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| 1. Have you ever been  diagnosed with any of  the following:  Please check all that apply. | * Neurodevelopmental Disorder(s) (e.g., Attention-Deficit/Hyperactivity Disorder) * Schizophrenia Spectrum and Other Psychotic Disorder(s) (e.g., Schizophrenia) * Bipolar and Related Disorder(s) (e.g., Bipolar I Disorder) * Depressive Disorder(s) (e.g., Major Depressive Disorder) * Anxiety Disorder(s) (e.g., Social Anxiety Disorder) * Obsessive-Compulsive and Related Disorder(s) (e.g., Obsessive-Compulsive Disorder) * Trauma-and-Stressor-Related Disorder(s) (e.g., Posttraumatic Stress Disorder) * Dissociative Disorder(s) (e.g., Dissociative Amnesia) * Somatic Symptom and Related Disorder(s) (e.g., Illness Anxiety Disorder) * Feeding and Eating Disorder(s) (e.g., Anorexia Nervosa) * Elimination Disorder(s) (e.g., Enuresis) * Sleep-Wake Disorder(s) (e.g., Insomnia) * Sexual Dysfunction(s) (e.g., Erectile Disorder) * Gender Dysphoria * Disruptive, Impulse-Control, and Conduct Disorder(s) (e.g., Oppositional-Defiant Disorder) * Substance-Related and Addictive Disorder(s)(e.g., Alcohol Use Disorder) * Neurocognitive Disorder(s) (e.g., Delirium) * Personality Disorder(s) (e.g., Borderline Personality Disorder) * Paraphilic Disorder(s) (e.g., Exhibitionistic Disorder) |  |
| Set up the questionnaire to automatically ask questions #2-5 for each disorder selected: | |  |
| 2. What year did you receive this diagnosis? | [Textbox] |  |
| 3. What type of professional  made the diagnosis? | * Psychiatrist * Clinical Psychologist * Pediatrician * Neurologist * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| 4. Are you currently receiving  treatment (e.g.,  medication, talk therapy)  for this disorder? | * Yes * No |  |
| 4.1 If yes, please select  which type(s) of  treatment options you  are currently  participating in. | * Psychotherapy (“Talk therapy”) * Medication * Support groups * Counseling centers * Residential mental health treatment * Case management * Complementary & Alternative treatment * Other: \_\_\_\_\_\_\_\_\_\_\_ |  |
| 5. If you are not currently  receiving treatment, have  you ever received  treatment (e.g.,  medication, talk therapy)  for this disorder? | * Yes * No |  |
| 5.1 If yes, please select  which type(s) of  treatment options  you have participated  in. | * Psychotherapy (“Talk therapy”) * Medication * Support groups * Counseling centers * Residential mental health treatment * Case management * Complementary & Alternative treatment * Other: \_\_\_\_\_\_\_\_\_\_\_ |  |
| 6. If you do not have a formal  diagnosis from a trained  clinician but suspect you  have any of the following,  please check all that apply. | * Neurodevelopmental Disorder(s) (e.g., Attention-Deficit/Hyperactivity Disorder) * Schizophrenia Spectrum and Other Psychotic Disorder(s) (e.g., Schizophrenia) * Bipolar and Related Disorder(s) (e.g., Bipolar I Disorder) * Depressive Disorder(s) (e.g., Major Depressive Disorder) * Anxiety Disorder(s) (e.g., Social Anxiety Disorder) * Obsessive-Compulsive and Related Disorder(s) (e.g., Obsessive-Compulsive Disorder) * Trauma-and-Stressor-Related Disorder(s) (e.g., Posttraumatic Stress Disorder) * Dissociative Disorder(s) (e.g., Dissociative Amnesia) * Somatic Symptom and Related Disorder(s) (e.g., Illness Anxiety Disorder) * Feeding and Eating Disorder(s) (e.g., Anorexia Nervosa) * Elimination Disorder(s) (e.g., Enuresis) * Sleep-Wake Disorder(s) (e.g., Insomnia) * Sexual Dysfunction(s) (e.g., Erectile Disorder) * Gender Dysphoria * Disruptive, Impulse-Control, and Conduct Disorder(s) (e.g., Oppositional-Defiant Disorder) * Substance-Related and Addictive Disorder(s)(e.g., Alcohol Use Disorder) * Neurocognitive Disorder(s) (e.g., Delirium) * Personality Disorder(s) (e.g., Borderline Personality Disorder) * Paraphilic Disorder(s) (e.g., Exhibitionistic Disorder) |  |
| Set up the questionnaire to automatically ask questions #7- for each disorder selected: | | |
| 7. What year was this diagnosis first suspected? | [Textbox] |  |
| 8. Who first suspected it? | * Self * Family member * Friend * Teacher * Other |  |
| 6.1 Are you currently receiving treatment (e.g.,  medication, talk therapy)  for this disorder? | Yes/No |  |
| If yes, please select  which type(s) of  treatment options you  are currently  participating in. | * Psychotherapy (“Talk therapy”) * Medication * Support groups * Counseling centers * Residential mental health treatment * Case management * Complementary & Alternative treatment   Other: \_\_\_\_\_\_\_\_\_\_\_ |  |
| If you are not currently  receiving treatment, have  you ever received  treatment (e.g.,  medication, talk therapy)  for this disorder? | * Yes/No |  |
|  | Are you currently receiving?  treatment (e.g.,  medication, talk therapy)   * for this disorder? |  |
| 6.2 If yes, then where? | * Social support groups * Online forums * Crisis hotlines * Community outreach programs * Religious institutions * Other: \_\_\_\_\_\_\_\_\_\_\_ |  |
| 7. Have you ever been  hospitalized for  psychiatric reasons? | * Yes * No |  |
| 8. Have any of your family  members been  diagnosed with one of the  above disorders? | * Yes * No |  |
| 8.1 If yes, then indicate  which family member  experienced the below  symptoms? | 1. Anxiety 2. Depression 3. Psychosis 4. Substance abuse 5. Hyperactivity 6. Dissociation 7. Hypervigilance 8. Distressing flashbacks 9. Fixation with eating behaviors 10. Persistent, invasive fears about illness 11. Difficulties sleeping or staying awake | * Mother * Father * Brother(s) * Sister(s) * Cousin(s) * Grandparent(s) * Aunt(s)/Uncle(s) * Niece(s)/Nephew(s) |
| 10. Do you feel that you have  people you can turn to for  help? | * Yes * No |  |
| 11. If you are receiving  treatment/support for a  diagnosed or suspected  disorder, has the COVID-  19 outbreak impacted the  frequency with which you  participate in such  services? | * Yes, involvement in treatment /support services has decreased * Yes, involvement in treatment/support services has increased * No, involvement in treatment/support services has not changed |  |
| 12. Since the COVID-19  outbreak, has the format  of treatment/services  changed (i.e., move to  Telehealth services)? | * Yes * No |  |
| 12.1 If yes, how would  you rate your  comfort engaging  in Telehealth  services? | * Not at all comfortable * Slightly comfortable * Moderately comfortable * Quite comfortable * Very comfortable |  |
| 12.2 If yes, how would  you rate your  satisfaction with  receiving mental  health services via  online/remote  platforms? | * Not at all satisfied * Slightly satisfied * Moderately satisfied * Quite satisfied * Very satisfied |  |