
07	Austrian	42	New Zealander
70	Belgian	43	Norwegian
09	Brazilian	44	Pakistani
10	Canadian	45	Polish
11	Caribbean or West Indian (Spanish-speaking)	46	Portuguese
12	Caribbean or West Indian (Non-Spanish speaking)	47	Puerto Rican
13	Central American (e.g., Nicaraguan, Guatemalan)	48	Russian
14	Chicano	49	Scottish
15	Chinese	50	Samoan
16	Cuban	51	Spanish
17	Czechoslovakian, Bohemian	52	Swedish
18	Danish	53	Swiss
19	Dutch	54	Taiwanese
20	English	55	Torres Strait Islander
21	Filipino	56	Turkish
22	Finnish	57	Vietnamese
23	French	58	Welsh
24	German	59	Yugoslavian
25	Greek	60	Other Asian (e.g., Thai, Laotian, Cambodian, Burmese)
26	Guamanian	61	Other Eastern European (e.g., Romanian, Bulgarian, Albanian)
27	Hungarian	62	Other Middle Easter (e.g., Arabian, Saudi, Kuwaiti, Qatari, Syrian, Omani)
28	Indian, Afghan	63	Other Pacific Islander (e.g., Okinawan, Tahitian)
29	Indonesian	64	Other South American (e.g., Chilean, Colombian)
30	Iranian	66	Other
31	Iraqi	(67	American, NOS)
32	Irish	(69	Aleutian Islander)
33	Israeli	(70	Belgian)
		(71	White, NOS)

RELIGION CODES

10- Catholic
20- Protestant, Baptist, Lutheran
25- Fundamentalist (Nazarene, Pentacostal, Jehovah's Witness, Foursquare Gospel Church, Brethren, Nazarene)
30- Jewish
40- Moslem
50- Buddhist
60- Not Affiliated/ Agnostic/ Athiest
70- Other (Unitarian, Hindu, Wicca, B'hai)
80- Greek-, Serbian-, Russian-Orthodox
90- Christian, other (Mormon, 7th day Adventist, Christian Scientist, charismatic, Mennonite)
91- Christian, NOS

MILITARY BRANCH CODES

1	NAVY
2	MARINES
3	ARMY
4	AIR FORCE
5	COAST GUARD
7	NATIONAL GUARD

Military Rank Codes

Enlisted Codes

101 (E-1): Seaman Recruit (Navy, Coast Guard), Private (Marines), Private (Army-no insignia), Airman Basic (Air Force)

102 (E-2): Seaman Apprentice (Navy, Coast Guard), Private First Class (Marines), Private (Army), Airman (Air Force)

103 (E-3): Seaman, Airman, or Aircraft Carrier (Navy, Coast Guard), Lance Corporal (Marines), Private First Class (Army), Airman First Class or Private First Class (Air Force)

104 (E-4): Petty Officer Third Class, Navy Corpsman Third Class (Navy, Coast Guard), Corporal (Marines), Corporal or Specialist 4 (Army), Sergeant or Senior Airman (Air Force)

105 (E-5): Petty Officer Second Class (Navy, Coast Guard), Sergeant (Marines), Sergeant or Specialist 5 (Army), Staff Sergeant (Air Force)

106 (E-6): Petty Officer First Class (Navy, Coast Guard), Staff Sergeant (Marines), Staff Sergeant or Specialist 6 (Army), Technical Sergeant (Air Force)

107 (E-7): Chief Petty Officer (Navy, Coast Guard), Gunnery Sergeant (Marines), Sergeant First Class (Army), Master Sergeant (Air Force)

108 (E-8): Senior Chief Petty Officer (Navy, Coast Guard), First Sergeant or Master Sergeant (Marines), First Sergeant or Master Sergeant (Army), Senior Master Sergeant (Air Force)

109 (E-9): Master Chief Petty Officer or Master Chief Petty Officer of the Navy (Navy), Master Chief Petty Officer or Master Chief Petty Officer of the Coast Guard (Coast Guard), Sergeant Major, Master Gunnery Sergeant, or Sergeant Major of the Marine Corps (Marines), Command Sergeant Major, Sergeant Major, or Sergeant Major of the Army (Army), Chief Master Sergeant or Chief Master Sergeant of the Air Force (Air Force)

