SDI & Migration		
Registration Date		
First Name		
Last Name		
Date of birth		
Date of Birth		
Age		
Sex at Birth	0, Female | 1, Male | 2, Other	
Which gender do you Identify with?	1, Male | 2, Female | 3, Non binary | 4, Transgender	
Family Link		
Number of siblings for subject that are alive		Type number - (0-10)
Birth order		Type number - (0-10)
Marital Status	1, 1.never married | 2, 2.married | 3, 3.divorced or separated | 4, 4.divorced and re-married | 5, 5.living with an intimate partner | 6, 6.widowed	
Education Status	1, Currently Studying | 2, Completed Studies | 3, Not yet Enrolled | 4, Never Enrolled | 5, Discontinued/Dropped Out	
Educational level :	1, Not literate | 2, Literate without any schooling | 3, Literate without formal schooling: through NFEC/AIEP | 4, literate though TLC/ AEC | 5, others | 6, Literate with formal schooling including EGS: below primary | 7, Primary | 8, Upper Primary/Middle | 9, secondary | 10, Higher Secondary | 11, Diploma/Certificate course | 12, Graduate | 13, Postgraduate and above	
Education [years]		Number
Specify Education :		

Reason for never enrolling	1, Parent not interested in studies | 2, Inadequate number of teachers | 3, School is far off | 4, To work for wage/salary | 5, For participating in other economic activities | 6, To look after younger siblings | 7, To attend other domestic chores | 8, Financial constraints | 9, Timings of educational institution not suitable | 10, For helping in household enterprises | 11, Language/medium of instruction used unfamiliar | 12, No tradition in the community | 13, Education not considered necessary | 0, Others	
Reason for Discontinuing/Dropping Out	1, Child not interested in studies | 2, Unable to cope up or failure in studies | 3, Unfriendly atmosphere at school | 4, Completed desired level/class | 5, To work for wage/salary | 6, For participating in other economic activities | 7, To look after younger siblings | 8, To attend other domestic chores | 9, Financial constraints | 10, Timings of educational institution not suitable | 11, For helping in household enterprises | 12, Language/medium of instruction used unfamiliar | 0, Others	
Reasons for Non-Enrollment/Dropout (Female Students Only)	1, Non-availability of lady teacher | 2, Non-availability of ladies toilet | 0, Others	
Other Reasons for Non-Enrollment/Dropout		Specify
Currently working?		Yes/No

<table>
<tr><td>Current Urban occupation</td><td>1, Legislators, Senior Officials & Managers |
2, Professionals |
3, Technicians and Associate Professionals |
4, Clerks |
5, Skilled Workers and Shop & Market Sales Workers |
6, Skilled Agricultural & Fishery Workers |
7, Craft & Related Trade Workers |
8, Plant & Machine Operators and Assemblers |
9, Elementary Occupation</td><td></td></tr>
<tr><td>Current Rural Occupation</td><td>1, Self employed in non agriculture |
2, Agricultural Labor |
3, Other Labor |
4, Self employed in Agriculture |
5, Others</td><td></td></tr>
<tr><td>Other's Specify</td><td></td><td></td></tr>
<tr><td>Primary language spoken in Father's side</td><td>5, Kannada |
4, Hindi |
15, Tamil |
16, Telugu |
18, English |
1, Assamese |
2, Bengali |
3, Gujarati |
6, Kashmiri |
7, Konkani |
8, Malayalam |
9, Manipuri |
10, Marathi |
11, Nepali |
12, Oriya |
13, Punjabi |
14, Sindhi |
17, Urdu |
19, Garo |
20, Khasi |
96, Other</td><td></td></tr>
<tr><td>Specify language spoken in Father's side</td><td></td><td></td></tr>
<tr><td>Specify language spoken in Mother's side</td><td>5, Kannada | 4, Hindi | 15, Tamil | 16, Telugu | 18, English | 1, Assamese | 2, Bengali | 3, Gujarati | 6, Kashmiri | 7, Konkani | 8, Malayalam | 9, Manipuri | 10, Marathi | 11, Nepali | 12, Oriya | 13, Punjabi | 14, Sindhi | 17, Urdu | 19, Garo | 20, Khasi | 96, Other</td><td></td></tr>
</table>

