Consents:

1. **Introduction:**
   1. Name, credentials, contact number
2. **Virtual Consent:**
   1. Private location?
   2. Eliminate sources of distraction?
   3. Current location:
   4. Current emergency contact
   5. Current phone number in case of lost connection
   6. Opportunity to review patient guide
      1. https://www.stjoes.ca/mydovetale-patient-guide-final-2019.pdf
   7. No recording devices
   8. In event of crisis, work with clinician to come up with safety plan
      1. Note that clinician may contact St. Joe’s Crisis Outreach and Support Team (COAST)/emergency services in a crisis
3. **Informed Consent:**
   1. Purpose + format of assessment
   2. Risks/benefits
   3. Research
   4. Teaching
   5. Confidentiality + limits
4. **Release of Info:**
   1. GP + other?
5. **Email Consent:**
   1. Email:
   2. For what:
      1. Scheduling
      2. Receiving handouts
      3. Receiving questionnaires
      4. Part of research database?

**DART Profile**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| [DATE:] | | [INTERVIEWER(S):] | | |
|  | | | | |
|  | | | | |
| [AGE:] | | |  | [RELATIONSHIP STATUS:] |
|  | | |  |  |
| [LIVING WITH:] | | |  | [CHILDREN:] |
|  | | |  |  |
| [EDUCATION:] | | |  | [OCCUPATION:] |
|  | | |  |  |
| [IF RELEVANT, REASON FOR NOT WORKING:] | | | | |
|  | | | | |
| [IF RELEVANT, SOURCE OF FINANCIAL SUPPORT:] | | | | |
|  |  | | | |
| [PRESENTING PROBLEMS:] | | | | |
|  | | | | |
|  | **What brought you here today? What is the main problem you are hoping to get help with?**  **How would describe your mood?** | | | |
|  |  | | | |
| [PSYCHIATRIC HISTORY:] | | | | |
|  | | | | |
|  | **Have you ever been given a mental health diagnosis?** [IF YES:]When and by whom?  **Have you ever been hospitalized for mental health concerns?** [IF YES:] When and for what reason? How long did you stay in the hospital?  **Are you currently taking any medications or substances for your mental health? Have you taken any in the recent past?**  ❑ Pharmacy printout | | | |

|  |  |
| --- | --- |
|  | **Have you participated in any therapy or other types of treatment for your mental health (other than medication)?**  **Any history of mental health difficulties in your family?** |
|  |  |
| [LIFE EVENTS OR STRESSORS IN PAST YEAR:] | |
|  | |
|  | **Have you experienced any major life changes or stressors in the last year?** (e.g., family & relationships, legal matters, work/school, finances, health of significant others, other stressors) |
|  |  |
| [RELEVANT MEDICAL HISTORY:] | |
|  | |
|  | **Do you currently have any physical health difficulties or medical issues?** (e.g., problems with your thyroid, seizures, allergies, or a head injury) |
|  | |
| [CONSUMES CAFFEINE:] ❑ Yes ❑ No Daily caffeine consumption: | |
|  | |
| [TOBACCO SMOKER:] ❑ Yes ❑ No Daily tobacco consumption: | |
|  | |
| [ALCOHOL USE:] ❑ Yes ❑ No Daily/weekly alcohol consumption: | |
|  | |
| [RECREATIONAL SUBSTANCE USE:] ❑ Yes ❑ No Daily/weekly substance consumption: | |

**INDEX**

1. [**MDD**](#MDD)
2. [**PDD**](#PDD)
3. [**Risk Assessment**](#Riskassessment)
4. [**Bipolar**](#Bipolar)
5. [**SAD**](#SAD)
6. [**OCD**](#OCD)
7. [**PD**](#PD)
8. [**Agoraphobia**](#Agoraphobia)
9. [**PTSD**](#PTSD)
10. [**GAD**](#GAD)
11. [**Illness Anxiety Disorder**](#IllnessAnxDx)
12. [**Specific Phobia**](#SpecificPhobia)
13. [**Alcohol Use Disorder**](#AUD)
14. [**Substance Use Disorder**](#SUD)
15. [**Psychosis**](#Psychosis)

**Depressive Disorders**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Major Depressive Disorder** | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| [CURRENT:] | | | | | | | | | | | | |  | [CURRENT:] | | | [LIFETIME:] | | | |
|  |  | | | | | | | | | | | |  |  |  |  |  |  | |  |
| 1. | **Over the past 2 weeks or longer:** | | | | | | | | | | | |  |  |  |  |  |  | |  |
|  |  | | | | | | | | | | | |  |  |  |  |  |  | |  |
|  | 1a. **Have you been bothered by significant low and depressed mood for most of the day, nearly every day?** | | | | | | | | | | | |  | **A** | **S** | **P** |  |  | |  |
|  |  | | | | When did this begin? Has your mood been consistently down since this time? When something positive happens, do you experience a brightening of your mood? | | | | | | | |  |  |  |  |  |  | |  |
|  |  | | | | | | | | | | | |  |  |  |  |  |  | |  |
|  | 1b. **Have you noticed a sharp decline in your enjoyment of, or interest in, activities for most of the day, nearly every day?** | | | | | | | | | | | |  | **A** | **S** | **P** |  |  | |  |
|  |  | | | | | When did this begin? Can you give me some examples? Is this true for most activities? Are there some activities that you still enjoy? | | | | | | |  |  |  |  |  |  | |  |
|  |  | | | | |  | | | | | | |  |  |  |  |  |  | |  |
|  | [NOTES:] | | | | | | | | | | | | | | | | | | | |
|  |  | | | | |  | | | | | | |  |  |  |  |  |  | |  |
| 2. |  | | | | | | | [AT LEAST ONE #1 ITEM IS CODED P] | | | | |  | **A** |  | **P** |  |  | |  |
|  |  | | | | | | |  | | | | |  |  |  |  |  |  | |  |
| [IF #2 IS CODED P, SKIP #3 AND PROCEED TO #6 FOR CURRENT EPISODE] | | | | | | | | | | | | |  |  |  |  |  |  | |  |
| [IF#2 IS CODED A, PROCEED TO #3a FOR LIFETIME EPISODE] | | | | | | | | | | | | |  |  |  |  |  |  | |  |
|  |  | | | | | | |  | | | | |  |  |  |  |  |  | |  |
| [LIFETIME:] | | | | | | | | | | | | |  |  |  |  |  |  | |  |
|  | | | | | | | | | | | | |  |  |  |  |  |  | |  |
| 3. | | **At any point in your life:** | | | | | | | | | | |  |  |  |  |  |  | |  |
|  | |  | | | | | | | | | | |  |  |  |  |  |  | |  |
|  | 3a. **Have you been bothered by significant low and depressed mood for most of the day, nearly every day, for at least 2 weeks in a row?** | | | | | | | | | | | |  |  |  |  | **A** | **S** | | **P** |
|  |  | | | | | | | When did this period of low mood begin? How long did this period last? Was your mood consistently low during this period? When did your mood return to normal? Has this happened more than once? | | | | |  |  |  |  |  |  | |  |
|  |  | | | | | | |  | | | | |  |  |  |  |  |  | |  |
|  | 3b. **Have you noticed a sharp decline in your enjoyment of, or interest in, activities for most of the day, nearly every day, for at least 2 weeks in a row?** | | | | | | | | | | | |  |  |  |  | **A** | **S** | | **P** |
|  |  | | | | | | When did this begin? How long did this period last? Was it most activities? Were there any activities that you still enjoyed? Has this happened more than once? | | | | | |  |  |  |  |  |  | |  |
|  |  | | | | | |  | | | | | | |  |  |  |  |  | |  |
|  | [NOTES:] | | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | |  | | | | |  |  |  |  |  |  | |  |
| 4. |  | | | | | | | [AT LEAST ONE #3 ITEM IS CODED P] | | | | |  |  |  |  | **A**  ⌧ |  | | **P** |
|  |  | | | | | | | | | | | |  |  |  |  |  |  | |  |
|  |  | | | | | | | | | | | |  | [CURRENT:] | | | [LIFETIME:] | | | |
|  |  | |  | | | | | | | | | |  |  |  |  |  |  | |  |
| 6. | **Thinking about your most severe 2 week period of depressed mood or loss of interest, did you also:** | | | | | | | | | | | |  |  |  |  |  |  | |  |
|  | 6a. **Notice a significant change in your appetite or weight?** | | | | | | | | | | | |  |  |  |  |  |  | |  |
|  |  | | | | | | | | | Did you lose/gain weight without trying to? | | |  |  |  |  |  |  | |  |
|  |  | | | | | | | | |  | | |  |  |  |  |  |  | |  |
|  | 6b. **Notice a change in your sleeping?** | | | | | | | | | | | |  |  |  |  |  |  | |  |
|  |  | | | | | | | | | Sleep too much or not enough? Have trouble falling asleep? Wake up earlier than expected? | | |  |  |  |  |  |  | |  |
|  |  | | | | | | | | |  | | |  |  |  |  |  |  | |  |
|  | 6c. **Notice being physically slowed down?** | | | | | | | | | | | |  |  |  |  |  |  | |  |
|  |  | | | | | | | | [IF NO:] **What about the opposite, were you very restless?** | | | |  |  |  |  |  |  | |  |
|  |  | | | | | | | | | Did people comment on this? What did they say? | | |  |  |  |  |  |  | |  |
|  |  | | | | | | | | |  | | |  |  |  |  |  |  | |  |
|  | 6d. **Feel fatigued or have low energy?** | | | | | | | | | | | |  |  |  |  |  |  | |  |
|  |  | | | | | | | | |  | | |  |  |  |  |  |  | |  |
|  | 6e. **Feel excessively guilty even without a good reason, or feel worthless?** | | | | | | | | | | | |  |  |  |  |  |  | |  |
|  |  | | | | | | | | | What sorts of things did you feel guilty about? What type of thoughts did you have about yourself? | | |  |  |  |  |  |  | |  |
|  |  | | | | | | | | | | | |  |  |  |  |  |  | |  |
|  | 6f. **Have trouble focusing, concentrating, or making minor decisions?** | | | | | | | | | | | |  |  |  |  |  |  | |  |
|  |  | | | | | | | | | Can you give me some examples? | | |  |  |  |  |  |  | |  |
|  |  | | | | | | | | |  | | |  |  |  |  |  |  | |  |
|  | 6g. **Have thoughts about death, harming yourself, or ending your life?** | | | | | | | | | | | |  |  |  |  |  |  | |  |
|  |  | | | | | | | | | | | |  |  |  |  |  |  | |  |
|  |  | | | | | | | | | | | |  |  |  |  | **A**  ⌧ |  | | **P** |
|  |  | | | | | | | | | | | |  |  |  |  |  |  | |  |
| 7. | [CLINICALLY SIGNIFICANT DISTRESS AND/OR IMPAIRMENT IS PRESENT. IF NOT KNOWN, ASK:] | | | | | | | | | | | |  | **A**  ⌧ | **S**  ⌧ | **P** | **A**  ⌧ | **S**  ⌧ | | **P** |
|  |  | | | | | | | | | | | |  |  |  |  |  |  | |  |
|  |  | | | Is/was it very upsetting for you that you have these symptoms? | | | | | | | | |  |  |  |  |  |  | |  |
|  |  | | | | | | | | | | | |  |  |  |  |  |  | |  |
|  |  | | | Have/did the symptoms interfere(d) with your ability to carry out daily activities? In what ways have/did they interfere(d)? Have/did they made it hard for you to work, socialize, go to school, or take care of things at home? | | | | | | | | |  |  |  |  |  |  | |  |
|  |  | | | | | | | | | | | |  |  | | |  | | | |
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|  |  | |  | | | | | | | | | |  |  |  |  |  | |  |  |
| 10. | **How many separate episodes similar to the one that we just discussed have you experienced in your life that lasted at least 2 weeks?** | | | | | | | | | | | |  | \_\_\_\_\_\_\_\_\_\_\_ | | | \_\_\_\_\_\_\_\_\_\_\_\_ | | | |
|  |  | | | | | | | | | | | |  |  | | |  | |  |  |
|  |  | | | | | | | | | | | |  |  |  |  |  | |  |  |
|  |  | | | | | | | | | | | |  |  |  |  |  | |  |  |
|  |  | | | | | | | | | | | |  | [CURRENT:] | | | [LIFETIME:] | | | |
|  |  | | | | | | | | | | | |  |  | | |  | | | |
|  |  | | DIAGNOSTIC IMPRESSION:  MAJOR DEPRESSIVE DISORDER | | | | | | | | | |  | **A**  ⌧ | **S** | **P** | **A**  ⌧ | | **S** | **P** |
|  |  | |  | | | | | | | | | |  |  |  |  |  | |  |  |
|  |  | | [SPECIFY:] | | | | | | | | | |  |  | | |  | | | |
|  |  | |  | | | | | | | | | |  |  |  |  |  | |  |  |
|  |  | | 1 EPISODE | | | | | | | |  | SINGLE EPISODE |  |  |  | ❒ |  | |  | ❒ |
|  |  | |  | | | | | | | |  |  |  |  |  |  |  | |  |  |
|  |  | | >1 EPISODE | | | | | | | |  | RECURRENT EPISODE |  |  |  | ❒ |  | |  | ❒ |
|  |  | | | | | | | | | | | |  |  | | |  | | | |
|  |  | | | | | | | | | | | |  |  | | |  | | | |
|  |  | | [SPECIFY:] | | | | | | | | | |  |  |  |  |  | |  |  |
|  |  | |  | | | | | | | | | |  |  |  |  |  | |  |  |
|  |  | |  | | | | | | | | | |  |  |  |  |  | |  |  |
| 13. | **How old were you when these symptoms first began?** | | | | | | | | | | | |  | \_\_\_\_\_\_\_\_\_\_\_\_ | | | \_\_\_\_\_\_\_\_\_\_\_\_ | | | |
|  |  | | | | | | | | | | | |  |  | | |  | | | |
| 14. | **How old were you when these symptoms began to be a problem for you?** | | | | | | | | | | | |  | \_\_\_\_\_\_\_\_\_\_\_\_ | | | \_\_\_\_\_\_\_\_\_\_\_\_ | | | |
|  |  | | | | | | | | | | | |  |  | | |  | | | |
| 15. | **On a scale from 0 to 10, 0 meaning not at all and 10 meaning extremely, how much are you bothered by your symptoms?** | | | | | | | | | | | |  | \_\_\_\_\_\_\_\_\_\_\_\_ | | | \_\_\_\_\_\_\_\_\_\_\_\_ | | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Persistent Depressive Disorder (Dysthymia)** | | | | | | | |
|  | | | | | | | |
| 1. | **Over the past 2 years, have you been bothered by significant low and depressed mood most of the day, more days than not?** | | |  | **A**  ⌧ | **S**  ⌧ | **P** |
|  | When did this begin? | |
|  |  |  | |  |  |  |  |
|  | [NOTES:] | | | | | | |
|  |  | | |  |  |  |  |
| 2. | **Over the past 2 years, when you've struggled with low mood, did you also have difficulty with:** | | |  |  |  |  |
|  |  | | |  |  |  |  |
|  |  | **Poor appetite or overeating?** | |  |  |  |  |
|  |  | | |  |  |  |  |
|  |  | **Sleep?** | |  |  |  |  |
|  |  | | Sleep too much or not enough? Have trouble falling asleep? Wake up earlier than expected? |  |  |  |  |
|  |  | | |  |  |  |  |
|  |  | **Fatigue or low energy?** | |  |  |  |  |
|  |  | | |  |  |  |  |
|  |  | **Low self-esteem or feeling badly about yourself?** | |  |  |  |  |
|  |  | | |  |  |  |  |
|  |  | **Concentration or decision-making?** | |  |  |  |  |
|  |  | | |  |  |  |  |
|  |  | **Feeling hopeless?** | |  |  |  |  |
|  |  | | |  |  |  |  |
|  | [AT LEAST TWO #2 ITEMS ARE CHECKED] | | |  | **A**  ⌧ |  | **P** |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 3. | [DEPRESSED MOOD AND ADDITIONAL SYMPTOMS WERE CONSISTENTLY PRESENT FOR AT LEAST 2 YEARS AND WITHOUT ANY BREAKS OF MORE THAN 2 MONTHS; IF NOT KNOWN, ASK:] | | | | | | | | |  | | **A**  ⌧ | |  | | | **P** | | |
|  | | In the past 2 years, has there been a period of time where your mood was not depressed for at least 2 months? | | | | | | | |  | |  | |  | | |  | | |
|  |  | | | | | | | | |  | |  | |  | | |  | | |
| 4. | [CLINICALLY SIGNIFICANT DISTRESS AND/OR IMPAIRMENT IS PRESENT. IF NOT KNOWN, ASK:] | | | | | | | | |  | | **A**  ⌧ | | **S**  ⌧ | | | **P** | | |
|  |  | | | | | | | | |  | |  | |  | | |  | | |
|  |  | | Is it very upsetting for you that you have these symptoms? | | | | | | |  | |  | |  | | |  | | |
|  |  | |  | | | | | | |  | |  | |  | | |  | | |
|  |  | | Have the symptoms interfered with your ability to carry out daily activities? In what ways have they interfered? Have they made it hard for you to work, socialize, go to school, or take care of things at home? | | | | | | |  | |  | |  | | |  | | |
|  |  | |  | | | | | | |  | |  | |  | | |  | | |
|  | [NOTES:] | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | |  | |  | |  | | |  | | |
|  |  | | | | | | | | |  | |  | |  | | |  | | |
|  | DIAGNOSTIC IMPRESSION:  PERSISTENT DEPRESSIVE DISORDER (DYSTHMIA) | | | | | | | | |  | | **A**  ⌧ | | **S** | | | **P** | | |
|  |  | | | | | | | | |  | |  | | | | | | | |
|  | | [SPECIFY:  FOR THE MOST RECENT 2 YEARS] | | | | | | | | | | | | | | | | | |
|  | |  | | | |  | | |  | | | | | | | | | | |
|  | | MAJOR DEPRESSIVE EPISODE HAS NOT BEEN PRESENT | | | |  | | | WITH PURE DYSTHYMIC SYNDROME | | | | | | | | | |  |
|  | |  | | | |  | | |  | | | | | | | | | |  |
|  | | MAJOR DEPRESSIVE EPISODE HAS BEEN PRESENT | | | |  | | | WITH PERSISTENT MAJOR DEPRESSIVE EPISODE | | | | | | | | | |  |
|  | |  | | | |  | | |  | | | | | | | | | |  |
|  | | MAJOR DEPRESSIVE EPISODE IS PRESENT, BUT THERE HAVE BEEN PERIODS OF AT LEAST 2 MONTHS WITH SYMPTOMS BELOW THE THRESHOLD FOR A FULL MAJOR DEPRESSIVE EPISODE | | | |  | | | WITH INTERMITTENT MAJOR DEPRESSIVE EPISODES, WITH CURRENT EPISODE | | | | | | | | | |  |
|  | |  | | | | |  |  | | | | | | | | | | |  |
|  | | FULL MAJOR DEPRESSIVE EPISODE IS NOT PRESENT, BUT THERE HAS BEEN ONE OR MORE MAJOR DEPRESSIVE EPISODES | | | | |  | WITH INTERMITTENT MAJOR DEPRESSIVE EPISODES, WITHOUT CURRENT EPISODE | | | | | | | | | | |  |
|  | |  | | [SPECIFY:] | | | | | | | | | | | | | | | |
|  | |  | |  |  | |  | | | | | | | | |  | | |  |
|  | |  | | PANIC ATTACKS ARE PRESENT IN THE CONTEXT OF THIS DISORDER | | |  | WITH PANIC ATTACKS | | | | | | | |  | | |  |
|  | |  | |  | | |  | | | | | | | | |  | | |  |
|  | |  | | [NOTE: TO ASSESS SYMPTOMS OF A PANIC ATTACK,  SEE PANIC ATTACK SPECIFIER AND PANIC DISORDER MODULE] | | |  |  | | | | | | | |  | | |  |
|  | |  | |  | | |  |  | | | | | | | |  | | |  |
|  | |  | |  | | |  |  | | | | | | | |  | | |  |
|  | |  | |  | | |  |  | | | | | | | |  | | |  |
| 8. | **How old were you when these symptoms first began?** | | | | | | | | |  | | \_\_\_\_\_\_\_\_ | | | | | | | |
|  |  | | | | | | | | |  | |  | | | | | | | |
| 9. | **How old were you when these symptoms began to be a problem for you?** | | | | | | | | |  | | \_\_\_\_\_\_\_\_ | | | | | | | |
|  |  | | | | | | | | |  | |  | | | | | | | |
| 10. | **On a scale from 0 to 10, 0 meaning not at all and 10 meaning extremely, how much are you bothered by your symptoms?** | | | | | | | | |  | | \_\_\_\_\_\_\_\_ | | | | | | | |

**MOOD MAP**

High

Normal/Healthy

**MOOD**

Low

Today

Birth

**TIME**

**This Mood Map can be used to assist with understanding the timeline associated with your mood symptoms. The line on the bottom represents time. The beginning of the line is the day you were born, and the end of the line represents today.**

**The line on the left represents your mood. The top of the line represents feeling high, excitable, or hyper. Everyone has moments when they feel more energetic, but for these episodes think about instances in which you have felt this way for at least several days in a row or longer and to the point that it was bothersome or caused problems for you.**

**The bottom of the line represents times when you felt depressed or lost interest/pleasure in things. Everyone has moments when they feel down or sad, but for these episodes think about instances in which you have felt this way for at least two weeks in a row or longer and to the point that it was bothersome or caused problems for you.**

**The middle of the line represents feeling about “normal” or healthy. Let’s assume that everyone is born with their mood being about normal. When did you first notice a change in your mood?**

**Risk Assessment**

[THIS MODULE CONTAINS SECTIONS ON CURRENT AND PAST SUICIDE RISK, SELF-HARM BEHAVIOUR, AND HOMICIDE RISK.]