Officer Codes

201 (O-1): Ensign (Navy, Coast Guard), Second Lieutenant (Marines), Second Lieutenant (Army), Second Lieutenant (Air Force)

202 (O-2): Lieutenant Junior Grade (Navy, Coast Guard), First Lieutenant (Marines), First Lieutenant (Army), First Lieutenant (Air Force)

203 (O-3): Lieutenant (Navy, Coast Guard), Captain (Marines), Captain (Army), Captain (Air Force)

204 (O-4): Lieutenant Commander (Navy, Coast Guard), Major (Marines), Major (Army), Major (Air Force)

205 (O-5): Commander (Navy, Coast Guard), Lieutenant Colonel (Marines), Lieutenant Colonel (Army), Lieutenant Colonel (Air Force)

206 (O-6): Captain (Navy, Coast Guard), Colonel (Marines), Colonel (Army), Colonel (Air Force)

207 (O-7): Rear Admiral Lower Half (Navy, Coast Guard), Brigadier General (Marines), Brigadier General (Army), Brigadier General (Air Force)

208 (O-8): Rear Admiral (Navy, Coast Guard), Major General (Marines), Major General (Army), Major General (Air Force)

209 (O-9): Vice Admiral (Navy, Coast Guard), Lieutenant General (Marines), Lieutenant General (Army), Lieutenant General (Air Force)

210 (O-10): Admiral (Navy, Coast Guard), General (Marines), General (Army), General (Air Force)

211 SPECIAL Fleet Admiral (Navy), General of the Army (Army), General of the Air Force (Air Force)

Warrant Codes

301 (W-2): Chief Warrant Officer (Navy, Marines, Amy, Air Force)

302 (W-3): Chief Warrant Officer (Navy, Marines, Army, Air Force)

303 (W-4): Chief Warrant Officer (Navy, Marines, Army, Air Force)

Age Onset and Recency Codes

1= Within the last two weeks
2= Two weeks to just under one month ago
3= One month to just under six months ago
4= Six months to a year ago
5= More than a year ago

EDITORS' MEDICATIONS LIST
ALPHABETICAL LISTING
April 7, 2000
(revised 3/20/2002)

A|B|C|D|E|F|G|H|I|K|L|M|N|O|P|Q|R|S|T|U|V|W|X|Y|Z

A

310.....ABILIFY
274.....ACCUTANE (ACNE MEDICATION)
273.....ACETAMINOPHEN
002.....ACTIFED
237.....ACYCLOVIR (HERPES)
003.....ADAPIN
930.....ADDERALL
004.....ADIPEX
217.....AIDS DRUGS
900.....ALCOHOL
005.....ALDOMET
006.....ALDORIL
007.....ALKA-SELTZER
215.....ALKALOIDS
232.....ALLERGY MEDS
008.....ALUMID
223.....AMBIEN/SLEEP MEDS
009.....AMINOPHYLLINE
001.....AMITRYPTYLINE
010.....AMPHETAMINES
239.....AMYL/BUTYL NITRITE
265.....ANAFRANIL
212.....ANAPROX
267.....ANASPAZ
011.....ANDREXIC
912.....ANESTHETICS
012.....ANTABUSE
013.....ANTACIDS
015.....ANTIBIOTICS
218.....ANTI-COAGULANTS
016.....ANTIDEPRESSANT
236.....ANTIDEPRESSANT-MAO INHIBITORS
014.....ANTI-DIARRHEAL
253.....ANTI-FUNGAL
202.....ANTIHISTAMINES
037.....ANTI-HYPERTENSIVE
220.....ANTI-INFLAMMATORY (non-steroidal)
281.....ANTI-MALARIAL (Lariam)
226.....ANTIPSYCHOTIC
017.....ANTIVERT
304.....ANTI-VIRAL

018.....ANXIOLYTIC
019.....APPETITE
020.....APRESOLINE
021.....ARTANE
240.....ARTHRITIS MEDS
240.....ARTHRITIS TREATMENT
022.....ASCRIPTIN
023.....ASENDIN
214.....ASERGIC
024.....ASPIRIN (ANY)
222.....ASTHMA MEDS (ANY)
025.....ATARAX
026.....ATIVAN
027.....AZENE
217.....AZT/AIDS DRUGS