Primary language spoken in Mother's side		
Religion	1, Hindu | 2, Muslim | 3, Christian | 4, Sikh | 5, Buddhist | 6, Jain | 7, Parsi | 8, None | 9, Other	
Caste (if known)		
State of origin	1, Jammu and Kashmir | 2, Himachal Pradesh | 3, Punjab | 4, Chandigarh | 5, Uttarakhand | 6, Haryana | 7, Delhi | 8, Rajasthan | 9, Uttar Pradesh | 10, Bihar | 11, Sikkim | 12, Arunachal Pradesh | 13, Nagaland | 14, Manipur | 15, Mizoram | 16, Tripura | 17, Meghalaya | 18, Assam | 19, West Bengal | 20, Jharkhand | 21, Odisha | 22, Chattisgarh | 23, Madhya Pradesh | 24, Gujarat | 25, Daman & Diu | 26, Dadra & Nagar Haveli | 27, Maharashtra | 29, Karnataka | 30, Goa | 31, Lakshadweep Islands | 32, Kerala | 33, Tamil Nadu | 34, Pondicherry | 35, Andaman and Nicobar Islands | 36, Telangana | 37, Andhra Pradesh | 38, Ladakh | 97, Other Territory	
State of residence	1, Jammu and Kashmir | 2, Himachal Pradesh | 3, Punjab | 4, Chandigarh | 5, Uttarakhand | 6, Haryana | 7, Delhi | 8, Rajasthan | 9, Uttar Pradesh | 10, Bihar | 11, Sikkim | 12, Arunachal Pradesh | 13, Nagaland | 14, Manipur | 15, Mizoram | 16, Tripura | 17, Meghalaya | 18, Assam | 19, West Bengal | 20, Jharkhand | 21, Odisha | 22, Chattisgarh | 23, Madhya Pradesh | 24, Gujarat | 25, Daman & Diu | 26, Dadra & Nagar Haveli | 27, Maharashtra | 29, Karnataka | 30, Goa | 31, Lakshadweep Islands | 32, Kerala | 33, Tamil Nadu | 34, Pondicherry | 35, Andaman and Nicobar Islands | 36, Telangana | 37, Andhra Pradesh | 38, Ladakh | 97, Other Territory	
Current address		
Pin Code		
Landmark		
Permanent Address - Same as current address?		
Permanent address		
Pincode - Permanent address		
Phone Number 1		

Phone Number 2		
Email		
Father's Education	7, Professional degree | 6, Graduate | 5, Intermediate/ diploma | 4, High school | 3, Middle school | 2, Primary school | 1, Illiterate	
Father's Occupation	10, Legislators, Senior Officials & Managers | 9, Professionals | 8, Technicians and Associate Professionals | 7, Clerks | 6, Skilled Workers and Shop & Market Sales Workers | 5, Skilled Agricultural & Fishery Workers | 4, Craft & Related Trade Workers | 3, Plant & Machine Operators and Assemblers | 2, Elementary Occupation | 1, Unemployed	
Mother's Education	7, Professional degree | 6, Graduate | 5, Intermediate/ diploma | 4, High school | 3, Middle school | 2, Primary school | 1, Illiterate	
Mother's Occupation	10, Legislators, Senior Officials & Managers | 9, Professionals | 8, Technicians and Associate Professionals | 7, Clerks | 6, Skilled Workers and Shop & Market Sales Workers | 5, Skilled Agricultural & Fishery Workers | 4, Craft & Related Trade Workers | 3, Plant & Machine Operators and Assemblers | 2, Elementary Occupation | 1, Unemployed	