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Suicide Risk (Current/Past)** | | | | | | |
|  |  | |  |  |  |  |
|  | [CURRENT THOUGHTS OF DEATH AND SUICIDAL IDEATION:] | |  |  |  |  |
|  |  | |  |  |  |  |
| 1. | **Do you currently have thoughts of your own death or of killing yourself?** | |  | **A** |  | **P** |
|  |  | What thoughts do you have (e.g., thinking things would be easier if you were no longer alive; wishing you would not wake up in the morning; thinking specifically about killing yourself)? When did these thoughts first start? How often do you have them? How long do they last (i.e., constant or fleeting)? When you have these thoughts, what do you do? Have there been other times in your life when you’ve had these thoughts? |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  | * [PASSIVE THOUGHTS OF DEATH – E.G., THINKING THINGS WOULD BE EASIER IF NO LONGER ALIVE; WISHING NOT TO WAKE UP IN THE MORNING] |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  | * [SUICIDAL IDEATION – E.G., SPECIFIC THOUGHTS ABOUT KILLING ONESELF] |  |  |  |  |
|  |  |  |  |  |  |  |
|  | [NOTES:] | | | | | |
|  |  | |  |  |  |  |
|  | [IF #1 IS CODED A, PROCEED TO #5 TO QUERY PAST SUICIDE RISK] | |  |  |  |  |
|  |  | |  |  |  |  |
|  | [CURRENT SUICIDE PLAN:] | |  |  |  |  |
|  |  | |  |  |  |  |
| 2. | **Do you have a plan of how you would kill yourself?** | |  | **A** |  | **P** |
|  |  | What is your plan? Do you have access to what you would need to carry out this plan? Have you made any preparations toward acting on it (e.g., researching ways to kill yourself; collecting pills if the plan is to overdose)? |  |  |  |  |
|  |  |  |  |  |  |  |
|  | [NOTES:] | | | | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | [CURRENT SUICIDAL INTENT:] | | | | | | |
|  |  | | | | | | |
| 3. | **Do you intend to kill yourself?** | | |  | **A** |  | **P** |
|  |  | On a scale from 0 to 10, where 0 is “*I would never act*” and 10 is “*I am definitely going to act*”, how likely is it that you are going to kill yourself today? \_\_\_\_\_\_\_\_\_  What about in the next week? \_\_\_\_\_\_\_\_\_  What about in the next month? \_\_\_\_\_\_\_\_\_ | |  |  |  |  |
|  |  |  | |  |  |  |  |
|  | [PROTECTIVE FACTORS:] | | |  |  |  |  |
|  |  | | |  |  |  |  |
| 4. | **What are some important reasons to stay alive?** | | |  |  |  |  |
|  |  |  | |  |  |  |  |
|  |  |  | * [FAMILY] * [FRIENDS] * [PETS] * [HEALTHCARE PROVIDERS] * [RELIGION] * [JOB] * [FUTURE FOCUS/PLANS] * [FEAR OF FAILED ATTEMPT] * [OTHER:] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |
|  |  |  | |  |  |  |  |
|  |  | On a scale from 0 to 10, where 0 is “*not at all confident*” and 10 is “*completely confident*”, how confident are you that you can keep yourself safe? \_\_\_\_\_\_\_\_\_ | |  |  |  |  |
|  |  | | |  |  |  |  |
|  | [PAST THOUGHTS OF DEATH AND SUICIDAL IDEATION:] | | |  |  |  |  |
|  |  | | |  |  |  |  |
| 5. | **Have you had thoughts of your own death or of killing yourself in the past?** | | |  | **A** |  | **P** |
|  |  | What thoughts did you have (e.g., thinking things would be easier if you were no longer alive; wishing you would not wake up in the morning; thinking specifically about killing yourself)? When was the last time you had these thoughts? How often did you have them? How long did they last? What did you do to manage them? | |  |  |  |  |
|  |  |  | |  |  |  |  |
|  |  | * [PASSIVE THOUGHTS OF DEATH – E.G., THINKING THINGS WOULD BE EASIER IF NO LONGER ALIVE; WISHING NOT TO WAKE UP IN THE MORNING] | |  |  |  |  |
|  |  |  | |  |  |  |  |
|  |  | * [SUICIDAL IDEATION – E.G. SPECIFIC THOUGHTS ABOUT KILLING ONESELF] | |  |  |  |  |
|  |  | | |  |  |  |  |
|  | [IF #5 IS CODED A, PROCEED TO SUICIDE RISK SUMMARY] | | |  |  |  |  |
|  |  | | |  |  |  |  |
|  | [PAST SUICIDE PLAN:] | | |  |  |  |  |
|  |  | | |  |  |  |  |
| 6. | **Did you have a plan to kill or harm yourself?** | | |  | **A** |  | **P** |
|  |  | What was your plan? When did you have this plan? Did you make any preparations toward acting on it? | |  |  |  |  |
|  |  | | |  |  |  |  |
|  | [NOTES:] | | | | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | [PAST SUICIDAL INTENT:] | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | |
| 7. | **Did you intend to kill or harm yourself?** | | | | | | |  | **A** | |  | **P** | |
|  |  | | | | | | |  |  | |  |  | |
|  | [PAST SUICIDE ATTEMPTS:] | | | | | | |  |  | |  |  | |
|  |  | | | | | | |  |  | |  |  | |
| 8. | **Have you ever attempted to kill yourself?** | | | | | | |  | **A** | |  | **P** | |
|  |  | Can you tell me what happened? Did you require any medical attention? When did this happen? Has this happened more than once? | | | | | |  |  | |  |  | |
|  |  |  | | | | | |  |  | |  |  | |
|  | [NOTES:] | | | | | | | | | | | | |
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|  |  |  | | | | | |  |  | |  |  | |
|  |  |  | | | | | |  |  | |  |  | |
|  | SUICIDE RISK SUMMARY: | | | | | | |  |  | |  |  | |
|  |  |  | | | | | |  |  | |  |  | |
|  | CURRENT SUICIDALITY: | | | | PAST SUICIDALITY: | | | | | | | | |
|  |  | | | |  | | | | | | | | |
|  | Thoughts of own death | | ❑ A | ❑ P | Thoughts of own death | | ❑ A | | | ❑ P | | | |
|  | Suicidal ideation | | ❑ A | ❑ P | Suicidal ideation | | ❑ A | | | ❑ P | | | |
|  | Suicide plan | | ❑ A | ❑ P | Suicide plan | | ❑ A | | | ❑ P | | | |
|  | Suicidal intent | | ❑ A | ❑ P | Suicidal intent | | ❑ A | | | ❑ P | | | |
|  | Suicide attempt in past year | | ❑ A | ❑ P | Previous suicide attempt | | ❑ A | | | ❑ P | | | |
|  |  | |  |  |  | |  | | |  | | | |
|  | INTERVENTIONS PROVIDED: | |  |  |  | |  | | |  | | | |
|  |  | |  |  |  | |  | | |  | | | |
|  | * Crisis resources provided | | * Safety plan discussed | | | * Imminent action taken (e.g., called 911, went to ER) | | | | | | | |
| * Other | |
|  |  | |  | | | | | | | | | | |
|  | [NOTES:] | | | | | | | | | | | |  |
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| **Self-Harm Behaviour (Current/Past)** | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | |  | |  | | |  | |  | |
|  | [CURRENT SELF-HARM BEHAVIOUR:] | | | | | | | |  | |  | | |  | |  | |
|  |  | | | | | | | |  | |  | | |  | |  | |
| 1. | **Do you currently engage in any self-harm behaviours, such as cutting, scratching, burning, or hitting yourself?** | | | | | | | |  | | **A** | | |  | | **P** | |
|  |  | What behaviours do you do? When was the last time that you hurt yourself? How often do you hurt yourself? What leads you to hurting yourself? Did any of your self-harm behaviours lead to injuries that needed medical attention? Are there any things that keep you from acting on your urges to self-harm (e.g., calling a friend, leaving the situation/environment)? When did this start? Have there been other times in your life when you’ve engaged in self-harm behaviours? | | | | | | |  | |  | | |  | |  | |
|  |  |  | | | | | | |  | |  | | |  | |  | |
|  | [NOTES:] | | | | | | | | | | | | | | | | |
|  |  | | | | | | | |  | |  | | |  | |  | |
|  | [PAST SELF-HARM BEHAVIOUR:] | | | | | | | |  | |  | | |  | |  | |
|  |  | | | | | | | |  | |  | | |  | |  | |
| 2. | [IF #1 IS CODED A, ASK:] **Have you ever done anything to hurt yourself on purpose?** | | | | | | | |  | | **A** | | |  | | **P** | |
|  |  | Cutting, scratching, burning, or hitting yourself? Can you tell me more about this? When did this happen? How often did this happen? Why did you hurt yourself? Did you ever need medical intervention as a result of this? | | | | | | |  | |  | | |  | |  | |
|  |  |  | | | | | | |  | |  | | |  | |  | |
|  | [NOTES:] | | | | | | | | | | | | | | | | |
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|  | SELF-HARM BEHAVIOUR SUMMARY: | | | | | | | |  | |  | | |  | |  | |
|  |  | | | |  | | | | | | | | | | | | |
|  | Self-harm in past month | | ❑ A | ❑ P |  | |  | | | | |  | | | | | |
|  | Self-harm in past 12 months | | ❑ A | ❑ P |  | |  | | | | |  | | | | | |
|  | History of self-harm | | ❑ A | ❑ P |  | |  | | | | |  | | | | | |
|  |  | |  |  |  | |  | | | | |  | | | | | |
|  | INTERVENTIONS PROVIDED: | |  |  |  | |  | | | | |  | | | | | |
|  |  | |  |  |  | |  | | | | |  | | | | | |
|  | * Crisis resources provided | | * Safety plan discussed | | | * Imminent action taken (e.g., called 911, went to ER) | | | | | | | | | | | |
| * Other | |
|  |  | |  | | | | | | | | | | | | | | |
|  | [NOTES:] | | | | | | | | | | | | | | | |  |
|  |  | | | | | | | | | | | | | | | | |
| **Homicide Risk (Current/Past)** | | | | | | | | | | | | | | | | | |
|  |  | | | | | | |  | |  | | |  | |  | | |
|  | [CURRENT HOMICIDAL IDEATION:] | | | | | | |  | |  | | |  | |  | | |
|  |  | | | | | | |  | |  | | |  | |  | | |
| 1. | **Do you currently have thoughts of hurting or killing someone else?** | | | | | | |  | | **A** | | |  | | **P** | | |
|  |  | What thoughts do you have? Do you have a specific person who you plan to harm? Why do you want to harm them? When was the last time you had these thoughts? How often do you have them? How long do they last? How do you manage these thoughts? | | | | | |  | |  | | |  | |  | | |
|  |  |  | | | | | |  | |  | | |  | |  | | |
|  | [IF #1 IS CODED A, PROCEED TO #5 TO QUERY PAST HOMICIDE RISK] | | | | | | |  | |  | | |  | |  | | |
|  |  |  | | | | | |  | |  | | |  | |  | | |
|  | [CURRENT HOMICIDE PLAN:] | | | | | | |  | |  | | |  | |  | | |
|  |  | | | | | | |  | |  | | |  | |  | | |
| 2. | **Have you developed a plan to act on these thoughts?** | | | | | | |  | | **A** | | |  | | **P** | | |
|  |  | Can you describe this plan? How long have you had this plan? Do you have access to what you would need to carry out this plan? Have you made any preparations toward acting on it? | | | | | |  | |  | | |  | |  | | |
|  |  |  | | | | | |  | |  | | |  | |  | | |
|  | [CURRENT HOMICIDAL INTENT:] | | | | | | |  | |  | | |  | |  | | |
|  |  | | | | | | |  | |  | | |  | |  | | |
| 3. | **Do you intend to act on these thoughts?** | | | | | | |  | | **A** | | |  | | **P** | | |
|  |  | On a scale from 0 to 10, where 0 is “*I would never act*” and 10 is “*I am definitely*  *going to act*”, how likely is it that you are going to act on these thoughts today? \_\_\_\_\_\_  What about in the next week? \_\_\_\_\_\_\_\_\_  What about in the next month? \_\_\_\_\_\_\_\_\_ | | | | | |  | |  | | |  | |  | | |
|  |  |  | | | | | |  | |  | | |  | |  | | |
|  | [NOTES:] | | | | | | | | | | | | | | | | |
|  |  |  | | | | | |  | |  | | |  | |  | | |
|  | [PROTECTIVE FACTORS:] | | | | | | | |  | |  | | |  | |  | |
|  |  | | | | | | | |  | |  | | |  | |  | |
| 4. | **What keeps you from acting on these thoughts?** | | | | | | | |  | |  | | |  | |  | |
|  |  |  | | | | | |  | |  | | |  | |  | | |
|  |  | On a scale from 0 to 10, where 0 is “*not at all confident*” and 10 is “*completely confident,*” how confident are you that you can keep yourself from acting on these thoughts or engaging in these behaviours? \_\_\_\_\_\_\_\_\_ | | | | | |  | |  | | |  | |  | | |
|  |  |  | | | | | |  | |  | | |  | |  | | |
|  | [PAST HOMICIDAL IDEATION:] | | | | | | |  | |  | | |  | |  | | |
|  |  | | | | | | |  | |  | | |  | |  | | |
| 5. | **Have you had thoughts of hurting or killing others in the past?** | | | | | | |  | | **A** | | |  | | **P** | | |
|  |  | Please describe these thoughts. When was the last time you had these thoughts? How often did you have them? How long did they last? What did you do to manage them? | | | | | |  | |  | | |  | |  | | |
|  |  | | | | | | |  | |  | | |  | |  | | |
|  | [IF #5 IS CODED A, PROCEED TO HOMICIDE RISK SUMMARY] | | | | | | |  | |  | | |  | |  | | |
|  |  | | | | | | |  | |  | | |  | |  | | |
|  | [PAST HOMICIDE PLAN:] | | | | | | |  | |  | | |  | |  | | |
|  |  | | | | | | |  | |  | | |  | |  | | |
| 6. | **Have you ever had a plan to kill or harm someone else?** | | | | | | |  | | **A** | | |  | | **P** | | |
|  |  | What thoughts did you have? How long have you had you this plan? Did you make any preparations toward acting on it? | | | | | |  | |  | | |  | |  | | |
|  |  |  | | | | | |  | |  | | |  | |  | | |
|  | [PAST HOMICIDAL INTENT:] | | | | | | |  | |  | | |  | |  | | |
|  |  | | | | | | |  | |  | | |  | |  | | |
| 7. | **Have you ever intended to kill or harm someone else?** | | | | | | |  | | **A** | | |  | | **P** | | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | [CURRENT/PAST HOMICIDAL BEHAVIOUR OR ATTEMPT:] | | | | | | |  |  | |  |  | |
|  |  | | | | | | |  |  | |  |  | |
| 8. | **Have you ever engaged in any behaviour to purposely hurt or kill someone else?** | | | | | | |  | **A** | |  | **P** | |
|  |  | Can you tell me what happened? When did this happen? Can you tell me more about this? Has this happened more than once? | | | | | |  |  | |  |  | |
|  |  |  | | | | | |  |  | |  |  | |
|  | [NOTES:] | | | | | | | | | | | | |
|  |  |  | | | | | |  |  | |  |  | |
|  | [ALSO INQUIRE ABOUT: ACCESS TO MEANS, LETHALITY OF PLAN, UNDERSTANDING OF CONSEQUENCES OF ACTIONS, AND ABILITY TO NOT ACT ON THOUGHTS] | | | | | | |  |  | |  |  | |
|  |  | | | | | | |  |  | |  |  | |
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|  |  | | | | | | |  |  | |  |  | |
|  | HOMICIDE RISK SUMMARY: | | | | | | |  |  | |  |  | |
|  |  | | | | | | |  |  | |  |  | |
|  | CURRENT HOMICIDALITY: | | | | PAST HOMICIDALITY: | | | | | | | | |
|  |  | | | |  | | | | | | | | |
|  | Homicidal ideation | | ❑ A | ❑ P | Homicidal ideation | | ❑ A | | | ❑ P | | | |
|  | Homicide plan | | ❑ A | ❑ P | Homicide plan | | ❑ A | | | ❑ P | | | |
|  | Homicidal intent | | ❑ A | ❑ P | Homicidal intent | | ❑ A | | | ❑ P | | | |
|  | Homicide attempt in past 12 months | | ❑ A | ❑ P | Previous homicide attempt | | ❑ A | | | ❑ P | | | |
|  |  | |  |  |  | |  | | |  | | | |
|  |  | |  |  |  | |  | | |  | | | |
|  | INTERVENTIONS PROVIDED: | |  |  |  | |  | | |  | | | |
|  |  | |  |  |  | |  | | |  | | | |
|  | * Crisis resources provided | | * Safety plan discussed | | | * Imminent action taken (e.g., called 911, went to ER) | | | | | | | |
| * Notify authorities | | * Notify person at risk | | |
|  |  | |  | | | | | | | | | | |
|  | [NOTES:] | | | | | | | | | | | |  |
|  |  | | | | | | | | | | | | |

**Hypomanic or Manic Episode**

[THIS MODULE BEGINS WITH GENERAL SCREENING QUESTIONS FOLLOWED BY SPECIFIC SECTIONS ON HYPOMANIC AND MANIC EPISODES. IF A RESPONSE OPTION IS MARKED WITH ⌧, FURTHER QUERY IN THIS MODULE SHOULD BE STOPPED REGARDLESS OF THE SECTION BEING ASSESSED, EXCEPT FOR ITEM #1 IN THE HYPOMANIC EPISODE SECTION, WHICH INCLUDES FURTHER INSTRUCTIONS.]