B

028.....BACTRIM
029.....BAKING SODA
203.....BARBITURATE - Esgic +
173.....BECLOVENT
030.....BELLA DONNA
031.....BENADRYL
032.....BENDECTIN
033.....BENTYL
034.....BENZODIAZEPINE
035.....BERROCA
262.....BETA BLOCKERS
314.....BIPOLAR MEDS
201.....BIRTH CONTROL PILLS
036.....BISODAL
037.....BLOOD PRESSURE
238.....BLOOD THINNER
287.....BUSPAR
038.....BUTABARBITAL

C

039.....CAFFEINE
214.....CAFFERGOT, DHE
086.....CALAN
040.....CALCIUM
278.....CALCIUM CHANNEL BLOCKERS
041.....CALM DOWN MEDS, NOS
278.....CARDIZEM (CALCIUM CHANNEL BLOCKER)
294.....CELEXA (CITALOPRAM)
042.....CENTRAX
143.....CHARDONNA

231.....CHEMOTHERAPY DRUGS
143.....CHLORAL HYDRATE
034.....CHLORAZEPATE
224.....CHOLESTEROL LOWERING DRUGS
045.....CIMETIDINE
901.....COCAINE
046.....CODEINE
047.....COGENTIN
219.....COLCHICINE
260.....COLD MEDS
048.....COMBID
902.....COMBINATION (SPEEDBALLS)
049.....COMPAZINE
050.....CONTROL
290.....COPAXONE (COPOLYMER-1; MS MED)
051.....CORGARD
173.....CORTISONE
052.....COUGH MEDS
238.....COUMADIN
010.....CRANK
249.....CYCLOSPORIN
311.....CYMBALTA
249.....CYTOXIN

D

053.....DALMANE
054.....DANTRIUM
055.....DARVON (ANY) - (DARVOCET)
056.....DECONGESTANTS (ENTAX LA)
057.....DELCID
228.....DEMEROL
246.....DEPAKOTE (VALPROIC ACID)
201.....DEPO-PROVERA
128.....DESIPRAMINE
058.....DESYREL (TRAZADONE)
059.....DEXATRIM
243.....DIABETES MELLITUS MEDS
034.....DIAZEPAM
060.....DIDREX
204.....DIDRONEL
061.....DIET PILLS
062.....DIETAC
063.....DIGEL
064.....DIGESTIVE ENZYMES
086.....DIGITALIS
065.....DILANTIN
066.....DILAUDID
067.....DIPHENHYDRAMINE

238.....DIPYRIDAMOLE
068.....DITROPAN
069.....DIURETICS
240.....DOLABID
070.....DONNAGEL W/PG
071.....DONNATAL
072.....DORIDEN HYDRATE
167.....DOXEPIN
970.....DRUG/ALCOHOL COMBINATION
073.....DULCOLAX
074.....DYAZIDE

E

911.....ECSTASY
282.....EFFEXOR
075.....ELAVIL
076.....ENDEP
077.....ENEMA
078.....ENERGY MEDS
056.....ENTAX LA (DECONGESTANT)
079.....ENZYMES
080.....EQUANIL
081.....ESIDREX
105.....ESKALITH
082.....ETHOBRAL
259.....EXPECTORANT

F

019.....FASTIN
220.....FELDENE
272.....FEMSTAT
989.....FENTANYL
229.....FERTILITY DRUGS
211.....FIORINAL, FIORICET
254.....FLAGYL
221.....FLEXERIL

G

303.....GABAPENTIN (NEURONTIN; ANTICONVULSANT)
291.....GALLSTONE DRUGS
083.....GAVISCON
084.....GELUSIL
267.....GI MEDICATIONS
261.....GLAUCOMA MEDICATION
295.....GLUCOPHAGE (DIABETES MEDICATION)
230.....GLUCOTROL

240.....GOLD SHOTS (Arthritis treatment)
219.....GOUT MEDS

H

225.....HALCION
085.....HALDOL
909.....HALLUCINOGENS
086.....HEART MEDS
258.....HERNIA MEDS
903.....HEROIN
202.....HISMANAL
307.....HIV/AIDS MEDS
087.....HORMONES
206.....HYCODINE (narcotic)
088.....HYDROCHLOROTHIAZIDE
270.....HYDROCODONE
231.....HYDROXIA
089.....HYGROTON
037.....HYPERTENSION MEDICATION
277.....HYTRIN (Prostate reduction medicine)