Total family monthly income	12, ≥1,85,895 | 10, 92,951-1,85,894 | 6, 69,535-92,950 | 4, 46,475-69,534 | 3, 27,883-46,474 | 2, 9,308-27,882 | 1, ≤9307	
Socio-economic status score		Update in Redcap, it will calculate
Socio-economic status Level		Update in Redcap, it will calculate
Do you own a house?	Yes/No	
Do you own an agricultural Land ?	Yes/No	
Do you own any non-agricultural land?	Yes/No	
Family description	1, Nuclear | 2, Joint | 3, Single Parent | 4, Grandparents Headed (where children are raised by a grandparent with no parent in the household) | 5, Grandparents supported (grandparents currently staying with the family)	
Others, please specify		
Number of male in the household		Number
Number of female in the household		
Total number of people in the household		
Number of female adults in the household		
Number of female members who are currently working		
Number of female members who are educated		
Do you have access to banking facilities		
Floor Type	1, Mud | 2, Bamboo / log | 3, Wood / plank | 4, brick / lime stone / stone | 5, cement | 6, Mosaic / tiles | 9, Others	
Others, please specify		

Wall Type	1, Gass/ straw/ leaves/ reeds/ bamboo etc | 2, mud (with / without bamboo) / unburnt brick | 3, Canvas / cloth | 4, Other katcha | 5, Timber | 6, burnt brick / stone / lime stone | 7, Iron or other metal sheet | 8, Cement / RBC / RCC | 9, Other pucca	
Others, please specify		
Roof type	1, Gass/ straw/ leaves/ reeds/ bamboo etc | 2, mud (with / without bamboo) / unburnt brick | 3, Canvas / cloth | 4, Other katcha | 5, Timber | 6, burnt brick / stone / lime stone | 7, Iron or other metal sheet | 8, Cement / RBC / RCC | 9, Other pucca	
Others, please specify		
No. of rooms		
Kitchen (Separate)	Yes/No	
Do you have any bathroom facility	1, Yes | 2, No	
Area of Stay	1, Urban | 2, Rural | 3, Semi- rural | 4, Slum | 5, Other	
Others, please specify		
Physical location of the slum	1, Along nallah/ drain | 2, Along railway line | 3, River bank / river bed | 4, Hilly terrain/ slope | 5, Park /open space | 6, Others	
Others, please specify		
Latitude		
Longitude		
Have you been admitted in hospital for any brain injury?	1, Yes | 2, No	
Are you currently on any medication?	1, Yes | 2, No	

If yes, what is it?	1, PainKillers | 2, Sleeping Pills | 3, Psychiatric medications | 4, Cardiovascular medications | 5, Medication for Seizures/Epilepsy | 6, Others_specify	
Others, specify		
Were you diagnosed with any mental illnesses?	1, Yes | 2, No	
If yes, please specify		
Specify the period of illness		
Whether the household migrated in to this village/town from some other place, anytime in the past?	1, Yes | 2, No	
How long ago	1, Within past year | 2, 1 -5 years | 3, 6-19 years | 4, 20 years or more	
Location of last place of residence	1, Same state and within the same district | 2, Same state but another district | 3, Outside the state | 4, Another country | 9, Not known	
pattern of migration (In)	1, With expected duration of stay less than 12 months (Temporary) | 2, With expected duration of stay 12 months or more (Temporary) | 3, Permanent	
reason for migration (In)	1, In search of employment | 2, in search of better employment | 3, Business | 4, To take up employment / better employment | 5, Transfer of service/ contract | 6, proximity to place of work | 7, Studies | 8, Natural disaster (drought, flood, tsunami, etc.) | 9, Social / political problems (riots, terrorism, political refugee, bad law and order, etc.) | 10, Displacement by development project | 11, Acquisition of own house/ flat | 12, Housing problems | 13, Health care | 14, Post retirement | 15, Marriage |	

	16, migration of parent/earning member of the family | 19, Others	
Others, please specify		
Have your parents migrated out of the household i.e., leaving the child/participant behind?	1, No | 2, Yes	
What was the pattern of their migration?	1, Temporary | 2, Permanent	
Approximately how many months in a year are your parents away from the household? (In case of temporary migration)	1, Less than 1 month a year | 2, Between 1 and 3 months a year | 3, Between 3 and 6 months a year | 4, Between 6 and 9 months a year | 5, More than 9 months a year	
What was the reason for migration (out)?	1, In search of employment | 2, in search of better employment | 3, Business | 4, To take up employment / better employment | 5, Transfer of service/ contract | 6, proximity to place of work | 7, Studies | 8, Natural disaster (drought, flood, tsunami, etc.) | 9, Social / political problems (riots, terrorism, political refugee, bad law and order, etc.) | 10, Displacement by development project | 11, Acquisition of own house/ flat | 12, Housing problems | 13, Health care | 14, Post retirement | 15, Marriage | 16, migration of parent/earning	