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1. | **Have you ever experienced abnormal and excessively elevated** **mood** **(e.g., feeling euphoric, very hyper, excitable, or high) that lasted most of the day for several days in a row?** | |  | **A** | **S** | **P** |
|  | Can you tell me more about what this was like for you? Was this more than just very happy mood, for example, feeling on top of the world or that you could do anything? Was your mood so extreme that you were acting very different than normal? Did other people notice or comment that you were not yourself? When did you experience this? How long did this last? Has this happened more than once? |  |
|  |  |  |  |  |  |  |
| 2. | **Have you ever experienced excessively irritable mood that lasted most of the day for several days in a row?** | |  | **A** | **S** | **P** |
|  |  | Can you tell me more about what this was like for you? Were you overly irritable or did you express frustration with people you didn’t know well? Did you overreact to minor annoyances? Did other people notice or comment that you were not yourself? When did you experience this? How long did this last? Has this happened more than once? |  |  |  |  |
|  |  |  |  |  |  |  |
|  | [NOTES:] | | | | | |
|  |  | |  |  |  |  |
|  | [#1 AND/OR #2 IS CODED P] | |  | **A**  ⌧ | **S** | **P** |
|  |  | |  |  |  |  |
| 3. | **Was this elevated or irritable mood associated with an unusual increase in your level of activity or energy that lasted most of the day for several days?** | |  | **A**  ⌧ | **S** | **P** |
|  |  | Can you tell me more about this? Did you begin many new projects including ones that you had little knowledge of how to do? Did you notice that this increased activity occurred at unusual hours for you? Did this cause any problems for you? |  |  |  |  |
|  |  |  |  |  |  |  |
|  | [NOTES:] | | | | | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 4. | | [IF MORE THAN ONE EPISODE, FOCUS ON THE MOST SEVERE EPISODE FOR THE REMAINDER OF MODULE. IF NOT KNOWN, ASK:] | | | | | |  |  |  | |  | |  | |  | |  | |
|  | |  | |  | | | |  |  |  | |  | |  | |  | |  | |
|  | | Considering all of the periods in your life when these symptoms were present, when did the most severe one occur? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  The next set of questions will focus on this period. | | | | | | | | | |  | |  | |  | |  | |
|  |  | | | | | | | | | |  | |  | |  | |  | |
| 5. | [ONLY CHECK IF SYMPTOM IS IDENTIFIED AS EXCESSIVE AND DIFFERENT THAN NORMAL:] | | | | | | | | | |  | |  | |  | |  | |
|  |  | | | | | | | | | |  | |  | |  | |  | |
|  | **During this period of elevated or irritable mood, did you:** | | | | | | | | | |  | |  | |  | |  | |
|  |  | | | | | | | | | |  | |  | |  | |  | |
|  |  | | 1. **Feel special or gifted?** | | | | | | | |  | |  | |  | |  | |
|  |  | | | | | Did you feel you had special talents or could do things that other people couldn’t do? Did you feel really good about yourself or that you could accomplish anything? | | | | | | |  | |  | |  | |
|  |  | |  | | | | | | | |  | |  | |  | |  | |
|  |  | | 1. **Need less sleep and still feel rested?** | | | | | | | |  | |  | |  | |  | |
|  |  | | | | | | How many hours of sleep were you getting? What’s typical for you? | | | |  | |  | |  | |  | |
|  |  | |  | | | | | | | |  | |  | |  | |  | |
|  |  | | 1. **Talk continuously so that it was difficult for people to interrupt you or feel pressured to keep talking?** | | | | | | | |  | |  | |  | |  | |
|  |  | |  | | | | | | | |  | |  | |  | |  | |
|  |  | | 1. **Have racing thoughts or have lots of ideas or thoughts on your mind?** | | | | | | | |  | |  | |  | |  | |
|  |  | | | | | | | | | |  | |  | |  | |  | |
|  |  | | 1. **Get easily distracted, for example, by objects in your environment?** | | | | | | | |  | |  | |  | |  | |
|  |  | | | | | | Did others notice this? How easily were you distracted? Did it result in difficulty maintaining a conversation? | | | | | |  | |  | |  | |
|  |  | | | | | |  | | | |  | |  | |  | |  | |
|  |  | | 1. **Have a dramatic increase in your level of activity (e.g., socially, at work or school, or sexually), or an increase in purposeless physical activity due to agitation or restlessness (e.g., pacing, tapping your feet, starting and stopping tasks)?** | | | | | | | |  | |  | |  | |  | |
|  |  | | | | | | Can you give me some examples? | | | |  | |  | |  | |  | |
|  |  | | | | | |  | | | |  | |  | |  | |  | |
|  |  | | 1. **Engage in a lot of activities that were potentially risky, but that you may not have recognized as risky at the time, such as spending too much money, uncharacteristic sexual activity, or impulsive financial decisions?** | | | | | | | |  | |  | |  | |  | |
|  |  | | | | | | | | | |  | |  | |  | |  | |
|  | [IF #1 IS CODED P (ELEVATED MOOD), AT LEAST THREE #5 ITEMS ARE CHECKED]  [IF #1 IS CODED A OR S, AND #2 IS CODED P (IRRITABLE MOOD),  AT LEAST FOUR #5 ITEMS ARE CHECKED] | | | | | | | | | |  | | **A**  ⌧ | |  | | **P** | |
|  |  | | | | | | | | | |  | |  | |  | |  | |
|  | [NOTES:] | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | |  | |  | |  | |  | |
| 6. | [DURATION AND/OR HOSPITALIZATION] | | | | | | | | | |  | |  | |  | |  | |
|  |  | | | | | | | | | |  | |  | |  | |  | |
|  | ❒ | | | | [DURATION OF EPSIODE LASTED 4-6 DAYS, FOR MOST OF THE DAY] | | | | | |  | |  | |  | |  | |
|  |  | | | | | | | | | |  | |  | |  | |  | |
|  | ❒ | | | | [DURATION OF EPISODE LASTED 7 DAYS OR LONGER, FOR MOST OF THE DAY] | | | | | |  | |  | |  | |  | |
|  |  | | | |  | | | | | |  | |  | |  | |  | |
|  |  | | | | [IF NOT KNOWN, ASK:] How long did this period of elevated or irritable mood last? | | | | | |  | |  | |  | |  | |
|  |  | | | | | | | | | |  | |  | |  | |  | |
| 7. | **Were you hospitalized because of these symptoms?** | | | | | | | | | |  | | **A** | |  | | **P** | |
|  |  | | | | | | | | | |  | |  | |  | |  | |
|  | [IF #7 IS CODED A AND EPISODE LASTED 4-6 DAYS, PROCEED TO HYPOMANIC EPISODE] | | | | | | | | | |  | |  | |  | |  | |
|  |  | | | | | | | | | |  | |  | |  | |  | |
|  | [IF #7 IS CODED P AND/OR EPISODE LASTED 7 DAYS OR LONGER, PROCEED TO MANIC EPISODE] | | | | | | | | | |  | |  | |  | |  | |

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Hypomanic Episode** | | | | | | | | | | | |
|  |  | | | | | |  |  |  |  | |
| 1. | [FOR A HYPOMANIC EPISODE, SYMPTOMS RESULT IN CHANGES IN LEVEL OF FUNCTIONING BUT NOT IN MARKED IMPAIRMENT. IF SYMPTOMS ARESEVERE ENOUGH TO CAUSE SIGNIFICANT INTERFERENCE IN SOCIAL OR OCCUPATIONAL FUNCTIONING, OR REQUIRE HOSPITALIZATION, CODE A AND PROCEED TO MANIC EPISODE. IF NOT KNOWN, ASK:] | | | | | |  | **A**  ⌧ |  | **P** | |
|  |  | | | | | |  |  |  |  | |
|  |  | | During this period, were you acting or behaving very differently than is typical for you? How did this change in your behaviour affect your day to day functioning? | | | |  |  |  |  | |
|  |  | |  | | | |  |  |  |  | |
| 2. | | [CHANGE IN MOOD AND LEVEL OF FUNCTIONING ARE OBSERVABLE BY OTHERS. IF NOT KNOWN ASK:] | | | | |  | **A**  ⌧ |  | | **P** |
|  | |  | | | | |  |  |  | |  |
|  | |  | | Did others notice these symptoms or comment that you were different than usual? | | |  |  |  | |  |
|  | |  | | | | |  |  |  | |  |
| 3. | | [PSYCHOTIC FEATURES ARE NOT PRESENT. IF PRESENT, CODE A AND PROCEED TO MANIC EPISODE.] | | | | |  | **A**  ⌧ |  | | **P** |
|  | |  | | | | |  |  |  | |  |
| 4. | | [THE SYMPTOMS ARE NOT BETTER ACCOUNTED FOR BY SUBSTANCE USE OR A MEDICAL CONDITION. IF A MEDICAL CONDITION IS PRESENT, THE SYMPTOMS ARE EXCESSIVE. IF NOT KNOWN, ASK:] | | | | |  | **A**  ⌧ |  | | **P** |
|  | |  | | | | |  |  | | | |
|  | |  | | Were you using any substances just before these symptoms began? Do you think this may have caused your symptoms or made them worse? [IF ALL SYMPTOMS PERSIST BEYOND THE PHYSIOLOGICAL EFFECT OF THE SUBSTANCE (E.G., ANTIDEPRESSANT MEDICATION), CODE P] | | |  |  |  | |  |
|  | |  | |  | | |  |  |  | |  |
|  | |  | | Did you have any medical conditions just before these symptoms began? Do you think this may have caused your symptoms or made them worse? | | |  |  |  | |  |
|  | |  | | | | |  |  |  | |  |
|  | |  | | | | |  |  |  | |  |
|  | | DIAGNOSTIC IMPRESSION:  LIFETIME HYPOMANIC EPISODE | | | | |  | **A**  ⌧ | **S** | | **P** |
|  | |  | | | | |  |  |  | |  |
|  | |  | | | | |  |  | | | |
|  | |  | | |  | [SPECIFY:] | | | | | |
|  | |  | | |  |  | | | | |  |
|  | | PANIC ATTACKS ARE PRESENT IN THE CONTEXT OF THIS EPISODE | | |  | WITH PANIC ATTACKS | | | | | ❒ |
|  | |  | | |  |  | | | | |  |
|  | | [NOTE: TO ASSESS SYMPTOMS OF A PANIC ATTACK,  SEE PANIC ATTACK SPECIFIER AND PANIC DISORDER MODULE] | | |  |  | | | | |  |
|  | |  | | |  |  | | | | |  |
| 5. | | **How old were you when these symptoms first began?** | | | | |  | \_\_\_\_\_\_\_\_ | | | |
|  | |  | | | | |  |  | | | |
| 6. | | **How old were you when these symptoms began to be a problem for you?** | | | | |  | \_\_\_\_\_\_\_\_ | | | |
|  | |  | | | | |  |  | | | |
| 7. | | **In your life, how many separate episodes, similar to the one that we just discussed, have you experienced that lasted at least 4 days?** | | | | |  | \_\_\_\_\_\_\_\_ | | | |
|  | |  | | | | |  |  | | | |
| 8. | | **On a scale from 0 to 10, 0 meaning not at all and 10 meaning extremely, how much are you bothered by your symptoms?** | | | | |  | \_\_\_\_\_\_\_\_ | | | |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Manic Episode** | | | | | | | | | |
|  |  | | | | |  |  | | |
| 1. | [SYMPTOMS RESULTED IN SEVERE AND MARKED IMPAIRMENT, HOSPITALIZATION, OR PSYCHOTIC FEATURES ARE PRESENT. IF NOT KNOWN, ASK:] | | | | |  | **A**  ⌧ |  | **P** |
|  |  | | | | |  |  |  |  |
|  |  | In what ways did these symptoms interfere? Did these symptoms make it hard for you to work, socialize, go to school, or take care of things at home? | | | |  |  |  |  |
|  |  |  | | | |  |  |  |  |
| 2. | [THE SYMPTOMS ARE NOT BETTER ACCOUNTED FOR BY SUBSTANCE USE OR A MEDICAL CONDITION. IF A MEDICAL CONDITION IS PRESENT, THE SYMPTOMS ARE EXCESSIVE. IF NOT KNOWN, ASK:] | | | | |  | **A**  ⌧ |  | **P** |
|  |  | | | | |  |  |  |  |
|  |  | | Were you using any substances just before these symptoms began? Do you think this may have caused your symptoms or made them worse? | | |  |  |  |  |
|  |  | | [IF *ALL* SYMPTOMS PERSIST BEYOND THE PHYSIOLOGICAL EFFECT OF THE SUBSTANCE (E.G., ANTIDEPRESSANT MEDICATION), CODE P] | | |  |  |  |  |
|  |  | |  | | |  |  |  |  |
|  |  | | Did you have any medical conditions just before these symptoms began? Do you think this may have caused your symptoms or made them worse? | | |  |  |  |  |
|  |  | | | | |  |  |  |  |
|  |  | | | | |  |  |  |  |
|  |  | | | | |  |  | | |
|  | DIAGNOSTIC IMPRESSION:  LIFETIME MANIC EPISODE | | | | |  | **A**  ⌧ | **S** | **P** |
|  |  | | | | |  |  | | |
|  |  | | | | |  | [SPECIFY:] | | |
|  |  | | | | |  |  | | |
|  | PANIC ATTACKS ARE PRESENT IN THE CONTEXT OF THIS EPISODE | | |  | WITH PANIC ATTACKS | | | | ❒ |
|  |  | | |  |  | | | |  |
|  | [NOTE: TO ASSESS SYMPTOMS OF A PANIC ATTACK,  SEE PANIC ATTACK SPECIFIER AND PANIC DISORDER MODULE] | | |  |  | | | |  |
|  |  | | |  |  | | | |  |
|  |  | | | | |  |  | | |
|  |  | | | | |  |  | | |
| 3. | **How old were you when these symptoms first began?** | | | | |  | \_\_\_\_\_\_\_\_ | | |
|  |  | | | | |  |  | | |
| 4. | **How old were you when these symptoms began to be a problem for you?** | | | | |  | \_\_\_\_\_\_\_\_ | | |
|  |  | | | | |  |  | | |
| 5. | **In your life, how many separate episodes, similar to the one that we just discussed, have you experienced that lasted at least 1 week?** | | | | |  | \_\_\_\_\_\_\_\_ | | |
|  |  | | | | |  |  | | |
| 6. | **On a scale from 0 to 10, 0 meaning not at all and 10 meaning extremely, how much are you bothered by your symptoms?** | | | | |  | \_\_\_\_\_\_\_\_ | | |

**Social Anxiety Disorder**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1. | **Do you experience a lot of anxiety or fear in social situations?** | | |  | **A**  ⌧ | **S**  ⌧ | | | **P** |
|  |  | | |  |  | | | | |
| 2. | **What is your biggest concern in social situations?** | | |  |  | | | | |
|  |  | | |  |  | | | | |
|  | [NOTES:] | | | | | | | | |
|  |  | | | | | | | | |
| 3. | [FEAR OF NEGATIVE EVALUATION OR OFFENDING OTHERS IS PRESENT. IF NOT KNOWN, ASK:]Do you fear that you could be negatively judged or evaluated by others, or are you very afraid that you might offend others? | | |  | **A**  ⌧ | **S**  ⌧ | | | **P** |
|  |  | | | | | | | | |
| 4. | **What types of social situations are particularly difficult for you?** | | |  |  | | | | |
|  |  | | |  |  | | | | |
|  |  | | Parties/social gatherings  Participating in meetings/classes  Making small talk/disclosing things about yourself  Talking to people in authority  Meeting new people  Writing/signing your name in public  Being the centre of attention  Talking on the phone or leaving messages  Sending e-mails or text messages  Going on a date/asking someone out  Asking someone a question/being asked questions  Exercising in public/going to the gym  Public speaking  Performing in front of others (e.g., playing an instrument or sport, dancing)  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  | | | | |
|  |  | | |  |  | | | | |
| 5. | **Do you feel anxious almost every time you are in one of these social situations?** | | |  | **A**  ⌧ | **S**  ⌧ | | | **P** |
|  |  | | |  |  |  | | |  |
| 6. | **Do you fear these social situations so much that you try hard to avoid them, or do you experience a lot of anxiety or distress if you have to face them?** | | |  | **A**  ⌧ | **S**  ⌧ | | | **P** |
|  |  | | |  |  | | | | |
| 7. | **Do you fear these social situations more than you should or more than makes sense?** | | |  | **A**  ⌧ | | **S**  ⌧ | **P** | |
|  |  |  | |  |  |  | | |  |
|  |  |  | |  |  |  | | |  |
|  |  | | |  |  | | | | |
| 8. | [THE FEAR, ANXIETY, OR AVOIDANCE HAS PERSISTED, TYPICALLY FOR AT LEAST 6 MONTHS. IF NOT KNOWN, ASK:] | | |  | **A**  ⌧ |  | | | **P** |
|  |  |  | | |  |  | | |  |
|  |  | How long has this been a problem for you? | | |  |  | | |  |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 9. | [CLINICALLY SIGNIFICANT DISTRESS AND/OR IMPAIRMENT IS PRESENT. IF NOT KNOWN, ASK:] | | | | |  | **A**  ⌧ | **S**  ⌧ | | **P** |
|  |  | | | | |  |  |  | |  |
|  |  | Is it very upsetting for you that you have these symptoms? | | | |  |  |  | |  |
|  |  |  | | | |  |  |  | |  |
|  |  | Have the symptoms interfered with your ability to carry out daily activities? In what ways have they interfered? Have they made it hard for you to work, socialize, go to school, or take care of things at home? | | | |  |  |  | |  |
|  |  | | | | |  |  |  | |  |
|  | [NOTES:] | | | | | | | | | |
|  |  | | | | |  |  | | | |
| 10. | [THE SYMPTOMS ARE NOT BETTER ACCOUNTED FOR BY SUBSTANCE USE OR A MEDICAL CONDITION. IF A MEDICAL CONDITION IS PRESENT, THE SYMPTOMS ARE EXCESSIVE. IF NOT KNOWN, ASK:] | | | | |  | **A**  ⌧ |  | **P** | |
|  |  | | | | |  |  | | | |
|  |  | Were you using any substances just before these symptoms began? Do you think this may have caused your symptoms or made them worse? | | | |  |  |  |  | |
|  |  |  | | | |  |  |  |  | |
|  |  | Did you have any medical conditions just before these symptoms began? Do you think this may have caused your symptoms or made them worse? | | | |  |  |  |  | |
|  |  | | | | |  |  |  |  | |
| 11. | [THE SYMPTOMS ARE NOT BETTER ACCOUNTED FOR BY ANOTHER MENTAL DISORDER] | | | | |  | **A**  ⌧ |  | **P** | |
|  |  | | | | |  |  | | | |
|  |  | | | | |  |  | | | |
|  | DIAGNOSTIC IMPRESSION:  SOCIAL ANXIETY DISORDER | | | | |  | **A**⌧ | **S** | | **P** |
|  |  | | | | |  |  | | | |
|  |  | | | | |  | [SPECIFY:] | | | |
|  |  | | | | |  |  | | | |
|  | FEAR IS LIMITED TO SPEAKING OR PERFORMING IN PUBLIC | |  | PERFORMANCE ONLY | | | | | | ❒ |
|  |  | |  |  | | | | | |  |
|  |  | |  |  |  | | [SPECIFY:] | | | |
|  |  | |  |  | | | | | |  |
|  | PANIC ATTACKS ARE PRESENT IN THE CONTEXT OF THIS DISORDER | |  | WITH PANIC ATTACKS | | | | | | ❒ |
|  |  | |  |  | | | | | |  |
|  |  | |  |  | | | | | |  |
|  |  | | | | |  |  | | | |
|  |  | | | | |  |  | | | |
| 11 | **How old were you when these symptoms first began?** | | | | |  | \_\_\_\_\_\_\_\_ | | | |
|  |  | | | | |  |  | | | |
| 12 | **How old were you when these symptoms began to be a problem for you?** | | | | |  | \_\_\_\_\_\_\_\_ | | | |
|  |  | | | | |  |  | | | |
| 13. | **On a scale from 0 to 10, 0 meaning not at all and 10 meaning extremely, how much are you bothered by your symptoms?** | | | | |  | \_\_\_\_\_\_\_\_ | | | |