I

210.....IBUPROFEN (Prescription)
234.....IBUPROFEN, ANY (Non-prescription)
090.....IMIPRAMINE
249.....IMMUNOSUPPRESSIVES
091.....IMODIUM
249.....IMURAN (immunosuppressive)
092.....INDERAL
024.....INDOCIN
245.....INH (Tuberculosis medication)
305.....INHALANTS
235.....INHALERS
093.....INSULIN
284.....INTERFERON
094.....IONAMIN
095.....IRON
096.....ISORDIL

K

097.....KAOPECTATE
302.....KETAMINE (SPECIAL K)
263.....KLONOPIN
098.....KUTRASE

L

099.....LASIX
313.....LAMICTAL
100.....LAXATIVES

101.....LEVSIN
102.....LIBRAX
103.....LIBRIUM
104.....LIMBITROL
297.....LIPITOR (CHOLESTEROL LOWERING MEDICATION)
105.....LITHIUM
106.....LITHOBID
107.....LOMOTIL
108.....LOPRESSOR
248.....LORAZEPAM
270.....LORCET
904.....LSD (Acid)
289.....LUVOX

M

109.....MALOX
266.....MAO-INHIBITORS
905.....MARIJUANA
110.....MECLIZINE
301.....MELATONIN
111.....MELLARIL
112.....MEPROBAMATE
113.....METAMUCIL
114.....METHADONE
249.....METHOTREXATE
212.....MIDRIN
212.....MIGRAINE, ANALGESIC
213.....MIGRAINE, NARCOTIC
214.....MIGRAINE, OTHER
214.....MIGRAL
115.....MILTOWN
116.....MINERALS
117.....MINIPRES
999.....MISSING
118.....MOM (MILK OF MAGNESIA)
250.....MOOD STABILIZER
206.....MORPHINE
119.....MOTRIN
997.....MULTIPLE DRUG COMBINATION
252.....MUSCLE RELAXANT
247.....MUSHROOMS
120.....MYLANTA
121.....MYLICON
122.....MYSOLINE

N

220.....NABUMETONE
123.....NALDECON
283.....NALTREXONE
220.....NAPROXIN
206.....NARCOTIC
016.....NARDIL
271.....NASAL SPRAY
125.....NAVANE
124.....NEMBUTAL
126.....NERVOUS STOMACH
264.....NEUROLEPTICS
303.....NEURONTIN (GABAPENTIN; ANTICONVULSANT)
308.....NEXIUM
280.....NICOTINE PATCH
991.....NITROUS OXIDE
000.....NO FAVORITE DRUG
127.....NOLUDAR
251.....NOLVADEX
257.....NORGESIC FORTE
201.....NORPLANT
128.....NORPRAMIN, DESIPRAMINE
129.....NORTRYPTALINE
296.....NORVASC (CALCIUM CHANNEL BLOCKER)
130.....NUTRALOX
131.....NYTOL/NYQUIL

O

906.....OPIATES (ALSO T'S AND BLUES)
988.....OPIUM
230.....ORAL INSULIN/GLUCOTROL
204.....OSTEOPOROSIS MED
996.....OTHER
990.....OTHER OPIATES
306.....OXYCONTIN/OXYCODONE

P

132.....PAIN MEDS
133.....PAMELOR
134.....PARABID PLATEAU
135.....PARAFON FORTE
136.....PARKINSON'S MEDS
236.....PARNATE (MAO Inhibiting Antidepressant)
279.....PAXIL
137.....PAXIPAM
910.....PCP
989.....P-DOPE
258.....PEPCID (for hernia)

138.....PEPTO BISMOL
299.....PERCOCET/PERCODAN
139.....PERTOFRANE
140.....PHENERGAN
142.....PHENOBARB
056.....PHENYLEPHRIN
143.....PLACIDYL
144.....PLEXONAL
173.....PREDNISONE
145.....PRELUDIN
267.....PREVACID
087.....PREMARIN
298.....PRILOSEC (HEARTBURN MEDICATION; H+ INHIBITOR)
146.....PRIMIDONE
312.....PRISTIQ
147.....PROBANTHINE
148.....PROLAMINE
149.....PROLIXIN
288.....PROSTATE MEDICATIONS
235.....PROVENTIL
150.....PROVERA
151.....PROZAC
247.....PSILOCYBIN
152.....PSYCHOSTIMULANT