	member of the family | 19, Others	
Others, specify		

Environmental Exposure Questionnaire		
We are investigating how climate, pollution, and urbanicity impact brain health. To study this we need information about all the places you have lived throughout your lifetime.		
Drinking Water	What is the main source of your drinking water?	1, Boiled Water | 2, Piped Water into Dwelling | 3, Public Tap | 4, Tube Well | 5, Well Protected | 6, Well Unprotected | 7, Spring Protected | 8, Spring Unprotected | 9, Rain Water Collection | 10, Surface Water (Tank or Pond) | 11, Other Surface Water (River, Stream, Lake, etc) | 12, Others _Specify | 13, Others (Tanker - Cart with tank etc)
	If others, please specify	
	What is your opinion of the quality of drinking water?	1, Bad in Taste | 2, Bad in Smell | 3, Bad in Taste and Smell | 4, No Defect | 5, Others
	Other's Specify	
	What is the method of treatment of drinking water by the household?	1, Treated Electronic Purifier | 2, Boiling | 3, Chemically Treated with Alum | 4, Chemically Treated with Bleach or Chlorine Tablets | 5, Filtered with Water Filter (Candle, Ceramic, Sand, etc) | 6, Filtered with Cloth | 7, Others | 8, Not Filtered
	If Others, please specify	

	What is the material of the main container in which drinking water is stored?	1, Non-metal: earthen | 2, Plastic | 3, Metal-Iron | 4, Galvanized Iron | 5, Copper | 6, Stainless Steel | 7, Brass | 8, Others | 9, No storage
	If Others, please specify	
	Is the availability of drinking water sufficient? (Sufficient throughout the year?)	1, Yes | 2, No
	Is the area you live in known for arsenic contamination in drinking water?	1, Yes | 2, No | 3, Don't Know
	Is the area you live in known for fluoride contamination in drinking water?	1, Yes | 2, No | 3, Don't Know
Sanitation	What is your access to a latrine?	1, Exclusive Use of Household | 2, Common Use of Households in the Building | 3, Public/Community Latrine Without Payment | 4, Public/Community Latrine with Payment | 5, Others_Specify | 6, No Latrine
	If Others, please specify	
	What is the type of latrine?	1, Flush/Pour-Flush to: Piped Sewer System | 2, Septic Tank | 3, Pit Latrine | 4, Others _Specify
	If Others, please specify	
	What kind of drainage system is there in your area?	1, Underground | 2, Covered Pucca | 3, Open Pucca | 4, Open Katcha | 5, No Drainage

	How do you dispose of household waste water?	1, Safe Re-Use After Treatment | 2, Disposed Off Without Treatment to: Open Low Land Areas | 3, Ponds | 4, Near by River | 5, Drainage System | 6, Others_Specify | 7, Disposed Off With or Without Treatment to Other Places | 8, Not known
	If others, please specify	
	What is the arrangement made for collection of garbage from the household?	1, By Panchayat/Municipality /Corporation | 2, By Resident/Group of Residents | 3, Others_Specify | 4, No Arragement
	If Others, please specify	
	Where is the site where garbage is deposited after removal from the household?	1, To Bio-Gas Plant or Manure Pit | 2, To Community Dumping Spot | 3, To Household's Individual Dumping Spot(s) | 4, Others_Specify | 5, Not known
	If Others, please specify	
	How frequently garbage is cleared?	1, Daily | 2, Not Daily but atleast Once a Week | 3, Not Even Once a Week | 4, Not Known
	Are there piles of exposed garbage visible along the roads?	1, Yes | 0, No
	How far is your household located from waste dumping / burning site?	1, 500 m | 2, 501-1000 m | 3, >1000 m | 4, Don't know
	Is your house located near a plastic waste site/dumping site of old electronic goods?	1, Yes | 0, No
	How far is your household located from landfill of waste?	1, 500 m | 2, 501-1000 m | 3, >1000 m | 4, Don't know
	How far is your household located	1, 500 m | 2, 501-1000 m | 3, >1000 m | 4, Don't know