**Obsessive-Compulsive Disorder**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | [OBSESSIONS:] | | | | | |  | |  | |  | | | | |  | |
|  |  | | | | | |  | |  | |  | | | | |  | |
| 1. | **Do you frequently have repetitive thoughts, urges, or images that are unwanted or intrusive and cause significant anxiety or distress?** | | | | | |  | | **A** | | **S** | | | | | **P** | |
|  |  | Can you give me some examples? Do you experience any of the following: | | | | |  | |  | |  | | | | |  | |
|  |  |  | | | | | | |  | |  | | | | |  | |
|  |  | Doubts about whether you’ve done things properly (e.g., locked door, turned off stove)  Thoughts about being dirty or contaminated (e.g., dirt, germs, chemicals, feces, contracting HIV)  Disturbing thoughts about intentionally or accidently harming yourself or others without wanting to (e.g., stabbing loved one, jumping off balcony, hitting pedestrians)  Unwanted and disturbing thoughts or images of a sexual nature (e.g., fears that you might be a pedophile)  Unwanted and disturbing thoughts or images of a religious nature (e.g., saying blasphemous things, images of the devil, doubts about doing the right/moral thing)?  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |  | |  | | | | |  | |
|  |  |  | | | | |  | |  | |  | | | | |  | |
|  |  | | | | | |  | |  | | | | | | | | |
|  | [IF #1 IS CODED A, SKIP TO #4] | | | | | |  | |  | | | | | | | | |
|  |  | | | | | |  | |  | | | | | | | | |
| 2. | **When you have these thoughts, do you try to ignore or suppress them, or neutralize them by thinking or doing something?** | | | | | |  | | **A** | | | **S** | | **P** | | | |
|  |  | Do you push them out of your mind? Perform a specific action? Think or say something? | | | | |  | |  | | | | | | | | |
|  |  | | | | | |  | |  | | |  | |  | | | |
| 3. | [OBSESSIONS ARE PRESENT, BOTH #1 AND #2 ARE CODED P] | | | | | |  | | **A** | | |  | | **P** | | | |
|  |  | | | | | |  | |  | | |  | |  | | | |
|  | [NOTES:] | | | | | | | | | | | | | | | | |
|  |  | | | | | |  | |  | | |  | |  | | | |
|  |  | | | | | |  | |  | | |  | |  | | | |
|  | [COMPULSIONS:] | | | | | |  | |  | | |  | |  | | | |
|  |  | | | | | |  | |  | | |  | |  | | | |
| 4. | **Do you engage in any repetitive behaviours or mental rituals that you can’t resist doing in response to upsetting thoughts or because of rules that you must follow?** | | | | | |  | | **A** | | | **S** | | **P** | | | |
|  |  | Can you give me some examples? Do you engage in any of the following: | | | | |  | |  | | |  | |  | | | |
|  |  |  | | | | |  | |  | | |  | |  | | | |
|  |  | Wash or clean excessively (e.g., hand washing, rituals around showering, washing dishes or surfaces in your home)  Check things over and over (e.g., locks, stoves, light switches, alarm system)  Do mental acts or behaviours (e.g., repeat words or phrases, counting, prayers, intentionally replace a bad thought with a good thought)  Rigidly follow routines or rules (e.g., morning/nighttime routine, cooking routine, work routine, eating according to a strict ritual)  Order or arrange things (e.g., items on tables/bookshelves, picture frames, items in drawers/cupboards/closets)  Do something repeatedly (e.g., rewriting or rereading materials, repeatedly touching or rubbing items, turning appliances on and off, going in and out of the doorway)?  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |  | |  | | |  | |  | | | |
|  |  |  | | | | |  | |  | | |  | |  | | | |
|  |  | | | | | | | | | | | | | | | | |
|  | [IF #4 IS CODED A, SKIP TO #7] | | | | | | | | | | | | | | | | |
|  |  | | | | | | |  | |  | | |  | |  | | | |
| 5. | **Do you do these behaviours or mental rituals in an attempt to reduce your distress or to prevent something bad from happening?** | | | | | | |  | | **A** | | | **S** | | **P** | | | |
|  |  | | | | | | |  | |  | | | | | | | | |
|  | [NOTES:] | | | | | | | | | | | | | | | | |
|  |  | | | | | | |  | |  | | | | | | | | |
| 6. | [COMPULSIONS ARE PRESENT, BOTH #4 AND #5 ARE CODED P] | | | | | | |  | | **A** | | |  | | **P** | | | |
|  |  | | | | | | |  | |  | | |  | |  | | | |
| 7. | [OBSESSIONS AND/OR COMPULSIONS ARE PRESENT, #3 AND/OR #6 ARE CODED P] | | | | | | |  | | **A**  ⌧ | | |  | | **P** | | | |
|  |  | | | | | | |  | |  | | |  | |  | | | |
| 8a. | **Do these thoughts or behaviours take up a lot of time?** | | | | | | |  | | **A** | | | **S** | | **P** | | | |
|  |  |  | | | | | |  | |  | | |  | |  | | | |
|  |  | How long do they take? Do they take more than one hour per day? | | | | | |  | |  | | |  | |  | | | |
|  |  | | | | | | |  | |  | | |  | |  | | | |
| 8b. | [CLINICALLY SIGNIFICANT DISTRESS AND/OR IMPAIRMENT IS PRESENT. IF NOT KNOWN, ASK:] | | | | | | |  | | **A** | | | **S** | | **P** | | | |
|  |  | | | | | | |  | |  | | |  | |  | | | |
|  |  | | Is it very upsetting for you that you have these symptoms? | | | | |  | |  | | |  | |  | | | |
|  |  | |  | | | | |  | |  | | |  | |  | | | |
|  |  | | Have the symptoms interfered with your ability to carry out daily activities? In what ways have they interfered? Have they made it hard for you to work, socialize, go to school, or take care of things at home? | | | | |  | |  | | |  | |  | | | |
|  |  | |  | | | | |  | |  | | |  | |  | | | |
|  | [AT LEAST ONE #8 ITEM IS CODED P] | | | | | | |  | | **A**  ⌧ | | |  | | **P** | | | |
|  |  | | | | | | |  | |  | | |  | |  | | | |
|  | [NOTES:] | | | | | | | | | | | | | | | | | |
|  |  | | | | | | |  | |  | | |  | |  | | | |
|  |  | | | | | | |  | |  | | |  | |  | | | |
| 9. | [THE SYMPTOMS ARE NOT BETTER ACCOUNTED FOR BY SUBSTANCE USE OR A MEDICAL CONDITION. IF A MEDICAL CONDITION IS PRESENT, THE SYMPTOMS ARE EXCESSIVE. IF NOT KNOWN, ASK:] | | | | | | |  | | **A**  ⌧ | | |  | | **P** | | | |
|  |  | | | | | | |  | |  | | |  | |  | | | |
|  |  | | Were you using any substances just before these symptoms began? Do you think this may have caused your symptoms or made them worse? | | | | |  | |  | | |  | |  | | | |
|  |  | |  | | | | |  | |  | | |  | |  | | | |
|  |  | | Did you have any medical conditions just before these symptoms began? Do you think this may have caused your symptoms or made them worse? | | | | |  | |  | | |  | |  | | | |
|  |  | | | | | | |  | |  | | |  | |  | | | |
| 10. | [THE SYMPTOMS ARE NOT BETTER ACCOUNTED FOR BY ANOTHER MENTAL DISORDER] | | | | | | |  | | **A**  ⌧ | | |  | | **P** | | | |
|  |  | | | | | | |  | |  | | |  | |  | | | |
|  | [NOTES:] | | | | | | | | | | | | | | | | | |
|  |  | | | | | | |  | |  | | |  | |  | | | |
|  |  | | | | | | |  | |  | | | | | | | | | |
|  | DIAGNOSTIC IMPRESSION:  OBSESSIVE-COMPULSIVE DISORDER | | | | | | |  | | **A**⌧ | | | **S** | | **P** | | | | |
|  |  | | | | | | |  | |  | | | | | | | | | |
|  |  | | | | | | |  | | [SPECIFY:] | | | | | | | | | |
|  |  | | | | | | |  | |  | | | | | | | | | |
|  | INDIVIDUAL IS AWARE THAT OCD BELIEFS ARE MOST LIKELY NOT TRUE, OR THAT THEY MAY OR MAY NOT BE TRUE | | | |  | WITH GOOD OR FAIR INSIGHT | | | | | | | | | ❒ | | | | |
|  |  | | | |  |  | | | | | | | | | | |  | | |
|  | INDIVIDUAL THINKS THAT OCD BELIEFS ARE PROBABLY TRUE | | | |  | WITH POOR INSIGHT | | | | | | | | | | | ❒ | | |
|  |  | | | |  |  | | | | | | | | | | |  | | |
|  | INDIVIDUAL HAS FULL CONVICTION THAT OCD BELIEFS ARE TRUE | | | |  | WITH ABSENT INSIGHT/DELUSIONAL | | | | | | | | | | | ❒ | | |
|  |  | | | |  |  | | | | | | | | | | |  | | |
|  | IF DEGREE OF INSIGHT IS NOT KNOWN, ASK: | | | |  |  | | | | | | | | | | |  | | |
|  | How convinced are you that your intrusive, unwanted  thoughts, urges or images are true? | | | |  |  | | | | | | | | | | |  | | |
|  |  | | | | | | |  |  | | | | | | | | | | |
|  |  | | | | | | |  | [SPECIFY:] | | | | | | | | | | |
|  |  | | | | | | |  |  | | | | | | | | | | |
|  | INDIVIDUAL ENDORSED CURRENT OR PAST HISTORY OF TIC DISORDER.  IF NOT KNOWN ASK: | | | |  | TIC-RELATED | | | | | | | | | | | ❒ | | |
|  |  | | | Have you ever been diagnosed with a tic disorder? |  |  | | | | | | | | | | |  | | |
|  |  | | | |  |  | | | | | | | | | | |  | | |
|  |  | | | |  |  | |  | [SPECIFY:] | | | | | | | | | | |
|  |  | | | |  |  | | | | | | | | | | |  | | |
|  | PANIC ATTACKS ARE PRESENT IN THE CONTEXT OF THIS DISORDER | | | |  | WITH PANIC ATTACKS | | | | | | | | | | | ❒ | | |
|  |  | | | |  |  | | | | | | | | | | |  | | |
|  | [NOTE: TO ASSESS SYMPTOMS OF A PANIC ATTACK,  SEE PANIC ATTACK SPECIFIER AND PANIC DISORDER MODULE] | | | |  |  | | | | | | | | | | |  | | |
|  |  | | | |  |  | | | | | | | | | | |  | | |
|  |  | | | | | | |  |  | | | | | | | | | | |
| 11. | **How old were you when these symptoms first began?** | | | | | | |  | \_\_\_\_\_\_\_\_ | | | | | | | | | | |
|  |  | | | | | | |  |  | | | | | | | | | | |
| 12. | **How old were you when these symptoms began to be a problem for you?** | | | | | | |  | \_\_\_\_\_\_\_\_ | | | | | | | | | | |
|  |  | | | | | | |  |  | | | | | | | | | | |
| 13. | **On a scale from 0 to 10, 0 meaning not at all and 10 meaning extremely, how much are you bothered by your symptoms?** | | | | | | |  | \_\_\_\_\_\_\_\_ | | | | | | | | | | |

**Panic Attack Specifier and Panic Disorder**

[THIS MODULE BEGINS WITH QUESTIONS TO IDENTIFY THE PRESENCE OF PANIC ATTACKS. RESPONSES TO #1-#3 ITEMS CAN BE USED TO DETERMINE THE PRESENCE OF A PANIC ATTACK WITHIN THE CONTEXT OF PANIC DISORDER OR THE PANIC ATTACK SPECIFIER. IF PANIC ATTACKS ARE UNEXPECTED, PROCEED WITH COMPLETING THE PANIC DISORDER SECTION. ANY RESPONSE OPTION WITH ⌧ SHOULD RESULT IN STOPPING ALL FURTHER QUERY IN THIS MODULE REGARDLESS OF THE SECTION BEING ASSESSED.]

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Panic Attack** | | | | | | | | | |
| 1. | **Have you ever had a panic attack, where you experienced an abrupt rush of physical symptoms or extreme fear?** | | |  | **A**  ⌧ | | | **S**  ⌧ | **P** |
|  |  | | |  |  | | |  |  |
| 2. | **Do the physical symptoms or extreme fear intensify and reach a peak within minutes?** | | |  | **A**  ⌧ | | | **S**  ⌧ | **P** |
|  |  |  | |  |
|  |  | How long does this take? | |  |
|  |  | | |  |  | | |  |  |
| 3. | **Thinking about your worst panic attack, did you experience:** | | |  |  | | |  |  |
|  |  | | |  |  | | |  |  |
|  |  | **Racing, pounding or skipping of your heart**  **Sweating**  **Trembling or shaking**  **Shortness of breath or difficulty breathing**  **Feeling as though you were choking**  **Chest pain or discomfort**  **Nausea or upset stomach**  **Feeling dizzy, faint, or lightheaded**  **Chills or hot-flushes**  **Numbness or tingling**  **Feeling detached from yourself or feeling as though things around you were unreal or strange**  **Fear of going crazy or losing control**  **Fear of dying** | |  |  | | |  |  |
|  |  | [AT LEAST FOUR #3 ITEMS ARE CHECKED] | |  | **A**  ⌧ | | |  | **P** |
|  |  |  | |  |  | | |  |  |
|  |  |  | |  |  | | |  |  |
|  |  | | |  |  | | | | | |
|  | IMPRESSION:  PANIC ATTACK | | |  | **A**  ⌧ | | **S** | | **P** | |
|  |  | | |  |  | |  | |  | |
| **Panic Disorder** | | | | | | | | | |
| 4. | **Do your panic attacks ever occur unexpectedly, out of the blue, or in situations where you did not expect to have one?** | | |  | **A** | | | **S** | **P** |
|  |  | |  |  |  | | |  |  |
|  |  | | [IF CODED A, QUERY TRIGGER OF PANIC ATTACKS:] What triggers your panic attacks? |  |  | | |  |  |
|  |  | |  |  |  | | |  |  |
|  | [NOTES:] | | | | | | | | | |
|  |  | | |  |  | | |  |  |
| 5. | [PRESENCE OF UNEXPECTED PANIC ATTACKS] | | |  | **A**  ⌧ | | |  | **P** |
|  |  | | |  |  | | |  |  |
| 6. | **Have you had more than one panic attack?** | | |  | **A**  ⌧ | | |  | **P** |
|  |  |  | |  |  |  |
|  |  | How often do they occur? When was your most recent panic attack? When did you first start having panic attacks? | |  |  |  |
|  |  | | |  |  | | |  |  |
| 7. | **In the past month, have you:** | | |  |  | | |  |  |
|  |  |  | | |  | | |  |  |
|  |  | **Worried about having more panic attacks**  **Worried about what the panic attacks mean (e.g., that there is something seriously wrong with you, that you’re going crazy)**  **Worried about the consequences of panic attacks (e.g., losing control of your bowel or bladder, vomiting, or having a heart attack)**  **Changed your behaviour because of the panic attacks (e.g., not leaving the house, ensuring an easy escape, avoiding exercise, more frequent visits to the doctor)** | | |  | | |  |  |
|  |  |  | | | |  | |  |  | |
|  | [AT LEAST ONE #7 ITEM IS CHECKED] | | |  | | **A**  ⌧ | |  | **P** | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 8. | [THE SYMPTOMS ARE NOT BETTER ACCOUNTED FOR BY SUBSTANCE USE OR A MEDICAL CONDITION. IF A MEDICAL CONDITION IS PRESENT, THE SYMPTOMS ARE EXCESSIVE. IF NOT KNOWN, ASK:] | |  | **A**  ⌧ |  | **P** |
|  |  | |  |  | | |
|  |  | Were you using any substances just before these symptoms began? Do you think this may have caused your symptoms or made them worse? |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  | Did you have any medical conditions just before these symptoms began? Do you think this may have caused your symptoms or made them worse? |  |  |  |  |
|  |  | |  |  |  |  |
| 9. | [THE SYMPTOMS ARE NOT BETTER ACCOUNTED FOR BY ANOTHER MENTAL DISORDER] | |  | **A**  ⌧ |  | **P** |
|  |  | |  |  | | |
|  |  | |  |  | | |
|  | DIAGNOSTIC IMPRESSION:  PANIC DISORDER | |  | **A**  ⌧ | **S** | **P** |
|  |  | |  |  |  |  |
|  |  | |  |  | | |
| 10. | **In what ways do these symptoms cause problems for you?** [NOT REQUIRED FOR DIAGNOSIS] | |  |  | | |
|  |  | |  |  | | |
|  | [NOTES:] | | | | | |
|  |  | |  |  | | |
| 11. | **How old were you when these symptoms first began?** | |  | \_\_\_\_\_\_\_\_ | | |
|  |  | |  |  | | |
| 12. | **How old were you when these symptoms began to be a problem for you?** | |  | \_\_\_\_\_\_\_\_ | | |
|  |  | |  |  | | |
| 13. | **On a scale from 0 to 10, 0 meaning not at all and 10 meaning extremely, how much are you bothered by your symptoms?** | |  | \_\_\_\_\_\_\_\_ | | |

**Agoraphobia**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1. | **Do you fear or avoid any situations because you might not be able to escape or get help if you were to have panic, incapacitating, or embarrassing symptoms?** | | | | |  | **A**  ⌧ | | | **S**  ⌧ | **P** | |
|  |  | | Can you tell me more about this fear? What types of situations do you avoid? | | |  |  | | |  |  | |
|  |  | | | | |  |  | | |  |  | |
|  | [NOTES:] | | | | | | | | | | | |
|  |  | | | | |  |  | | |  |  | |
| 2. | **Does this fear come up in any of the following situations:** | | | | |  |  | | | | | |
|  |  | **Using transportation (e.g., cars, buses, trains, planes)**  **Being in open spaces (e.g., parking lots, fields, bridges)**  **Being in enclosed places (e.g., shops, theatres, elevators)**  **Standing in a line or crowd**  **Leaving your home alone** | | | |  |  | | | | | |
|  | [AT LEAST TWO #2 ITEMS ARE CHECKED] | | | | |  | **A**  ⌧ | | |  | **P** | |
|  |  | | | | |  |  | | | | | |
| 3. | **Do these situations almost always cause you fear or anxiety?** | | | | |  | **A**  ⌧ | | | **S**  ⌧ | **P** | |
|  |  | | | | |  |  | | | | | |
|  |  | | | | |  |  | | | | | |
| 4. | **When you are faced with these situations, do you:** | | | | |  |  | | | | | |
|  |  | **Try to avoid them**  **Endure them with a lot of anxiety or distress**  **Need a friend or family member to accompany you** | | | |  |  | | | | | |
|  |  | | | | |  |  | | | | | |
|  | [AT LEAST ONE #4 ITEM IS CHECKED] | | | | |  | **A**  ⌧ | | |  | **P** | |
|  |  | | | | |  |  | | | | | |
|  | [NOTES:] | | | | | | | | | | | |
|  |  | | | | |  |  | | | | | |
| 5. | [THE FEAR OR ANXIETY IS DISPROPORTIONATE TO ACTUAL THREAT POSED BY SITUATION AND TO SOCIOCULTURAL CONTEXT. IF NOT KNOWN, ASK:] | | | | |  | **A**  ⌧ | | | **S**  ⌧ | **P** | |
|  |  | | | | |  |  | | |  |  | |
|  |  | Do you feel as though your fear or anxiety about these situations is more than it should be? What makes you say that? | | | |  |  | | |  |  | |
|  |  | | | | |  |  | | |  |  | |
| 6. | [THE FEAR, ANXIETY, OR AVOIDANCE HAS PERSISTED, TYPICALLY FOR AT LEAST 6 MONTHS. IF NOT KNOWN, ASK:] | | | | |  | **A**  ⌧ | | |  | **P** | |
|  |  | | | | |  |  | | |  |  | |
|  |  | How long has this been a problem for you? | | | |  |  | | |  |  | |
|  |  |  | | | |  |  | | |  |  | |
| 7. | [CLINICALLY SIGNIFICANT DISTRESS AND/OR IMPAIRMENT IS PRESENT. IF NOT KNOWN, ASK:] | | | | |  | **A**  ⌧ | | | **S**  ⌧ | **P** | |
|  |  | | | | |  |  | | |  |  | |
|  |  | Is it very upsetting for you that you have these symptoms? | | | |  |  | | |  |  | |
|  |  |  | | | |  |  | | |  |  | |
|  |  | Have the symptoms interfered with your ability to carry out daily activities? In what ways have they interfered? Have they made it hard for you to work, socialize, go to school, or take care of things at home? | | | |  |  | | |  |  | |
|  |  | | | | |  | |  | |  | |  | |
| 8. | [THE SYMPTOMS ARE NOT BETTER ACCOUNTED FOR BY A MEDICAL CONDITION. IF A MEDICAL CONDITION IS PRESENT, THE SYMPTOMS ARE EXCESSIVE. IF NOT KNOWN, ASK:] | | | | |  | | **A**  ⌧ | |  | | **P** | |
|  |  | | | | |  | |  | | | | | |
|  |  | Did you have any medical conditions just before these symptoms began? Do you think this may have caused your symptoms or made them worse? | | | |  | |  | |  | |  | |
|  |  | | | | |  | |  | |  | |  | |
| 9. | [THE SYMPTOMS ARE NOT BETTER ACCOUNTED FOR BY ANOTHER MENTAL DISORDER] | | | | |  | | **A**  ⌧ | |  | | **P** | |
|  |  | | | | |  | |  | | | | | |
|  | [NOTES:] | | | | | | | | | | | | |
|  |  | | | | |  | |  | | | | | |
|  |  | | | | |  | |  | | | | | |
|  |  | | | | |  | |  | | | | | |
|  | DIAGNOSTIC IMPRESSION:  AGORAPHOBIA | | | | |  | | | **A**  ⌧ | **S** | | **P** | |
|  |  | | | | |  | | |  | | | | |
|  |  | | | | |  | | | [SPECIFY:] | | | | |
|  |  | | | | |  | | |  | | | | |
|  | PANIC ATTACKS ARE PRESENT IN THE CONTEXT OF THIS DISORDER | | |  | WITH PANIC ATTACKS | | | | | | | ❒ | |
|  |  | | |  |  | | | | | | |  | |
|  | [NOTE: TO ASSESS SYMPTOMS OF A PANIC ATTACK,  SEE PANIC ATTACK SPECIFIER AND PANIC DISORDER MODULE] | | |  |  | | | | | | |  | |
|  |  | | |  |  | | | | | | |  | |
|  |  | | | | |  | | |  | | | | |
|  |  | | | | |  | | |  | | | | |
| 10 | **How old were you when these symptoms first began?** | | | | |  | | | \_\_\_\_\_\_\_\_ | | | | |
|  |  | | | | |  | | |  | | | | |
| 11 | **How old were you when these symptoms began to be a problem for you?** | | | | |  | | | \_\_\_\_\_\_\_\_ | | | | |
|  |  | | | | |  | | |  | | | | |
| 12 | **On a scale from 0 to 10, 0 meaning not at all and 10 meaning extremely, how much are you bothered by your symptoms?** | | | | |  | | | \_\_\_\_\_\_\_\_ | | | | |

**Posttraumatic Stress Disorder and Acute Stress Disorder**

[THIS MODULE BEGINS WITH A TRAUMA EXPOSURE SUMMARY AND INCLUDES SECTIONS ON POSTTRAUMATIC STRESS DISORDER AND ACUTE STRESS DISORDER. AFTER COMPLETING THE TRAUMA EXPOSURE SUMMARY, PROCEED TO THE RELEVANT SECTION BASED ON TIME SINCE TRAUMA EXPOSURE. ANY RESPONSE OPTION WITH ⌧ SHOULD RESULT IN STOPPING ALL FURTHER QUERY IN THIS MODULE REGARDLESS OF THE SECTION BEING ASSESSED.]