Q

153.....QUAALUDES
154.....QUIET WORLD
155.....QUINAMM

R

156.....RAISE SPIRITS
997.....REFUSED
258.....REGLAN
220.....RELAFEN
292.....REMERON (MIRTAZEPINE)
157.....RESERPINE
034.....RESTORIL
283.....REVIA
158.....RIOPAN
159.....RITALIN
160.....ROLAIDS
299.....ROXYCODONE/OXYCODONE

S

161.....SALUTENSIN
162.....SECONAL

920.....SEDATIVES
244.....SEIZURE MEDICATIONS
233.....SELDANE
163.....SEPTRA
164.....SERAX
165.....SERENTIL
226.....SEROQUEL
293.....SERZONE (NEFAZADONE)
166.....SINEMET
167.....SINEQUAN
223.....SLEEP MEDS
168.....SLEEPEZE
169.....SLOW K
315.....SNRI
907.....SOLVENTS
170.....SOMA
171.....SOMINEX
302.....SPECIAL K (KETAMINE)
930.....SPEED
206.....STADAL
172.....STELAZINE
173.....STEROIDS
930.....STIMULANTS
174.....STIMULAX
308.....STOMACH ACID MED
260.....SUDAFED/COLD MEDS
256.....SULFA DRUG (can be included as antibiotic)
286.....SYMADINE
175.....SYNTHROID

T

176.....TAGAMET
177.....TALWIN
276.....TAMOXIFEN (for cancer treatment)
178.....TEGRETOL
220.....TELECTIN (NON-STERIODAL ANTI-INFLAMMATORY)
275.....TENORMIN
179.....TENUATE DOSEPAN
222.....THEO-DUR (ASTHMA MEDS)
111.....THIORIDAZINE
180.....THORAZINE
181.....THYROID MEDS
182.....TIGAN
183.....TITRALAC
184.....TOFRANIL
998.....TOO NUMEROUS TO CODE
269.....TORADOL
990.....TRAMADOL
185.....TRANQUILIZERS
186.....TRANXENE
058.....TRAZADONE (DESYREL)

283..... TREXAN
187..... TRIAVIL
265..... TRICYCLIC ANTIDEPRESSANTS
188..... TRIDIONE
241..... TRILAFON
189..... TRYPTOPHAN
245..... TUBERCULOSIS MEDICATIONS
190..... TUINAL
191..... TUMS
192..... TYLENOL
046..... TYLENOL #3 (CODIENE)
206..... TYLOX (Narcotic)

U

193..... ULCER MEDS
131..... UNISOM
995..... UNKNOWN
285..... URINARY MEDICATIONS

V

194..... VALIUM
246..... VALPROIC ACID (DEPAKOTE)
086..... VERAPAMIL
034..... VERSED
309.....VIAGRA
270..... VICODIN
195..... VISTARIL
196..... VITAMINS

W

197..... WELLBUTRIN
317.....WHET
316.....WOOLIES
300..... WYGESIC

X

198..... XANAX

Y

272..... YEAST INFECTION MEDS

Z

268..... ZANTAC
016..... ZOLOFT
199..... ZOMAX

Physical Illness/Condition Codes

100	Neurologic disease/condition
200	Cardiovascular disease/condition
201	Coronary artery disease
202	Cerebrovascular disease
203	Atherosclerotic peripheral vascular disease
204	High blood pressure
300	Pulmonary/Respiratory disease condition, NOS (cough, sinus infection)
301	Cancer of lung
302	Chronic obstructive pulmonary disease/emphysema
303	Respiratory infection (Bronchitis)
304	Asthma
305	Cancer of larynx
400	Endocrine/metabolic disease/condition (diabetes)
500	Hematologic
600	Gastro-intestinal disease/condition
601	Cancer of oral cavity
602	Peptic ulcer disease
603	Non-cancerous disease of the oral cavity
700	Genito-urinary disease/condition
800	Dermatologic disease/condition
900	Musculo-skeletal disease/condition
950	Gynecologic disease/condition
999	Other
99	Unknown/missing/refused