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1. | **At any point in your life, have you been exposed to a traumatic event, such as sexual or physical assault or abuse, a serious accident, natural disaster, war, or learning about something like this happening to someone that you’re close to?** | | | | |  | **A**  ⌧ | **S**  ⌧ | | **P** | |
|  | |  | | |
|  | | Can you tell me about what happened? | | |
|  |  | |  | | |  |  |  | |  | |
|  | [CODE P ONLY IF TRAUMA INCLUDED ACTUAL OR THREATENED DEATH, SERIOUS INJURY OR SEXUAL VIOLENCE THROUGH DIRECT EXPOSURE, OBSERVING IT OCCUR TO ANOTHER PERSON, LEARNING IT HAS OCCURRED TO A CLOSE FAMILY MEMBER OR FRIEND, OR THROUGH EXTREME OR REPEATED EXPOSURE TO AVERSIVE DETAILS THROUGH A WORK-RELATED ROLE.]   1. **Trauma: Date:** 2. **Trauma: Date:** 3. **Trauma: Date:** 4. **Trauma: Date:** 5. **Trauma: Date:** | | | | | | |  | |  | |
|  | [IF MULTIPLE TRAUMAS ARE REPORTED:]  Of these events, which one is currently causing you the most distress? | | | [MOST DISTRESSING EVENT:]  [#1a] ❒ [#1b] ❒ [#1c] ❒ | | | | | | | |
|  | [IF TRAUMATIC EVENT OCCURRED MORE THAN 1 MONTH AGO, PROCEED TO **POSTTRAUMATIC STRESS** **DISORDER** SECTION.] | | | | | | | | | | |
|  |  | | | | | | | | | | |
|  | [IF TRAUMATIC EVENT OCCURRED WITHIN THE LAST MONTH, PROCEED TO **ACUTE STRESS DISORDER** SECTION.] | | | | | | | | | | |
|  |  | | | | | | | | | | |
| **Posttraumatic Stress Disorder** | | | | | | | | | | | |
|  | | | | | | | | | | | |
|  | [PROCEED WITH QUESTIONS BELOW FOCUSING ON MOST DISTRESSING EVENT.] | | | | | | | | | | |
|  |  | | | | | | | | | | |
| 1. | **Sometimes events like these keep coming back into our minds. Over the past month, have you:** | | | | | | | |  | |  |
|  |  | | | |  | |  | |  | |  |
|  | **Had upsetting memories of [event] when you didn’t want to ?** | | | |  | |  | |  | |  |
|  |  |  | | |  | |  | |  | |  |
|  | **Had upsetting dreams related to [event]?** | | | |  | |  | |  | |  |
|  |  |  | | |  | |  | |  | |  |
|  | **Felt or acted as though [event] was happening again?** | | | |  | |  | |  | |  |
|  |  |  | | |  | |  | |  | |  |
|  | **Become very upset when reminded of [event]?**  What kinds of things remind you of the event? How do you feel when reminded of the event? | | | |  | |  | |  | |  |
|  |  | | | |  | |  | |  | |  |
|  | **Had a physical response when reminded of [event]?**  What kinds of things remind you of the event? How does your body respond when reminded of the event? | | | |  | |  | |  | |  |
|  |  | | | |  | |  | |  | |  |
|  | [AT LEAST ONE #1 ITEM IS CHECKED] | | | |  | | **A**  ⌧ | |  | | **P** |
|  |  | | | |  | |  | |  | |  |
|  | [NOTES:] | | | | | | | | | | |
|  |  | | | |  | |  | |  | |  |
| 2. | **Over the past month, have you:** | | | |  | |  | |  | |  |
|  |  | | | |  | |  | |  | |  |
|  |  | **Avoided or made attempts to avoid upsetting memories, thoughts, or feelings related to [event]**  What have you tried to avoid? How have you tried to avoid those things? | | | | |  | |  | |  |
|  |  |  | | | | |  | |  | |  |
|  |  | **Avoided or tried to avoid people, objects, or situations that reminded you of [event]**  What have you tried to avoid? How have you tried to avoid those things? | | | | |  | |  | |  |
|  |  | | | |  | |  | |  | |  |
|  | [AT LEAST ONE #2 ITEM IS CHECKED] | | | |  | | **A**  ⌧ | |  | | **P** |
|  |  | | | |  | |  | |  | |  |
|  | [NOTES:] | | | | | | | | | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 3. | **These next questions ask you about symptoms that either began or worsened after [event] and that you’ve continued to experience over the past month. Over the past month, have you:** | |  |  | |  |  |
|  |  | |  |  | |  |  |
|  |  | **Been less interested or engaged in a number of activities you used to enjoy?**  What kinds of things have you lost interest in or been less engaged in? | | |  |  |  |
|  |  |  | | |  |  |  |
|  |  | **Felt disconnected from others?** | | |  |  |  |
|  |  |  | | |  |  |  |
|  |  | **Been unable to experience positive emotions**?  Which emotions are hard to feel? | | |  |  |  |
|  |  |  | | |  |  |  |
|  |  | **Had difficulty recalling important parts of [event]?**  Why do you think that you should be able to remember these parts?  [CHECK ONLY IF DIFFICULTY RECALLING IS NOT RELATED TO HEAD INJURY, LOSS OF CONSCIOUSNESS, NORMAL FORGETTING OF NONSALIENT DETAILS, OR SUBSTANCE USE] | | |  |  |  |
|  |  |  | | |  |  |  |
|  |  | **Had persistent strong negative beliefs about yourself, others, or the world?**  What kind of beliefs do you have? | | |  |  |  |
|  |  |  | | |  |  |  |
|  |  | **Blamed yourself or others for the [event] or its consequences?**  [CHECK ONLY IF BLAME IS DISTORTED] | | |  |  |  |
|  |  |  | | |  |  |  |
|  |  | **Persistently experienced negative emotions such as fear, anger, horror, guilt or shame?**  Which emotions do you experience? | | |  |  |  |
|  |  |  | | |  |  |  |
|  | [AT LEAST TWO #3 ITEMS ARE CHECKED] | |  | | **A**  ⌧ |  | **P** |
|  |  | |  | |  |  |  |
|  | [NOTES:] | | | | | | |
|  |  | |  | |  |  |  |
| 4. | **These next questions also ask you about symptoms that either began or worsened after [event] and that you’ve continued to experience over the past month. Over the past month, have you:** | |  | |  |  |  |
|  |  | |  | |  |  |  |
|  |  | **Felt irritable or had angry outbursts even when there wasn’t much to provoke you?**  How do you show your irritability and anger? | | |  |  |  |
|  |  |  |  | |  |  |  |
|  |  | **Done things that were reckless, potentially dangerous, or harmful to you?**  What kind of things have you done? | | |  |  |  |
|  |  |  | | |  |  |  |
|  |  | **Been highly attentive or on guard even when there was no reason to be?** |  | |  |  |  |
|  |  |  |  | |  |  |  |
|  |  | **Been particularly jumpy or easily startled?** |  | |  |  |  |
|  |  | **Had difficulty concentrating?** |  | |  |  |  |
|  |  |  | | |  |  |  |
|  |  | **Had difficulty with sleep, such as falling asleep, staying asleep, waking up early, or getting restful sleep?** | | |  |  |  |
|  |  |  |  | |  |  |  |
|  | [AT LEAST TWO #4 ITEMS ARE CHECKED] | |  | | **A**  ⌧ |  | **P** |
|  |  | |  | |  |  |  |
|  | [NOTES:] | | | | | | |
|  |  | | | | | | |
| 5. | **Did these symptoms that you just told me about begin within 6 months of [event]?** | |  | | **A** |  | **P** |
|  |  | |  | |  |  |  |
|  |  | [IF CODED A, ASK:] When did these symptoms begin? |  | |  |  |  |
|  |  |  |  | |  |  |  |
|  |  | [IF SYMPTOM ONSET IS 6 MONTHS OR LONGER AFTER THE EVENT, NOTE THE DELAYED EXPRESSION SPECIFIER BELOW] |  | |  |  |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 6. | **Have you been experiencing these symptoms consistently for at least the past month?** | | | | | | |  | **A**  ⌧ |  | | **P** |
|  |  | | | | | | |  |  |  | |  |
| 7. | [CLINICALLY SIGNIFICANT DISTRESS AND/OR IMPAIRMENT IS PRESENT. IF NOT KNOWN, ASK:] | | | | | | |  | **A**  ⌧ | **S**  ⌧ | | **P** |
|  |  | | | | | | |  |  |  | |  |
|  |  | Is it very upsetting for you that you have these symptoms? | | | | | |  |  |  | |  |
|  |  |  | | | | | |  |  |  | |  |
|  |  | | Have the symptoms interfered with your ability to carry out daily activities? In what ways have they interfered? Have they made it hard for you to work, socialize, go to school, or take care of things at home? | | | |  | |  | |  |  |
|  |  | |  | | | |  | |  | |  |  |
| 8. | [THE SYMPTOMS ARE NOT BETTER ACCOUNTED FOR BY SUBSTANCE USE OR A MEDICAL CONDITION. IF A MEDICAL CONDITION IS PRESENT, THE SYMPTOMS ARE EXCESSIVE. IF NOT KNOWN, ASK:] | | | | | |  | | **A**  ⌧ | |  | **P** |
|  |  | | | | | |  | |  | | | |
|  |  | | Were you using any substances just before these symptoms began? Do you think this may have caused your symptoms or made them worse? | | | |  | |  | |  |  |
|  |  | |  | | | |  | |  | |  |  |
|  |  | | Did you have any medical conditions just before these symptoms began? Do you think this may have caused your symptoms or made them worse? | | | |  | |  | |  |  |
|  |  | |  | | | |  | |  | |  |  |
|  |  | |  | | | |  | |  | |  |  |
|  |  | | | | | |  | |  | | | |
|  | DIAGNOSTIC IMPRESSION:  POSTTRAUMATIC STRESS DISORDER | | | | | |  | | **A**⌧ | | **S** | **P** |
|  |  | | | | | |  | |  | | | |
|  |  | | | | | |  | | [SPECIFY:] | | | |
|  |  | | | | | |  | |  | | | |
|  | ONSET OF POSTTRAUMATIC STRESS DISORDER IS DELAYED BY 6 MONTHS  OR LONGER FOLLOWING THE EVENT | | |  | WITH DELAYED EXPRESSION | | | | | | | ❒ |
|  |  | | |  |  | | | | | | |  |
|  |  | | |  |  | | | | | | |  |
|  |  | | | | | |  | | [SPECIFY:] | | | |
|  |  | | | | | |  | |  | | | |
|  | PERSISTENT OR RECURRENT EXPERIENCES OF FEELING DETACHED FROM OR OUTSIDE OF ONE’S MIND OR BODY, OR OF UNREALITY OF SURROUNDINGS  IF NOT KNOWN, ASK: | | |  | WITH DISSOCIATIVE SYMPTOMS | | | | | | | ❒ |
|  |  | | |  |  | | | | | | |  |
|  | In response to the trauma and continuing over the past month,  have you often felt detached from or outside of your mind or body?  In response to the trauma and continuing over the past month, have you felt as though things around you are unreal, distant, or distorted,  or as if you are in a dream? | | |  |  | | | | | | |  |
|  |  | | |  |  | | | | | | |  |
|  | [NOTE: DISSOCIATIVE SYMPTOMS MUST NOT BE BETTER ACCOUNTED FOR BY SUBSTANCE USE OR A MEDICAL CONDITION] | | |  |  | | | | | | |  |
|  |  | | |  |  | | | | | | |  |
|  |  | | | |  |  | | | [SPECIFY:] | | | |
|  |  | | | |  | | | | | | |  |
|  | PANIC ATTACKS ARE PRESENT IN THE CONTEXT OF THIS DISORDER | | |  | WITH PANIC ATTACKS | | | | | | | ❒ |
| [NOTE: TO ASSESS SYMPTOMS OF A PANIC ATTACK,  SEE PANIC ATTACK SPECIFIER AND PANIC DISORDER MODULE] | | |
|  |  |  | | | | | | |  |
|  |  | | |  |  | | | | | | |  |
|  |  | | |  |  | | | | | | |  |
|  |  | | |  |  | | | | | | |  |
| 9. | [IF NOT KNOWN, ASK:] How old were you when these symptoms first began? | | | | |  | | | \_\_\_\_\_\_\_\_ | | | |
|  |  | | | | |  | | |  | | | |
| 10. | [IF NOT KNOWN, ASK:] How old were you when these symptoms began to be a problem for you? | | | | |  | | | \_\_\_\_\_\_\_\_ | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| 11. | **On a scale from 0 to 10, 0 meaning not at all and 10 meaning extremely, how much are you bothered by your symptoms?** |  | \_\_\_\_\_\_\_\_ |
|  | | | |

**Generalized Anxiety Disorder**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1. | **Over the past 6 months or longer, have you been excessively anxious and worried about various things?** | | | | | |  | | **A**  ⌧ | **S**  ⌧ | | | **P** |
|  |  | | What sort of things do you worry about? When things are going well, do you still tend to worry a lot? Do people tell you that you worry more than you need to? | | | |  | |  |  | | |  |
|  |  | | | | | |  | |  |  | | |  |
|  | [NOTES:] | | | | | | | | | | | | |
|  |  | | | | | |  | |  |  | | |  |
| 2. | Do you also excessively worry about: | | | | | |  | |  |  | | |  |
|  |  | | | | | |  | |  |  | | |  |
|  |  | | Daily matters  Work or school  Finances  Your health/well-being  Health/well-being of others  Relationships  The future  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |  | |  |  | | |  |
|  |  | | | | | |  | |  |  | | |  |
| 3. | **Has this anxiety and worry been affecting you more days than not over the past 6 months?** | | | | | |  | | **A**  ⌧ |  | | | **P** |
|  |  | | | | | |  | |  |  | | |  |
| 4. | **Do you find it hard to control your worry?** | | | | | |  | | **A**  ⌧ | **S**  ⌧ | | | **P** |
|  |  | | Once you start worrying, are you able to stop? What do you do to try to “turn off” the worry? How effective are these strategies? | | | |  | |
|  |  | | | | | |  | |  |  | | |  |
|  | [NOTES:] | | | | | | | | | | | | |
|  |  | | | | | |  | |  |  | | |  |
| 5. | **Over the past 6 months, when you’ve been excessively anxious and worried, have you:** | | | | | |  | |  |  | | |  |
|  |  | | | | | |  | |  |  | | |  |
|  |  | | **Been restless, keyed up, or on edge** | | | |  | |  |  | | |  |
|  |  | |  | | | |  | |  |  | | |  |
|  |  | | **Been easily fatigued** | | | |  | |  |  | | |  |
|  |  | |  | | | |  | |  |  | | |  |
|  |  | | **Had problems with concentration or having your mind go blank** | | | |  | |  |  | | |  |
|  |  | |  | | | |  | |  |  | | |  |
|  |  | | **Been irritable** | | | |  | |  |  | | |  |
|  |  | |  | | | |  | |  |  | | |  |
|  |  | | **Experienced muscle tension** | | | |  | |  |  | | |  |
|  |  | |  | | | |  | |  |  | | |  |
|  |  | | **Had difficulty with sleep, such as falling asleep, staying asleep, waking up early, or not getting a restful sleep** | | | |  | |  |  | | |  |
|  |  | | | | | |  | |  |  | | |  |
|  | [AT LEAST THREE #5 ITEMS ARE CHECKED] | | | | | |  | | **A**  ⌧ |  | | | **P** |
|  |  | | | | | |  | |  |  | | |  |
| 6. | [CLINICALLY SIGNIFICANT DISTRESS AND/OR IMPAIRMENT IS PRESENT. IF NOT KNOWN, ASK:] | | | | | |  | | **A**  ⌧ | **S**  ⌧ | | | **P** |
|  |  | | | | | |  | |  |  | | |  |
|  |  | | Is it very upsetting for you that you have these symptoms? | | | |  | |  |  | | |  |
|  |  | |  | | | |  | |  |  | | |  |
|  |  | | Have the symptoms interfered with your ability to carry out daily activities? In what ways have they interfered? Have they made it hard for you to work, socialize, go to school, or take care of things at home? | | | |  | |  |  | | |  |
|  |  | |  | | | |  | |  |  | | |  |
|  | [NOTES:] | | | | | | | | | | | | |
|  | |  | | | | | |  |  | |  | |  | |
| 7. | | [THE SYMPTOMS ARE NOT BETTER ACCOUNTED FOR BY SUBSTANCE USE OR A MEDICAL CONDITION. IF A MEDICAL CONDITION IS PRESENT, THE SYMPTOMS ARE EXCESSIVE. IF NOT KNOWN, ASK:] | | | | | |  | **A**  ⌧ | |  | | **P** | |
|  | |  | | | | | |  |  | |  | |  | |
|  | |  | | Were you using any substances just before these symptoms began? Do you think this may have caused your symptoms or made them worse? | | | |  |  | |  | |  | |
|  | |  | |  | | | |  |  | |  | |  | |
|  | |  | | Did you have any medical conditions just before these symptoms began? Do you think this may have caused your symptoms or made them worse? | | | |  |  | |  | |  | |
|  | |  | | | | | |  |  | |  | |  | |
| 8. | | [THE SYMPTOMS ARE NOT BETTER ACCOUNTED FOR BY ANOTHER MENTAL DISORDER] | | | | | |  | **A**  ⌧ | |  | | **P** | |
|  | |  | | | | | |  |  | |  | |  | |
|  | |  | | | | | |  |  | |  | |  | |
|  | |  | | | | | |  |  | | | | | |
|  | | DIAGNOSTIC IMPRESSION:  GENERALIZED ANXIETY DISORDER | | | | | |  | **A**  ⌧ | | | **S** | **P** | |
|  | |  | | | | | |  |  | | | | | |
|  | |  | | | | | |  | [SPECIFY:] | | | | | |
|  | |  | | | | | |  |  | | | | | |
|  | | PANIC ATTACKS ARE PRESENT IN THE CONTEXT OF THIS DISORDER | | |  | WITH PANIC ATTACKS | | | | | | | ❒ | |
|  | |  | | |  |  | | | | | | |  | |
|  | | [NOTE: TO ASSESS SYMPTOMS OF A PANIC ATTACK,  SEE PANIC ATTACK SPECIFIER AND PANIC DISORDER MODULE] | | |  |  | | | | | | |  | |
|  | |  | | |  |  | | | | | | |  | |
|  | |  | | | | | |  |  | | | | | |
|  | |  | | | | | |  |  | | | | | |
| 9. | | **How old were you when these symptoms first began?** | | | | | |  | \_\_\_\_\_\_\_\_ | | | | | |
|  | |  | | | | | |  |  | | | | | |
| 10. | | **How old were you when these symptoms began to be a problem for you?** | | | | | |  | \_\_\_\_\_\_\_\_ | | | | | |
|  | |  | | | | | |  |  | | | | | |
| 11. | | **On a scale from 0 to 10, 0 meaning not at all and 10 meaning extremely, how much are you bothered by your symptoms?** | | | | | |  | \_\_\_\_\_\_\_\_ | | | | | |

**Illness Anxiety Disorder**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 1. | **Are you preoccupied with having or developing a serious illness?** | | |  | **A**  ⌧ | **S**  ⌧ | **P** |
|  | What illness are you concerned about? Are you concerned about any other illnesses? | |  |
|  |  | | |  |  |  |  |
|  | [NOTES:] | | | | | | |
|  |  | | |  |  |  |  |
| 2. | **Do you currently experience any physical symptoms that are related to this concern?** | | |  |  |  |  |
|  | What kind of symptoms are you experiencing (e.g., pain, fatigue, weakness, shortness of breath, dizziness)? Have you been diagnosed with a medical condition that is related to these symptoms? If so, what has your doctor said? Have they ordered more tests or made referrals? | |  |
|  |  |  | |  |  |  |  |
|  | [NO PHYSICAL SYMPTOMS ARE REPORTED OR IF PHYSICAL SYMPTOMS ARE PRESENT, THEY ARE OF MILD INTENSITY OR CORRESPOND TO NORMAL PHYSIOLOGICAL SENSATIONS. IF A MEDICAL CONDITION IS PRESENT, THE CONCERN IS CLEARLY EXCESSIVE.] | | |  | **A**  ⌧ |  | **P** |
|  |  | | |  |  |  |  |
|  | [NOTES:] | | | | | | |
|  |  | | |  |  |  |  |
| 3. | **Do your concerns about your health cause you significant anxiety?** | |  | | **A**  ⌧ | **S** | **P** |
|  | Do other people think that you’re very anxious about your health? What does your doctor think? Do you get anxious when you hear that someone else is sick? |  | |
|  |  |  |  | |  |  |  |
| 4a. | | **Do you repeatedly engage in any behaviours to reduce your anxiety about your health, such as checking your body, seeing your doctor, or reading health-related information?** | |  | | **A** | **S** | **P** |
|  | |  | |  | |  |  |  |
| 4b. | | **Does your anxiety about your health cause you to avoid any situations or activities, such as going to the hospital or doctor or visiting someone who is sick?** | |  | | **A** | **S** | **P** |
|  | |  | |  | |  |  |  |
|  | | [AT LEAST ONE #4 ITEM IS CODED P] | |  | | **A**  ⌧ |  | **P** |
|  | |  | |  | |  |  |  |
|  | | [NOTES:] | | | | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 5. | | [PREOCCUPATION WITH PHYSICAL ILLNESS HAS PERSISTED FOR AT LEAST 6 MONTHS. DOES NOT NEED TO BE THE SAME CONCERN FOR THE ENTIRE DURATION OF 6 MONTHS. IF NOT KNOWN, ASK:] | | | | | |  | | **A**  ⌧ |  | **P** |
|  | |  | | | | | |  | |  |  |  |
|  | |  | How long has this been a problem for you? | | | | |  | |  |  |  |
|  | |  | | | | | |  | |  |  |  |
|  | |  | | | | | |  | |  |  |  |
| 6. | | [THE SYMPTOMS ARE NOT BETTER ACCOUNTED FOR BY ANOTHER MENTAL DISORDER] | | | | | |  | | **A**  ⌧ |  | **P** |
|  | |  | | | | | |  | |  |  |  |
|  | |  | | | | | |  | |  |  |  |
|  | |  | | | | | |  | |  | | |
|  | | DIAGNOSTIC IMPRESSION:  ILLNESS ANXIETY DISORDER | | | | | |  | | **A**⌧ | **S** | **P** |
|  | |  | | | | | |  | |  | | |
|  | |  | | | | | |  | | [SPECIFY:] | | |
|  | |  | | | | | |  | |  | | |
|  | | MEDICAL VISITS, TESTS, AND PROCEDURES ARE OFTEN USED | |  | | CARE-SEEKING TYPE | | | | | | ❒ |
|  | |  | |  | |  | | | | | |  |
|  | | MEDICAL CARE IS RARELY USED | |  | | CARE-AVOIDANT TYPE | | | | | | ❒ |
|  | |  | |  | |  | | | | | |  |
|  | |  | | |  | |  |  | | [SPECIFY:] | | |
|  | |  | | |  | |  | | | | |  |
|  | | PANIC ATTACKS ARE PRESENT IN THE CONTEXT OF THIS DISORDER | | |  | | WITH PANIC ATTACKS | | | | | ❒ |
|  | |  | | |  | |  | | | | |  |
|  | | [NOTE: TO ASSESS SYMPTOMS OF A PANIC ATTACK,  SEE PANIC ATTACK SPECIFIER AND PANIC DISORDER MODULE] | | |  | |  | | | | |  |
|  | |  | | |  | |  | | | | |  |
|  | |  | | |  | |  | | | | |  |
|  | |  | | |  | |  | | | | |  |
| 7. | **How old were you when these symptoms first began?** | | | | | | |  | \_\_\_\_\_\_\_\_ | | |
|  |  | | | | | | |  |  | | |
| 8. | **How old were you when these symptoms began to be a problem for you?** | | | | | | |  | \_\_\_\_\_\_\_\_ | | |
|  |  | | | | | | |  |  | | |
| 9. | **On a scale from 0 to 10, 0 meaning not at all and 10 meaning extremely, how much are you bothered by your symptoms?** | | | | | | |  | \_\_\_\_\_\_\_\_ | | |

**Specific Phobia**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1. | **Almost everyone has things or situations that they are afraid of. However, for this section I would like to know if you have any fears that come up frequently for you and are causing a lot of distress or interference in your life. Are you particularly afraid of any:** | | | | | | | | | | | | | | | | | | | | | | |  | | | | | |
|  |  | | | | | | | | | | | | | | | | | | | |  | | |  | | | | | |
|  |  | | | **Animals or insects** (e.g., dogs, snakes, spiders, mice, sharks)  What is it that you are most concerned about with regard to [phobia]?  **Situations in nature or the environment** (e.g., heights, storms, water)  What is it that you are most concerned about with regard to [phobia]?  **Blood, injections, or injury** (e.g., needles, seeing blood, getting bloodwork)  What is it that you are most concerned about with regard to [phobia]?  **Specific situations** (e.g., airplanes, elevators, enclosed places, driving)  What is it that you are most concerned about with regard to [phobia]?  **Other situations or things** (e.g., choking, vomiting, dental/medical procedures)  What is it that you are most concerned about with regard to [phobia]? | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | [AT LEAST ONE #1 ITEM IS CHECKED] | | | | | | | | | | | | | | | | | | | |  | | | **A**  ⌧ | |  | | **P** | |
|  |  | | | | | | | | | | | | | | | | | | | |  | | |  | |  | |  | |
|  | [FOR EACH FEAR ENDORSED ABOVE, COMPLETE A COLUMN BELOW] | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | |  | [PHOBIA 1:] | | | | | [PHOBIA 2:] | | | | | | | | | | [PHOBIA 3:] | | | | | | | |
|  |  | | | | |  | \_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |
|  |  | | | | |  |  | | | | |  | | | | | | | | | |  | | | | | | | |
| 2. | **Do you almost always experience intense fear or anxiety when you think about, encounter, or are exposed to [phobic object/situation]?** | | | | |  | **A**  ⌧ |  | | **P** | | **A**  ⌧ | | |  | | | **P** | | | | **A**  ⌧ | | | |  | | **P** | |
|  |  | | | | |  |  |  | |  | |  | | |  | | |  | | | |  | | | |  | |  | |
| 3a. | **Do you try to avoid [phobic object/situation] or anything related to [phobic object/situation]?** | | | | |  | **A** |  | | **P** | | **A** | | |  | | | **P** | | | | **A** | | | |  | | **P** | |
|  | | | What kind of things do you avoid? Do you avoid thinking about it or things that remind you of it? | |  |  |  | |  | |  | | |  | | |  | | | |  | | | |  | |  | |
|  |  | | | | |  |  |  | |  | |  | | |  | | |  | | | |  | | | |  | |  | |
| 3b. | **When faced with or thinking about [phobic object/ situation] or things related to [phobic object/situation], do you endure it with a lot of anxiety or distress?** | | | | |  | **A** |  | | **P** | | **A** | | |  | | | **P** | | | | **A** | | | |  | | **P** | |
|  |  | | | | |  |  |  | |  | |  | | |  | | |  | | | |  | | | |  | |  | |
|  | [AT LEAST ONE #3 ITEM IS PRESENT] | | | | |  | **A**  ⌧ |  | | **P** | | **A**  ⌧ | | |  | | | **P** | | | | **A**  ⌧ | | | |  | | **P** | |
|  |  | | | | |  |  | | | | | |  | | | | | | | | | |  | | | | | | | |
|  |  | | | | |  | [PHOBIA 1] | | | | | | | [PHOBIA 2] | | | | | | | | | | | [PHOBIA 3] | | | | | | | |
|  |  | | | | |  |  |  | |  | | | |  | | |  | | |  | | | | |  | |  | |  | | | |
| 4. | [THE FEAR OR ANXIETY IS DISPROPORTIONATE TO ACTUAL THREAT POSED BY PHOBIC OBJECT/SITUATION AND TO SOCIOCULTURAL CONTEXT. IF NOT KNOWN, ASK:] | | | | |  | **A**  ⌧ |  | | **P** | | | | **A**  ⌧ | | |  | | | **P** | | | | | **A**  ⌧ | |  | | **P** | | | |
|  |  | | | | |  |  |  | |  | | | |  | | |  | | |  | | | | |  | |  | |  | | | |
|  |  | | Do you feel as though your fear or anxiety about [phobic object/situation] is more than it should be? What makes you say that? | | |  |  |  | |  | | | |  | | |  | | |  | | | | |  | |  | |  | | | |
|  |  | | | | |  |  |  | |  | | | |  | | |  | | |  | | | | |  | |  | |  | | | |
| 5. | [THE FEAR, ANXIETY, OR AVOIDANCE HAS PERSISTED, TYPICALLY FOR AT LEAST 6 MONTHS. IF NOT KNOWN, ASK:] | | | | |  | **A**  ⌧ |  | | **P** | | | | **A**  ⌧ | | |  | | | **P** | | | | | **A**  ⌧ | |  | | **P** | | | |
|  |  | | | | |  |  |  | |  | | | |  | | |  | | |  | | | | |  | |  | |  | | | |
|  |  | | How long has this been a problem for you? | | |  |  |  | |  | | | |  | | |  | | |  | | | | |  | |  | |  | | | |
|  |  | | | | |  |  | |  |  | | | |  | |  | | |  | | | | | |  | |  | |  | | |
| 6. | [CLINICALLY SIGNIFICANT DISTRESS AND/OR IMPAIRMENT IS PRESENT. IF NOT KNOWN, ASK:] | | | | |  | **A**  ⌧ | | **S**  ⌧ | **P** | | | | **A**  ⌧ | | **S**  ⌧ | | | **P** | | | | | | **A**  ⌧ | | **S**  ⌧ | | **P** | | |
|  |  | | | | |  |  | |  |  | | | |  | |  | | |  | | | | | |  | |  | |  | | |
|  |  | | | Is it very upsetting for you that you have these symptoms | |  |  | |  |  | | | |  | |  | | |  | | | | | |  | |  | |  | | |
|  |  | | |  | |  |  | |  |  | | | |  | |  | | |  | | | | | |  | |  | |  | | |
|  |  | | | Have the symptoms interfered with your ability to carry out daily activities? In what ways have they interfered? Have they made it hard for you to work, socialize, go to school, or take care of things at home? | |  |  | |  |  | | | |  | |  | | |  | | | | | |  | |  | |  | | |
|  |  | | | | |  |  | |  | |  | | |  | |  | | |  | | | | | |  | |  | |  | | | | |
| 7. | [THE SYMPTOMS ARE NOT BETTER ACCOUNTED FOR BY SUBSTANCE USE OR A MEDICAL CONDITION. IF A MEDICAL CONDITION IS PRESENT, THE SYMPTOMS ARE EXCESSIVE. IF NOT KNOWN, ASK:] | | | | |  | **A**  ⌧ | |  | | **P** | | | **A**  ⌧ | |  | | | **P** | | | | | | **A**  ⌧ | |  | | **P** | | | | |
|  |  | | | | |  |  | |  | |  | | |  | |  | | |  | | | | | |  | |  | |  | | | | |
|  |  | Were you using any substances just before these symptoms began? Do you think this may have caused your symptoms or made them worse? | | | |  |  | |  | |  | | |  | |  | | |  | | | | | |  | |  | |  | | | | |
|  |  | | | | |  |  | |  | |  | | |  | |  | | |  | | | | | |  | |  | |  | | | | |
|  |  | Did you have any medical conditions just before these symptoms began? Do you think this may have caused your symptoms or made them worse? | | | |  |  | |  | |  | | |  | |  | | |  | | | | | |  | |  | |  | | | | |
|  |  | | | | |  |  | |  | |  | | |  | |  | | |  | | | | | |  | |  | |  | | | | |
| 8. | [THE SYMPTOMS ARE NOT BETTER ACCOUNTED FOR BY ANOTHER MENTAL DISORDER] | | | | |  | **A**  ⌧ | |  | | **P** | | | **A**  ⌧ | |  | | | **P** | | | | | | **A**  ⌧ | |  | | **P** | | | | |
|  |  | | | | |  |  | |  | |  | | |  | |  | | |  | | | | | |  | |  | |  | | | | |
|  |  | | | | |  |  | |  | |  | | |  | |  | | |  | | | | | |  | |  | |  | | | | |
|  |  | | | | |  |  | |  | |  | | |  | |  | | |  | | | | | |  | |  | |  | | | | |
|  |  | | | | |  | [PHOBIA 1:] | | | | | | | [PHOBIA 2:] | | | | | | | | | | | [PHOBIA 3:] | | | | | | | | |
|  |  | | | | |  | \_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
|  | DIAGNOSTIC IMPRESSION:  SPECIFIC PHOBIA | | | | |  | **A**  ⌧ | | **S** | | **P** | | | **A**  ⌧ | | **S** | | | **P** | | | | | | **A**  ⌧ | | **S** | | **P** | | | | |
|  |  | | | | |  |  | |  | |  | | |  | |  | | |  | | | | | |  | |  | |  | | | | |
|  | [SPECIFY:] | | | | |  |  | |  | |  | | |  | |  | | |  | | | | | |  | |  | |  | | | | |
|  |  | | | | |  |  | |  | |  | | |  | |  | | |  | | | | | |  | |  | |  | | | | |
|  | ANIMAL | | | | |  |  | |  | | ❒ | | |  | |  | | | ❒ | | | | | |  | |  | | ❒ | | | | |
|  | NATURAL ENVIRONMENT | | | | |  |  | |  | | ❒ | | |  | |  | | | ❒ | | | | | |  | |  | | ❒ | | | | |
|  | BLOOD-INJECTION-INJURY | | | | |  |  | |  | | ❒ | | |  | |  | | | ❒ | | | | | |  | |  | | ❒ | | | | |
|  | SITUATIONAL | | | | |  |  | |  | | ❒ | | |  | |  | | | ❒ | | | | | |  | |  | | ❒ | | | | |
|  | OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |  |  | |  | | ❒ | | |  | |  | | | ❒ | | | | | |  | |  | | ❒ | | | | |
|  |  | | | | |  |  | |  | |  | | |  | |  | | |  | | | | | |  | |  | |  | | | | |
|  |  | | | | |  | [PHOBIA 1] | | | | | | | [PHOBIA 2] | | | | | | | | | | | [PHOBIA 3] | | | | | | | | |
|  | [SPECIFY:] | | | | |  |  | |  | |  | | |  | |  | | |  | | | | | |  | |  | |  | | | | |
|  |  | | | | |  |  | |  | |  | | |  | |  | | |  | | | | | |  | |  | |  | | | | |
| PANIC ATTACKS ARE PRESENT IN THE CONTEXT OF THIS DISORDER | | | | | WITH PANIC ATTACKS |  |  | |  | | ❒ | | |  | |  | | | ❒ | | | | | |  | |  | | ❒ | | | | |
|  |  | | | | |  |  | |  | |  | | |  | |  | | |  | | | | | |  | |  | |  | | | | |
| [NOTE: TO ASSESS SYMPTOMS OF A PANIC ATTACK,  SEE PANIC ATTACK SPECIFIER AND PANIC DISORDER MODULE] | | | | |  |  |  | |  | |  | | |  | |  | | |  | | | | | |  | |  | |  | | | | |
|  |  | | | | |  |  | |  | |  | | |  | |  | | |  | | | | | |  | |  | |  | | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |
| 9. | **How old were you when these symptoms first began?** |  | \_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |  |  |
| 10. | **How old were you when these symptoms began to be a problem for you?** |  | \_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |  |  |
| 11. | **On a scale from 0 to 10, 0 meaning not at all and 10 meaning extremely, how much are you bothered by your symptoms?** |  | \_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Alcohol Use Disorder (Current/Early Remission)**

[THIS MODULE ASSESSES SYMPTOMS OF ALCOHOL USE DISORDER IN THE PAST 12 MONTHS. USE THE CHART BELOW TO CREATE A TIMELINE FOR THE PAST 12 MONTHS. CORRESPONDING DATES AND SIGNIFICANT EVENTS MAY BE NOTED BELOW TO PROVIDE ANCHORS TO AID MEMORY RECALL.]