ALCOHOL EQUIVALENCIES

HARD LIQUOR (includes simple mixed drinks)

1 highball or shot glass	= 1 drink
½ pint of liquor	= 6 drinks
1 pint of liquor	= 12 drinks
1 fifth of liquor	= 20 drinks
1 quart of liquor	= 24 drinks
1 liter of liquor	= 25.4 drinks
1 gallon of liquor	= 96 drinks

WINE (includes champagne)

1 glass of wine (5-6 oz.)	= 1 drink
1 bottle of wine (750 ml)	= 6 drinks
1 liter of wine	= 6 drinks
1 (12 oz.) wine cooler	= 1 drink

BEER (including lite beer)

1 (12 oz.) beer	= 1 drink
1 (40 oz.) beer	= 3.3 drinks
1 case of beer	= 24 drinks
1 qt	= 2.6 drinks

OTHER (includes complex mixed ddrinks with more than one liquor, sherry, port wine, malt liquor, liquers)

1 (12 oz.) bottle of malt liquor (e.g. Zima, Colt 45)	= 1 drink
1 pint of fortified wine (e.g. Mad Dog)	= 5 drinks
1 fifth of fortified wine (e.g. Mad Dog)	= 8 drinks

1 DRINK = APPROXIMATELY 9 GM ABSOLUTE ALCOHOL

CARD E2

USED TO DRINK	FOR SAME EFFECT, NEEDED TO INCREASE TO:
3	5
4	6
5	8
6	9
7	11
8	12

COCAINE CONVERSIONS:

1 OUNCE = 28 GRAMS

½ OUNCE = 14 GRAMS

1/3 OUNCE = 9.3 GRAMS

¼ OUNCE = 7 GRAMS

1/5 OUNCE = 5.6 GRAMS

1/6 OUNCE = 4.7 GRAMS

1/7 OUNCE = 4.0 GRAMS

1/8 OUNCE = 3.5 GRAMS (8-BALL)

1/12 OUNCE = 2.3 GRAMS

1/16 OUNCE = 1.75 GRAMS

GRAMS TO DOLLARS:

¼ GRAM = $10 (DIME BAG)
½ GRAM = $20
8-BALL = $100

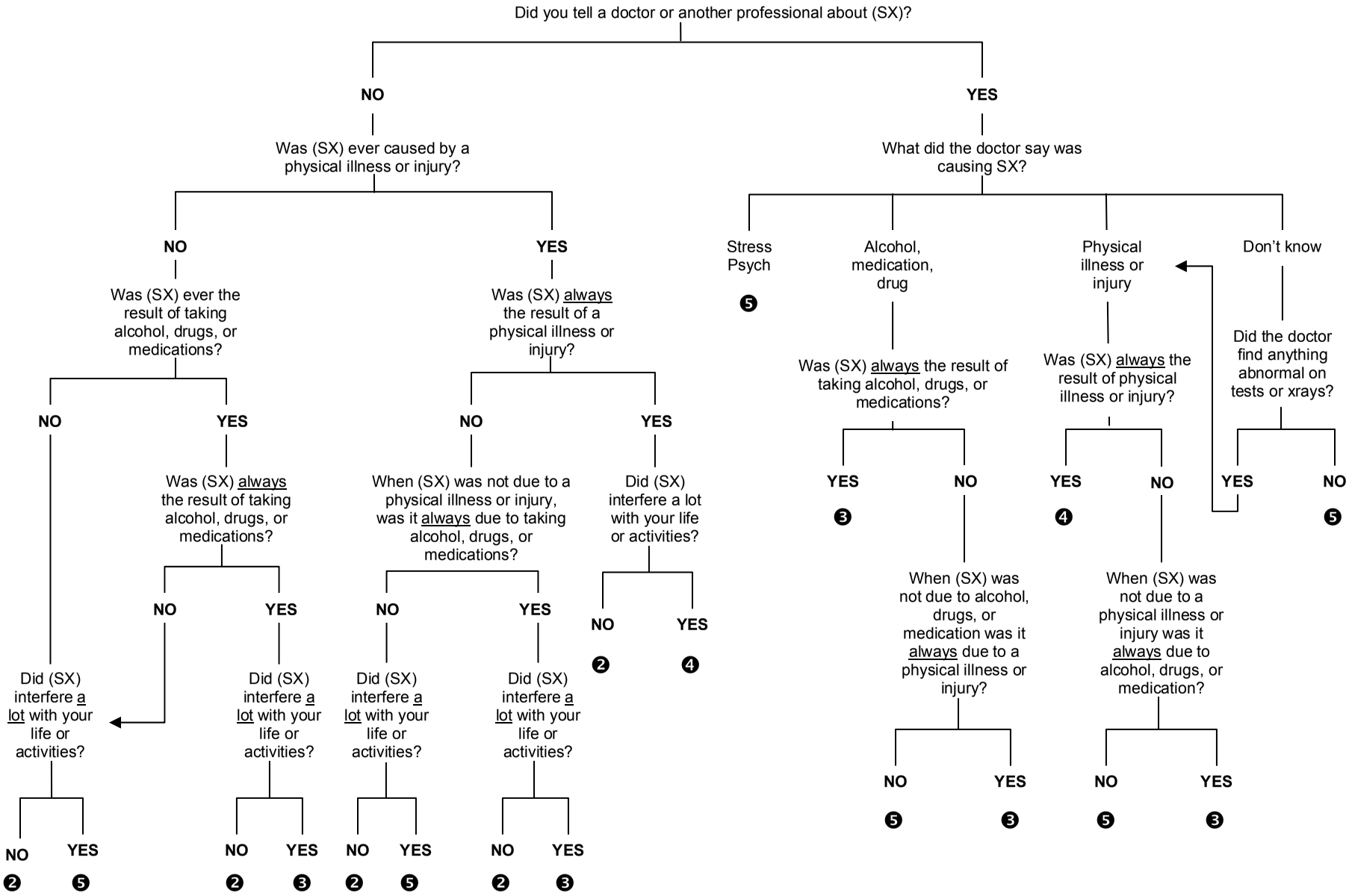
HEROIN CONVERSIONS:

1 BUNDLE = 10 BAGS
1 BAG = $10

MARIJUANA CONVERSIONS:

1 DIME BAG = 2 JOINTS
15 DIME BAGS = 1 OUNCE = 30 JOINTS
1 BLUNT = 3 JOINTS
1 BOWL = BETWEEN 1/32 AND 1/16 OUNCE
1 JOINT= $1.25-$2.50

Flow Chart for SSAGA-II Probing



CARD J

SEDATIVES
Barbiturates
Sleeping Pills
Valium
Librium
Tranquillizers
Quaaludes
Xanax

STIMULANTS
Cocaine
Crack
Cocoa Leaves
Amphetamines
Speed
White crosses
Black Beauties
Crank

OPIATES
Heroin
Codeine
Demerol
Morphine
Percodan
Methadone
Darvon
Opium
Dilaudid

MARIJUANA
Hashish

Psychedelics
LSD (Acid)
Psilocybin

CARD O

01 EXPERIENCED DIRECT COMBAT IN A WAR

02 SERIOUSLY PHYSICALLY ATTACKED OR ASSAULTED

03 PHYSICALLY ABUSED AS A CHILD

04 SERIOUSLY NEGLECTED AS A CHILD

05 RAPED

06 SEXUALLY MOLESTED OR ASSAULTED

07 THREATENED WITH A WEAPON, HELD CAPTIVE, OR KIDNAPPED

08 WITNESSED SOMEONE BEING BADLY INJURED OR KILLED

09 INVOLVED IN A FLOOD, FIRE, OR OTHER NATURAL DISASTER

10 INVOLVED IN A LIFE THREATENING ACCIDENT

11 SUFFERED A GREAT SHOCK BECAUSE ONE OF THE ABOVE EVENTS HAPPENED TO SOMEONE CLOSE TO YOU

12 OTHER

SPECIAL CODES

7, 97, 997, & 9997 = REFUSAL

8, 98, 998, & 9998 = THE MAXIMUM AMOUNT, I.E. USE 98 IF $\geq$ 100

9, 99, 999, & 9999 = DOESN'T KNOW

NOTE: FOR SOME FIELDS, ESPECIALLY THE SINGLE DIGIT FIELDS, 7, 8, AND 9 MAY MEAN SOMETHING ELSE THIS WILL BE ACCOUNTED FOR WHEN IT COMES TIME TO ANALYZE THE DATA.