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | [PAST YEAR] | | | | [CURRENT] | | | |  |
|  |  |  | |  | |  |  | | |  |
| Date: |  |  |  |  |  |  | |  |  |  |
|  | [12 MONTHS AGO] | |  |  | [3 MONTHS AGO] | | |  | [TODAY] | |
|  |  | |  |  |  | | |  |  | |
| Events: |  | |  |  |  | | |  |  | |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | |  | [CURRENT  0-3m ago:] | | | [PAST YEAR  4-12m ago:] | | |
|  |  | |  |  |  |  |  |  |  |
| 1. | [CURRENT:] **In the past 3 months, have you consumed any alcohol?** | |  | **A**  ⌧ |  | **P** |  |  |  |
|  |  | When was the last time you drank alcohol? How many days in a typical week do you drink alcohol? How many drinks do you usually have on a single occasion? What types of alcoholic drinks are you having? When did you start using alcohol in this way? |  |  |  |  |  |  |  |
|  |  | |  |  |  |  |  |  |  |
| 2. | [IF NO CURRENT USE:] **In the past 12 months, have you consumed any alcohol?** | |  |  |  |  | **A**  ⌧ |  | **P** |
|  |  | When was your period of heaviest use in the past year? How many days in a typical week did you drink alcohol at that time? How many drinks did you usually have on a single occasion? What types of alcoholic drinks were you having? When did this pattern start? When did this period of use end? |  |  |  |  |  |  |  |
|  |  | |  |  |  |  |  |  |  |
|  | [NOTES:] | | | | | | | | |
|  |  | |  |  |  |  |  |  |  |
| 3. | **Has your alcohol use bothered you or caused you problems?** | |  | **A** | **S** | **P** | **A** | **S** | **P** |
|  |  | |  |  |  |  |  |  |  |
|  | [NOTES:] | | | | | | | | |
|  |  | |  |  |  |  |  |  |  |
| 4. | [#3 IS CODED P AND/OR ALCOHOL USE IS DEEMED CLINICALLY CONCERNING] | |  | **A**  ⌧ |  | **P** | **A**  ⌧ |  | **P** |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | |  | | | | |  | | [CURRENT  0-3m ago:] | | | | | | [PAST YEAR  4-12m ago:] | | | | | | | | | |
|  | | |  | | | | |  | |  | |  | |  | |  | |  | | | | |  | | |
| 5. | | | **During this period of problematic alcohol use:** | | | | |  | |  | |  | |  | |  | |  | | | | |  | | |
|  | | |  | | | | |  | |  | |  | |  | |  | |  | | | | |  | | |
|  | | | 5a. **On days that you drank alcohol, did you drink a lot more than you planned to or for longer than you intended?** | | | | |  | |  | |  | |  | |  | |  | | | | |  | | |
|  | | |  | | | | |  | |  | |  | |  | |  | |  | | | | |  | | |
|  | | | 5b. **Did you want to, or repeatedly try to, cut down or stop drinking alcohol but were unable to?** | | | | |  | |  | |  | |  | |  | |  | | | | |  | | |
|  | | |  | | | | |  | |  | |  | |  | |  | |  | | | | |  | | |
|  | | | 5c. **Did you spend a lot of time trying to get alcohol, drinking, or recovering from your alcohol use?** | | | | |  | |  | |  | |  | |  | |  | | | | |  | | |
|  | | |  | | On average, how many hours of your day (or week)? | | |  | |  | |  | |  | |  | |  | | | | |  | | |
|  | | |  | | | | |  | |  | |  | |  | |  | |  | | | | |  | | |
|  | | | 5d. **Did you experience strong urges or cravings to drink?** | | | | |  | |  | |  | |  | |  | |  | | | | |  | | |
|  | | |  | | | | |  | |  | |  | |  | |  | |  | | | | |  | | |
|  | | | 5e. **Did your drinking repeatedly interfere with your duties at work, school, or home?** | | | | |  | |  | |  | |  | |  | |  | | | | |  | | |
|  | | |  | | | If you hadn’t been drinking, would things have turned out differently? | |  | |  | |  | |  | |  | |  | | | | |  | | |
|  | | |  | | | | |  | |  | |  | |  | |  | |  | | | | |  | | |
|  | | | 5f. **Did your drinking repeatedly cause you problems in social situations or in your relationships with other people?** | | | | |  | |  | |  | |  | |  | |  | | | | |  | | |
|  | | |  | | [IF YES:] Did you continue to drink despite these problems? [CHECK ONLY IF USE CONTINUED DESPITE PROBLEMS] | | |  | |  | |  | |  | |  | |  | | | | |  | | |
|  | | |  | | | | |  | |  | |  | |  | |  | |  | | | | |  | | |
|  | | | 5g. **Did you reduce or give up any of your usual activities because of your drinking?** | | | | |  | |  | |  | |  | |  | |  | | | | |  | | |
|  | | |  | | Spending less time on hobbies because of drinking? Spending less time with family or friends because of drinking? | | |  | |  | |  | |  | |  | |  | | | | |  | | |
|  | | |  | |  | | |  | |  | |  | |  | |  | |  | | | | |  | | |
|  | | | 5h. **Did you drink alcohol in situations that could have been dangerous or in which you could have been harmed?** | | | | |  | |  | |  | |  | |  | |  | | | | |  | | |
|  | | |  | | Have you driven while intoxicated or not been able to remember how you got home? Engaged in risky behaviours, such as swimming or using machinery while intoxicated? | | |  | |  | |  | |  | |  | |  | | | | |  | | |
|  | | |  | |  | | |  | |  | |  | |  | |  | |  | | | | |  | | |
|  | | | 5i. **Did your drinking repeatedly cause or worsen any medical or mental health problems?** | | | | |  | |  | |  | |  | |  | |  | | | | |  | | |
|  | | |  | | [IF YES:] Did you continue to drink despite these problems? [CHECK ONLY IF USE CONTINUED DESPITE PROBLEMS] | | |  | |  | |  | |  | |  | |  | | | | |  | | |
|  | | |  | |  | | |  | |  | |  | |  | |  | |  | | | | |  | | |
|  | | | 5j. [TOLERANCE]: **Did you need to drink greater amounts of alcohol to get the same effect as before, or did you get less of an effect when using the same amount of alcohol?** | | | | |  | |  | |  | |  | |  | |  | | | | |  | | |
|  | | |  | |  | | |  | |  | |  | |  | |  | |  | | | | |  | | |
|  | | |  | | | | |  | | [CURRENT  0-3m ago:] | | | | | | [PAST YEAR  4-12m ago:] | | | | | | | | | |
|  | | |  | | | | |  | |  | |  | |  | |  | |  | | | | |  | | |
|  | | | 5k. [WITHDRAWAL]: **When you’ve reduced or stopped drinking, did you experience any withdrawal symptoms** [AT LEAST TWO SYMPTOMS BELOW ARE NEEDED]**, or use alcohol or a similar substance to reduce or prevent withdrawal symptoms?** | | | | |  | |  | |  | |  | |  | |  | | | | |  | | |
|  | | |  | | | | |  | |  | |  | |  | |  | |  | | | | |  | | |
|  | | |  | | * Sweating, or increased heart rate * Shaky hands * Difficulty sleeping * Nausea or vomiting * Seeing or hearing things that others didn’t perceive, or experiencing strange physical sensations * Agitation or restlessness * Anxiety * Seizures | | |  | |  | |  | |  | |  | |  | | | | |  | | |
|  | | |  | | | | |  | |  | |  | |  | |  | |  | | | | |  | | |
|  | | |  | | | | |  | |  | |  | |  | |  | |  | | | | |  | | |
|  | | | [AT LEAST TWO #5 ITEMS RELATED TO CURRENT USE ARE CHECKED] | | | | |  | | **A**  ⌧ | |  | | **P** | |  | |  | | |  | | |
|  | |  | | | | | |  | | |  | | | | | |  | | | | | | | | |
| 6. | | | [AT LEAST TWO #5 ITEMS RELATED TO USE in the past year ARE CHECKED] | | | | |  | |  | |  | |  | | | **A**  ⌧ | |  | | | | **P** | | |
|  | | |  | | | | |  | |  | |  | |  | | |  | |  | | | |  | | |
|  | |  | | | | | |  | | |  | |  | |  | |  | |  | | | |  | | |
| 7. | | [FOR PAST YEAR USE ONLY: NONE OF THE SYMPTOMS OF ALCOHOL USE DISORDER HAVE BEEN PRESENT IN THE PAST THREE MONTHS (CRAVINGS MAY STILL BE PRESENT). IF NOT KNOWN ASK:] | | | | | |  | | |  | |  | |  | | **A** | |  | | | | **P** | | |
|  | |  | | | | | |  | | |  | |  | |  | |  | |  | | | |  | | |
|  | |  | | | Have you engaged in problematic alcohol use or had any of the symptoms we just discussed in the past three months? Can you describe in what ways the symptoms have been problematic or which symptoms you’ve had in the past three months? | | |  | | |  | |  | |  | |  | |  | | | |  | | |
|  | |  | | | | | |  | | |  | |  | |  | |  | |  | | | |  | | |
|  | | [NOTES:] | | | | | | | | | | | | | | | | | | | | | | | | |
|  | |  | | | | | |  | | |  | |  | |  | |  | |  | | | |  | | |
|  | |  | | | | | |  | | | | | | | |  | |  | | |  | | | | | |
|  | | DIAGNOSTIC IMPRESSION:  ALCOHOL USE DISORDER | | | | | |  | | | | | | | | **A**  ⌧ | | **S** | | | **P** | | | | | |
|  | |  | | | | | |  | | | | | | | |  | |  | | |  | | | | | |
|  | |  | | | | | |  | | | [SPECIFY:] | | | | | | | | | | | | | | | |
|  | |  | | | | | |  | | |  | | | | | | | | | | | | | | | |
|  | | #7 IS CODED P [NO SYMPTOMS PRESENT IN THE PAST 3 MONTHS] | | | | | |  | | | IN EARLY REMISSION | | | | | | | | | ❒ | | | | | | |
|  | |  | | | | | |  | | |  | | | | | | | | |  | | | | | | |
|  | |  | | | | | |  | | | [SPECIFY:] | | | | | | | | | | | | | | | |
|  | |  | | | | | |  | | |  | | | | | | | | | | | | | | | |
|  | | ALCOHOL IS NOT USED DUE TO BEING IN A CONTROLLED ENVIRONMENT  (E.G., CARE FACILITY, PRISON)  TO BE USED AS AN ADDITIONAL SPECIFIER OF REMISSION) | | | | | |  | | | IN A CONTROLLED ENVIRONMENT | | | | | | | | | ❒ | | | | | | |
|  | |  | | | | | |  | | |  | | | | | | | | |  | | | | | | |
|  | |  | | | | | |  | | | [SPECIFY:] | | | | | | | | | | | | | | | |
|  | |  | | | | | |  | | |  | | | | | | | | | | | | | | | |
|  | | TWO-THREE #5 ITEMS ARE CODED P | | | | | |  | | | MILD | | | | | | | | |  | | | | | | |
|  | |  | | | | | |  | | |  | | | | | | | | |  | | | | | | |
|  | | FOUR-FIVE #5 ITEMS ARE CODED P | | | | | |  | | | MODERATE | | | | | | | | |  | | | | | | |
|  | |  | | | | | |  | | |  | | | | | | | | |  | | | | | | |
|  | | *≥* SIX #5 ITEMS ARE CODED P | | | | | |  | | | SEVERE | | | | | | | | |  | | | | | | |
|  | |  | | | | | |  | | |  | | | | | | | | | | | | | | | |
|  | |  | | | | | |  | | | [SPECIFY:] | | | | | | | | | | | | | | | |
|  | |  | | | | | |  | | |  | | | | | | | | | | | | | | | |
|  | | PANIC ATTACKS ARE PRESENT IN THE CONTEXT OF THIS DISORDER | | | | | |  | | | WITH PANIC ATTACKS | | | | | | | | | ❒ | | | | | | |
|  | |  | | | | | |
|  | | [NOTE: TO ASSESS SYMPTOMS OF A PANIC ATTACK,  SEE PANIC ATTACK SPECIFIER AND PANIC DISORDER MODULE] | | | | | |
|  | |  | | | | | |  | | |  | | | | | | | | |  | | | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| 8. | **How old were you when these symptoms first began?** |  | \_\_\_\_\_\_\_\_ |
|  |  |  |  |
| 9. | **How old were you when these symptoms began to be a problem for you?** |  | \_\_\_\_\_\_\_\_ |
|  |  |  |  |
| 10. | **On a scale from 0 to 10, 0 meaning not at all and 10 meaning extremely, how much are you bothered by your symptoms?** |  | \_\_\_\_\_\_\_\_ |

**Substance Use Disorder (Current/In Early Remission)**

[THIS MODULE ASSESSES SYMPTOMS OF SUBSTANCE USE DISORDER IN THE PAST 12 MONTHS. USE CHART BELOW TO CREATE TIMELINE FOR THE PAST 12 MONTHS. CORRESPONDING DATES AND SIGNIFICANT EVENTS SHOULD BE NOTED BELOW TO PROVIDE ANCHORS TO AID MEMORY RECALL.]

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | [PAST YEAR] | | | | [CURRENT] | | |  |
|  |  |  | | | |  | | |  |
| Date: |  | | | | | | | | |
|  | [12 MONTHS AGO] | |  |  | [3 MONTHS AGO] | |  | [TODAY] | |
|  |  | |  |  |  | |  |  | |
| Events: |  | |  |  |  | |  |  | |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | |  | [CURRENT  0-3m ago:] | | | [PAST YEAR  4-12m ago:] | | |
|  |  | |  |  |  |  |  |  |  |
| 1. | [CURRENT:] **Have you used recreational drugs or medications to get high or to change how you were feeling in the in the past 3 months?** | |  | **A**  ⌧ |  | **P** |  |  |  |
|  |  | |  |  |  |  |  |  |  |
|  |  | [IF CODING P, QUERY WHICH SUBSTANCES WERE USED AND DATE RANGE OF LAST USE USING THE CHART]: Which substances have you used? When was the last time you used [substance]? How many times in a typical week did you use [substance]? When did you start using [substance]? |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  | |  |  |  |  |  |  |  |
| 2. | [IF NO CURRENT USE:] **Have you used recreational drugs or medications to get high or to change how you were feeling in the past 12 months?** | |  |  |  |  | **A**  ⌧ |  | **P** |
|  |  | |  |  |  |  |  |  |  |
|  |  | [IF CODING P, QUERY WHICH SUBSTANCES WERE USED AND DATE RANGE OF LAST USE USING THE CHART]: When was the period of heaviest use in the past year? Which substances did you use? How many times in a typical week do you use [substance]? When did you start using [substance]? How long did this period of use last? |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  | [**CANNABIS** – E.G., POT/HERB/WEED/GRASS/GANJA, THC, HASHISH/RESIN, HASH OIL]   * [CURRENT:] Frequency: \_\_\_\_\_\_ x per day/week/month/year Date range of use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * [PAST YEAR:] Frequency: \_\_\_\_\_\_ x per day/week/month/year Date range of use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   [**SEDATIVE, HYPNOTIC, OR ANXIOLYTIC** – E.G., PRESCRIPTION SLEEPING MEDICATIONS AND PRESCRIPTION ANTIANXIETY MEDICATIONS, SUCH AS BENZODIAZEPINES, BENZODIAZEPINE-LIKE DRUGS (E.G., ZOLPIDEM, ZALEPLON), CARBAMATES (E.G., GLUTETHIMIDE, MEPROBAMATE), BARBITURATES (E.G., SECOBARBITAL), AND BARBITURATE-LIKE HYPNOTICS (E.G., GLUTETHIMIDE, METHAQUALONE)]   * [CURRENT:] Frequency: \_\_\_\_\_\_ x per day/week/month/year Date range of use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * [PAST YEAR:] Frequency: \_\_\_\_\_\_ x per day/week/month/year Date range of use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |

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|  | [**OPIOID** – E.G., MORPHINE, HEROIN, OPIUM, CODEINE, DILAUDID, OXYCODONE, FENTANYL, HYDROMORPHONE]   * [CURRENT:] Frequency: \_\_\_\_\_\_ x per day/week/month/year Date range of use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * [PAST YEAR:] Frequency: \_\_\_\_\_\_ x per day/week/month/year Date range of use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   [**STIMULANT** – E.G., COCAINE, AMPHETAMINES, RITALIN, DEXEDRINE, METH/SPEED/CHALK, ICE/CRYSTAL/CRANK]   * [CURRENT:] Frequency: \_\_\_\_\_\_ x per day/week/month/year Date range of use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * [PAST YEAR:] Frequency: \_\_\_\_\_\_ x per day/week/month/year Date range of use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   [**HALLUCINOGEN—PHENCYCLIDINE** – E.G., PCP/ANGEL DUST/ROCKET FUEL, KETAMINE]   * [CURRENT:] Frequency: \_\_\_\_\_\_ x per day/week/month/year Date range of use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * [PAST YEAR:] Frequency: \_\_\_\_\_\_ x per day/week/month/year Date range of use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   [**HALLUCINOGEN—**OTHER – E.G., LSD/ACID, PSILOCYBIN, MESCALINE, DOM, MDMA/ECSTASY/MOLLY, DMT, SALVIA, MORNING GLORY SEEDS]  [SPECIFY HALLUCINOGEN:] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   * [CURRENT:] Frequency: \_\_\_\_\_\_ x per day/week/month/year Date range of use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * [PAST YEAR:] Frequency: \_\_\_\_\_\_ x per day/week/month/year Date range of use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   [**INHALANT** – E.G., GLUE, FUEL, PAINT, TOLUENE/SOLVENT]   * [CURRENT:] Frequency: \_\_\_\_\_\_ x per day/week/month/year Date range of use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * [PAST YEAR:] Frequency: \_\_\_\_\_\_ x per day/week/month/year Date range of use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   [**CAFFEINE** – E.G., COFFEE, TEA, CAFFEINATED SODA, ENERGY AIDS, OVER-THE-COUNTER ANALGESICS AND COLD REMEDIES, WEIGHT LOSS AIDS, CHOCOLATE]   * [CURRENT:] Frequency: \_\_\_\_\_\_ x per day/week/month/year Date range of use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * [PAST YEAR:] Frequency: \_\_\_\_\_\_ x per day/week/month/year Date range of use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   [**TOBACCO** – E.G., CIGARETTES, CHEWING TOBACCO, SMOKELESS TOBACCO/E-CIGARETTE]   * [CURRENT:] Frequency: \_\_\_\_\_\_ x per day/week/month/year Date range of use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * [PAST YEAR:] Frequency: \_\_\_\_\_\_ x per day/week/month/year Date range of use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   [**OTHER (OR UNKOWN) SUBSTANCE** – E.G., ANABOLIC STEROIDS, NSAIDs, CORTISOL, ANTIHISTAMINES, NITROUS OXIDE, KAVA]  [SPECIFY SUBSTANCE:] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   * [CURRENT:] Frequency: \_\_\_\_\_\_ x per day/week/month/year Date range of use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * [PAST YEAR:] Frequency: \_\_\_\_\_\_ x per day/week/month/year Date range of use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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|  |  | | | | | | | | |  | [CURRENT  0-3m ago:] | | | | | | | [PAST YEAR  4-12m ago:] | | | | |
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| 3. | **Has your substance use bothered you or caused you problems?** | | | | | | | | |  | **A** | | **S** | | | **P** | | **A** | | **S** | | **P** |
|  |  | | | | | | | | |  |  | |  | | |  | |  | |  | |  |
|  | [#3 IS CODED P AND/OR SUBSTANCE USE IS DEEMED CLINICALLY CONCERNING] | | | | | | | | |  | **A**  ⌧ | |  | | | **P** | | **A**  ⌧ | |  | | **P** |
|  |  | | | | | | | | |  |  | |  | | |  | |  | |  | |  |
|  | [NOTES:] | | | | | | | | | | | | | | | | | | | | | |
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|  | [LIST SUBSTANCES THAT ARE BOTHERSOME, CAUSE PROBLEMS, OR ARE DEEMED CLINICALLY CONCERNING. IF NOT KNOWN, ASK :] | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | | | | | | | |
|  | **Which of the substances that you told me about cause problems for you?** | | | | | | | | | | | | | | | | | | | | | |
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|  | 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | |
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|  | 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | |
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|  | 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | |
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|  |  | | | | [SUBSTANCE 1:]  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | [SUBSTANCE 2:]  \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | [SUBSTANCE 3:]  \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
|  |  | | | |  | | | |  | | | | | | | |  | | | | | |
| 4. | **During this period of use:** | | |  | 0-3 mos. |  | 4-12 mos. | | 0-3 mos. | | |  | | 4-12 mos. | | | 0-3 mos. | |  | | 4-12 mos. | |
|  |  | | |  |  |  |  | |  | | |  | |  | | |  | |  | |  | |
|  | 4a. **On days that you used [substance], did you use a lot more than you planned to or for a longer period of time than intended?** | | |  |  |  |  | |  | | |  | |  | | |  | |  | |  | |
|  |  | | |  |  |  |  | |  | | |  | |  | | |  | |  | |  | |
|  | 4b. **Did you want to, or repeatedly try to, cut down or stop using [substance], but were unable to?** | | |  |  |  |  | |  | | |  | |  | | |  | |  | |  | |
|  |  | | |  |  |  |  | |  | | |  | |  | | |  | |  | |  | |
|  | 4c. **Did you spend a lot of time trying to get [substance], using it, or recovering from its effects?** | | |  |  |  |  | |  | | |  | |  | | |  | |  | |  | |
|  |  | | On average, how many hours of your day (or week) are taken up with getting [substance], consuming it, or recovering from it? |  |  |  |  | |  | | |  | |  | | |  | |  | |  | |
|  | |  | |  |  |  | |  |  | | |  | | |  | |  | |  | |  | |
|  | | 4d. **Did you experience strong urges or cravings to use [substance]?** | |  |  |  | |  |  | | |  | | |  | |  | |  | |  | |
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|  |  | | | | [SUBSTANCE 1:]  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | [SUBSTANCE 2:]  \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | [SUBSTANCE 3:]  \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
|  |  | | | |  | | | | |  | | | | | | |  | | | | |
| 4. | **During this period of use:** | | |  | | 0-3 mos. |  | 4-12 mos. | | 0-3 mos. |  | | 4-12 mos. | | | 0-3 mos. | |  | | 4-12 mos. | |
|  |  | | |  | |  |  |  | |  |  | |  | | |  | |  | |  | |
|  | | 4e. **Did your [substance] use repeatedly interfere with your duties at work, school, or home?** | |  | |  |  | |  |  |  | | |  | |  | |  | |  | |
|  | |  | |  | |  |  | |  |  |  | | |  | |  | |  | |  | |
|  | | 4f. **Did your [substance] use repeatedly cause you problems in social situations or in your relationships with other people?** | |  | |  |  | |  |  |  | | |  | |  | |  | |  | |
|  | |  | [IF YES:] Did you continue to use despite these problems?[CHECK ONLY IF USE CONTINUED DESPITE PROBLEMS] |  | |  |  | |  |  |  | | |  | |  | |  | |  | |
|  | |  | |  | |  |  | |  |  |  | | |  | |  | |  | |  | |
|  | | 4g. **Did you reduce or give up any of your usual activities because of your [substance] use?** | |  | |  |  | |  |  |  | | |  | |  | |  | |  | |
|  | |  | Spending less time on hobbies because of your [substance] use? Spending less time with family or friends because of it? |  | |  |  | |  |  |  | | |  | |  | |  | |  | |
|  | |  | |  | |  |  | |  |  |  | | |  | |  | |  | |  | |
|  | | 4h. **Did you use [substance] in situations that could have been dangerous or in which you could have been harmed?** | |  | |  |  | |  |  |  | | |  | |  | |  | |  | |
|  | |  | Have you driven while high or not been able to remember how you got home? Engaged in risky behaviours, such as swimming or using machinery while high? |  | |  |  | |  |  |  | | |  | |  | |  | |  | |
|  | |  | |  | |  |  | |  |  |  | | |  | |  | |  | |  | |
|  | | 4i. **Did your [substance] use repeatedly cause or worsen any medical or mental health problems?** | |  | |  |  | |  |  |  | | |  | |  | |  | |  | |
|  | |  | [IF YES:] Did you continue to use despite these problems? [CHECK ONLY IF USE CONTINUED DESPITE PROBLEMS] |  | |  |  | |  |  |  | | |  | |  | |  | |  | |
|  | |  |  |  | |  |  | |  |  |  | | |  | |  | |  | |  | |
|  | | 4j. [TOLERANCE]: **Did you need to use greater amounts of [substance] to get the same effect as before, or did you get less of an effect when using the same amount of [substance]?** | |  | |  |  | |  |  | |  | | |  |  | | |  | |  |
|  | |  | |  | |  |  | |  |  | |  | | |  |  | | |  | |  |
|  | | 4k. [WITHDRAWAL]: **When you’ve reduced or stopped using [substance], did you experience any withdrawal symptoms** [ASSESS USING SUBSTANCE SPECIFIC WITHDRAWAL SYMPTOMS AT END OF MODULE] **or did you ever use alcohol or a substance to reduce or prevent withdrawal symptoms?** | |  | |  |  | |  |  | |  | | |  |  | | |  | |  |
|  | |  | |  | |  |  | |  |  | |  | | |  |  | | |  | |  |
|  | | [WITHDRAWAL SYMPTOMS (#4k) ARE NOT APPLICABLE TO  PHENCYCLIDINE, OTHER HALLUCINOGENS, AND INHALANTS.  DO NOT QUERY WITHDRAWAL FOR THESE SUBSTANCES.] | |  | |  |  | |  |  | |  | | |  |  | | |  | |  |

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|  | |  | |  | [SUBSTANCE 1:]  \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | [SUBSTANCE 2:]  \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | [SUBSTANCE 3:]  \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
|  | |  | |  |  | | |  | | |  | | |
|  | |  | |  | 0-3 mos. |  | 4-12 mos. | 0-3 mos. |  | 4-12 mos. | 0-3 mos. |  | 4-12 mos. |
|  | |  | |  |  |  |  |  |  |  |  |  |  |
|  | | [AT LEAST TWO #4 ITEMS RELATED TO  CURRENT USE ARE CHECKED] | |  | **A P**  ⌧ | | | **A P**  ⌧ | | | **A P**  ⌧ | | |
|  | |  | |  |  | | |  | | |  | | |
|  | | [AT LEAST TWO #4 ITEMS RELATED TO  PAST USE ARE CHECKED] | |  | **A P**  ⌧ | | | **A P**  ⌧ | | | **A P**  ⌧ | | |
|  | |  | |  |  |  |  |  |  |  |  |  |  |
|  | | [FOR PAST YEAR USE ONLY:] | |  |  |  |  |  |  |  |  |  |  |
|  | |  | |  |  |  |  |  |  |  |  |  |  |
| 5. | | [NONE OF THE SYMPTOMS OF SUBSTANCE USE DISORDER HAVE BEEN PRESENT IN THE PAST 3 MONTHS (CRAVINGS MAY STILL BE PRESENT). IF NOT KNOWN, ASK:] | |  | **A P** | | | **A P** | | | **A P** | | |
|  |  | Have you engaged in problematic [substance] use or had any of the symptoms we just discussed in the past 3 months? Can you describe in what ways they have been problematic or which symptoms you’ve had in the past 3 months? |  |  | | |  | | |  | | |
|  |  |  |  |  | | |  | | |  | | |
|  | [NOTES:] | | | | | | | | | | | |

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|  |  | | |  | [SUBSTANCE 1:]  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | [SUBSTANCE 2:]  \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | [SUBSTANCE 3:]  \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
|  |  | | |  |  | | |  | | |  | | |
|  | DIAGNOSTIC IMPRESSION:  [SUBSTANCE] USE DISORDER | | |  | **A**  ⌧ | **S** | **P** | **A**  ⌧ | **S** | **P** | **A**  ⌧ | **S** | **P** |
|  |  | | |  |  |  |  |  |  |  |  |  |  |
|  | [NAME OF SUBSTANCE SHOULD BE SPECIFIED IN THE DIAGNOSIS, E.G., METHAMPHETAMINE USE DISORDER. IF MORE THAN ONE SUBSTANCE USE DISORDER IS PRESENT, ALL SHOULD BE DIAGNOSED.] | | |  |  |  |  |  |  |  |  |  |  |
|  |  | | |  |  |  |  |  |  |  |  |  |  |
|  | [SPECIFY:] | | |  |  |  |  |  |  |  |  |  |  |
|  |  | | |  |  |  |  |  |  |  |  |  |  |
|  | #5 IS CODED P  (I.E., NO USE IN PAST 3 MONTHS) | IN EARLY REMISSION | |  |  |  |  |  |  |  |  |  |  |
|  |  | | |  |  |  |  |  |  |  |  |  |  |
|  | [SPECIFY:] | | |  |  |  |  |  |  |  |  |  |  |
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|  | SUBSTANCE IS NOT USED DUE TO BEING IN A CONTROLLED ENVIRONMENT (E.G., CARE FACILITY, PRISON). TO BE USED AS AN ADDITIONAL REMISSIONSPECIFIER. | | IN A CONTROLLED ENVIRONMENT |  |  |  |  |  |  |  |  |  |  |

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|  |  | |  | [SUBSTANCE 1:]  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | [SUBSTANCE 2:]  \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | [SUBSTANCE 3:]  \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
|  |  | |  |  |  |  |  |  |  |  |  |  |
|  | [SPECIFY:] | |  |  |  |  |  |  |  |  |  |  |
|  |  | |  |  |  |  |  |  |  |  |  |  |
|  | TWO-THREE #4 ITEMS ARE CODED P | MILD |  |  |  |  |  |  |  |  |  |  |
|  | FOUR-FIVE #4 ITEMS ARE CODED P | MODERATE |  |  |  |  |  |  |  |  |  |  |
|  | ≥ SIX #4 ITEMS ARE CODED P | SEVERE |  |  |  |  |  |  |  |  |  |  |
|  |  | |  |  |  |  |  |  |  |  |  |  |
|  | [SPECIFY:] | |  |  |  |  |  |  |  |  |  |  |
|  |  | |  |  |  |  |  |  |  |  |  |  |
|  | RECEIVING MAINTENANCE THERAPY  FOR SUBSTANCE USE DISORDER RELATED TO OPIOID USE | ON MAINTENANCE THERAPY |  |  |  |  |  |  |  |  |  |  |
|  |  | |  |  |  |  |  |  |  |  |  |  |
|  | [SPECIFY:] | |  |  |  |  |  |  |  |  |  |  |
|  |  | |  |  |  |  |  |  |  |  |  |  |
|  | PANIC ATTACKS ARE PRESENT IN THE CONTEXT OF THIS DISORDER | WITH PANIC ATTACKS |  |  |  | ❒ |  |  | ❒ |  |  | ❒ |
|  |  | |  |  |  |  |  |  |  |  |  |  |
|  | [NOTE: TO ASSESS SYMPTOMS OF A PANIC ATTACK,  SEE PANIC ATTACK SPECIFIER AND PANIC DISORDER MODULE] |  |  |  |  |  |  |  |  |  |  |  |
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|  |  | |  |  |  |  |  |  |  |  |  |  |
| 6. | **How old were you when these symptoms first began?** | |  | \_\_\_\_\_\_\_\_\_\_\_\_\_ | | | \_\_\_\_\_\_\_\_\_\_\_\_\_ | | | \_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
|  |  | |  |  |  |  |  |  |  |  |  |  |
| 7. | **How old were you when these symptoms began to be a problem for you?** | |  | \_\_\_\_\_\_\_\_\_\_\_\_\_ | | | \_\_\_\_\_\_\_\_\_\_\_\_\_ | | | \_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
|  |  | |  |  |  |  |  |  |  |  |  |  |
| 8. | **On a scale from 0 to 10, 0 meaning not at all and 10 meaning extremely, how much are you bothered by your symptoms?** | |  | \_\_\_\_\_\_\_\_\_\_\_\_\_ | | | \_\_\_\_\_\_\_\_\_\_\_\_\_ | | | \_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
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| **Substance Specific Withdrawal Symptoms** | | | | | | | | |
| [WITHDRAWAL SYMPTOMS ARE NOT APPLICABLE TO PHENCYCLIDINE, OTHER HALLUCINOGENS, AND INHALANTS.] | | | | | | | | |
|  |  |  | | |  |  | | |
|  |  | [CURRENT  0-3m ago:] | | |  | [PAST YEAR  4-12m ago:] | | |
| [CANNABIS – E.G., POT/HERB/WEED/GRASS/GANJA, THC, HASHISH/RESIN, HASH OIL:] | |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| In the week after you stopped using [substance], did you start to experience: |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| * Irritability, anger, or aggression * Anxiety or nervousness * Difficulty with sleep or upsetting dreams * Decreased appetite or weight loss * Restlessness * Depressed mood * Stomach pain, shakiness or tremors, sweating, fever, chills, or headaches that cause you significant discomfort |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| [CANNABIS WITHDRAWAL: AT LEAST THREE ITEMS ARE CHECKED] |  | **A** |  | **P** |  | **A** |  | **P** |
|  |  |  |  |  |  |  |  |  |
| [SEDATIVE, HYPNOTIC, OR ANXIOLYTIC – E.G., PRESCRIPTION SLEEPING MEDICATIONS AND PRESCRIPTION ANTIANXIETY MEDICATIONS, SUCH AS BENZODIAZEPINES, BENZODIAZEPINE-LIKE DRUGS (E.G., ZOLPIDEM, ZALEPLON), CARBAMATES (E.G., GLUTETHIMIDE, MEPROBAMATE), BARBITURATES (E.G., SECOBARBITAL), AND BARBITURATE-LIKE HYPNOTICS (E.G., GLUTETHIMIDE, METHAQUALONE):] |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| In the hours or days after you stopped using [substance], did you start to experience: |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| * Sweating, or increased heart rate * Shaky hands * Difficulty sleeping * Nausea or vomiting * Seeing or hearing things that others didn’t perceive, or feeling strange physical sensations * Agitation or restlessness * Anxiety * Seizures |  |  |  |  |  |  |  |  |
| [SEDATIVE, HYPNOTIC, OR ANXIOLYTIC WITHDRAWAL:  AT LEAST TWO ITEMS ARE CHECKED] |  | **A** |  | **P** |  | **A** |  | **P** |
|  |  |  |  |  |  |  |  |  |
| [OPIOID – E.G., MORPHINE, HEROIN, OPIUM, CODEINE, DILAUDID, OXYCODONE, FENTANYL, HYDROMORPHONE:] |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| In the minutes or days after you stopped using [substance], did you start to experience: |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| * Depressed mood * Nausea or vomiting * Achy muscles (e.g., back and legs) |  |  |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | [CURRENT  0-3m ago:] | | |  | [PAST YEAR  4-12m ago:] | | |
|  |  |  |  |  |  |  |  |  |
| * Watery eyes or runny nose * Dilated pupils, goose bumps or hairs standing on end, or sweating * Diarrhea * Yawning * Fever * Difficulty with sleep |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| [OPIOID WITHDRAWAL: AT LEAST THREE ITEMS ARE CHECKED] |  | **A** |  | **P** |  | **A** |  | **P** |
|  |  |  |  |  |  |  |  |  |
| [STIMULANT – E.G., COCAINE, AMPHETAMINES, MDMA/ECSTASY, RITALIN, DEXEDRINE, METH/SPEED/CHALK, ICE/CRYSTAL/CRANK:] |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| In the hours or days after you stopped using [substance], did you start to experience: |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| * Fatigue * Vivid nightmares * Difficulty sleeping or oversleeping * Increased appetite * Feeling slowed down or agitated/restless |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| [STIMULANT WITHDRAWAL: AT LEAST TWO ITEMS ARE CHECKED] |  | **A** |  | **P** |  | **A** |  | **P** |
|  |  |  |  |  |  |  |  |  |
| [CAFFEINE – E.G., COFFEE, TEA, CAFFEINATED SODA, ENERGY AIDS, OVER-THE-COUNTER ANALGESICS AND COLD REMEDIES, WEIGHT LOSS AIDS, CHOCOLATE:] |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| Within 24 hours after you stopped using [substance], did you start to experience: |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| * Headache * Fatigue or drowsiness * Depressed mood or irritability * Concentration difficulties * Feeling flu-like (e.g., nauseous, vomiting, achy muscles) |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| [CAFFEINE WITHDRAWAL: AT LEAST THREE ITEMS ARE CHECKED] |  | **A** |  | **P** |  | **A** |  | **P** |
|  |  |  |  |  |  |  |  |  |
| [TOBACCO – E.G., CIGARETTES, CHEWING TOBACCO, SMOKELESS TOBACCO:] |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| Within 24 hours after you stopped using [substance], did you start to experience: |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| * Irritability or anger * Anxiety * Concentration difficulties * Increased appetite * Feeling agitated/restless * Depressed mood * Difficulty with sleep |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| [TOBACCO WITHDRAWAL: AT LEAST FOUR ITEMS ARE CHECKED] |  | **A** |  | **P** |  | **A** |  | **P** |
|  |  |  |  |  |  |  |  |  |

**Psychosis Screen**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | [THIS MODULE IS A SCREENING TOOL. IF AN ITEM BELOW IS ENDORSED OR WAS ENDORSED ON THE DART QUESTIONNAIRE, FURTHER ASSESSMENT OF SCHIZOPHRENIA SPECTRUM AND RELATED PSYCHOTIC DISORDERS ALGORITHM, OR PSYCHOSIS IN THE PRESENCE OF OTHER CONDITIONS MAY BE WARRANTED.] | | | |  | |  | |  | |  | |
|  |  | | | |  | |  | |  | |  | |
|  | [FOR EACH ITEM ENDORSED, ASK FOR AT LEAST ONE EXAMPLE AND USE THE FOLLOWING QUESTIONS TO ASSESS FREQUENCY, DEGREE OF DISTORTION, AND LEVEL OF CULTURAL APPROPRIATENESS OF THE EXPERIENCE(S):] | | | |  | |  | |  | |  | |
|  |  | | | |  | |  | |  | |  | |
|  |  | | 1. How often do you have this experience? 2. When/where are you when this occurs? 3. Why do you think you have this experience? 4. Have other people in your community/family had this or a similar experience? How would they explain this experience? Would they agree with your explanation? 5. Is there more than one possible explanation for your experience? 6. How confident are you that your interpretation of your experience is correct? | |  | |  | |  | |  | |
|  |  | | | |  | |  | |  | |  | |
|  | [CODE P BELOW ONLY IF THERE IS CLEAR EVIDENCE OF DISTORTION IN THINKING AND/OR PERCEPTION, IF THE CONTENT IS CLEARLY ATYPICAL WITHIN THEIR SOCIAL OR CULTURAL CONTEXT, AND IF THE EXPERIENCE DOES NOT OCCUR ONLY WHEN WAKING OR FALLING ASLEEP.] | | | |  | |  | |  | |  | |
|  |  | | | |  | |  | |  | |  | |
|  | **Now I am going to ask you about some less common experiences that people sometimes have.** | | | |  | |  | |  | |  | |
|  |  | | | |  | |  | |  | |  | |
| 1. | **Over the past 6 months, have you:** | | | |  | |  | |  | |  | |
|  |  | | | |  | |  | |  | |  | |
|  |  | | * **Heard things, such as voices or other noises, that other people couldn’t hear** * **Been able to see things that other people couldn’t see** * **Had other experiences involving your senses that other people couldn’t detect (e.g., smelling or tasting things that others could not smell or taste, strange or unusual sensations on your skin)** | |  | |  | |  | |  | |
|  |  | | | |  | |  | |  | |  | |
|  | [NOTES:] | | | | | | | | | | | |
|  |  | | | |  | |  | |  | |  | |
| 2. | **Over the past 6 months, have you been convinced that:** | | | |  | |  | |  | |  | |
|  |  | | | |  | |  | |  | |  | |
|  |  | | * **People were spying on you, plotting against you, or going out of their way to harm or harass you** * **You were being sent special messages (e.g., from TV, songs that you’ve heard, things that you’ve read)** * **Someone else could read your mind or hear your thoughts, or have you felt that you could read another person’s mind or hear their thoughts** | |  | |  | |  | |  | |
|  | |  | | * **You had special powers or that you could do things that most people could not do** * **You might be someone who is famous or powerful** * **There is something very wrong with your bodily functions or sensations, or the way your body looks** * **Someone of special importance is in love with you** * **Your partner is being unfaithful to you even though there was no evidence to suggest this** | | | |  | |  | |  | |
|  | |  | | | |  | |  | |  | |  | |
|  | | [NOTES:] | | | | | | | | | | | |
|  | |  | | | |  | |  | |  | |  | |
| 3. | | [OBSERVED PRESENCE OF:] | | | |  | |  | |  | |  | |
|  | |  | | | |  | |  | |  | |  | |
|  | |  | | * [DISORGANIZED THINKING (AS REFLECTED IN SPEECH) THAT RESULTS IN IMPAIRED COMMUNICATION (E.G., SWITCHING TOPICS, INCOMPREHENSIBLE)] * [GROSSLY DISORGANIZED OR ABNORMAL MOTOR BEHAVIOUR] * [NEGATIVE SYMPTOMS (E.G., FLATTENED AFFECT, AVOLITION)] | | | |  | |  | |  | |
|  | |  | | | |  | |  | |  | |  | |
|  | | [NOTES:] | | | | | | | | | | | |
|  | |  | | | |  | |  | |  | |  | |
|  | | [AT LEAST ONE item in #1-3 is checked] | | | |  | | **A**  ⌧ | |  | | **P** | |
|  | |  | | | |  | |  | |  | |  | |
|  | |  | | | |  | |  | |  | |  | |
|  | | IMPRESSION:  PSYCHOTIC SYMPTOMS LIKELY PRESENT IN THE PAST 6 MONTHS | | | |  | | **A**  ⌧ | | **S** | | **P** | |
|  | |  | | | |  | |  | |  | |  | |

**Summary of Areas of Difficulty:**

**Goals**