	from sewage treatment?	
	Are there any obstructed sewers/ gutters/ canals in your community?	1, Yes | 0, No | 2, Don't know
	Are there standing pools of water (not including marshes, lakes) in your area?	1, Yes | 0, No | 2, Don't know
	Is animal manure visible along the road in your community?	1, Yes | 0, No
	Whether the household faced problem of flies/mosquitoes during last year?	1, Yes Severe | 2, Moderate | 3, No
Air Pollution	Is the air in your community visibly polluted?	1, Yes | 0, No
	How is the ventilation of the dwelling unit	1, Good | 2, Satisfactory | 3, Bad
	What air conditioning system is in your household?	1, Central Air | 2, Window Units | 3, Fan | 4, Air cooler | 5, Open Windows | 6, None
	What is the primary source of energy for lighting in your house?	1, Kerosene | 2, Other Oil | 3, Gas | 4, Candle | 5, Electricity | 6, Others_ Specify | 7, No Lighting Arrangement
	If Others, please specify	
	What is the primary source of energy for cooking in your house?	1, Coal | 2, Firewood Chips | 3, LPG | 4, Gobar Gas | 5, Dung Cake | 6, Charcoal | 7, Kerosene | 8, Electricity | 9, Others_Specify | 10, No Cooking Arragement
	If Others, please specify	

Air Pollution If coke/coal/firewood and chips/ gobar-gas/ dung cake/ charcoal is used in your household for cooking	Since how long have you been exposed?	1, 5 years | 2, 5 - 10 years | 3, >10 years
	How much time are you exposed per day?	1, 2 hours | 2, 2 to 4 hours | 3, >4 hours
Exposure to cigarette smoke / SMT	How often does someone smoke inside enclosed areas of your home?	1, Daily | 2, Weekly | 3, Monthly | 4, Never
	Did the father/any other family member smoke around the time of your birth (when you were below 3 years)? If so, how long were you exposed?	1, Daily | 2, Weekly | 3, Monthly | 4, Never
	Did the father / any other family member smoke during your childhood (above 3 yrs to 12 years)? If so, How long were you exposed?	1, Daily | 2, Weekly | 3, Monthly | 4, Never
	Did the father / any other family member smoke during your adolescence (12 and above)? If so, how long were you exposed per day?	1, Daily | 2, Weekly | 3, Monthly | 4, Never
	Did your mother smoke or chew tobacco before or around the time of your birth (when you were below 3 years of age)? If so, how much time exposed per day?	1, Daily | 2, Weekly | 3, Monthly | 4, Never

	Did your mother smoke or chew tobacco during your childhood (3- 12 years of age)? If so, how much time exposed ?	1, Daily | 2, Weekly | 3, Monthly | 4, Never
	Did your mother smoke or chew tobacco during your adolescence (12 years and above) If so , how much time were you exposed per day?	1, Daily | 2, Weekly | 3, Monthly | 4, Never
Traffic Exhaust Exposure Now we are going to ask you about your exposure to smoke from vehicle exhaust	Proximity to Main road: How far is your house located from the main road?	1, Less than 0.5 Km | 2, 0.5 - 1 Km | 3, 1 - 2 Km | 4, 2 - 5 Km | 5, 5 Km and more
	Are you exposed to smoke from vehicle exhaust during any part of the day?	1, Yes | 2, No
	Please mention the duration per day (hours) (Max 24)	
	Years of exposure (years):	
	Do you have any of these effects because of traffic exposure?	1, Sleeplessness | 2, Running Nose | 3, Heavy Eye | 4, Asthmatic Attack | 5, Headache | 6, others_specify | 7, None of the above
	If Others, please specify	
Exposure to Electromagnetic radiation	How far your household is located from a cell phone tower?	1, 50 m | 2, 51 - 100 m | 3, > 100 m | 4, Not Applicable | 5, Don't know

	How far your household is located from a high tension electricity line?	1, 50 m | 2, 51 - 100 m | 3, > 100 m | 4, Not Applicable | 5, Don't know
	Is your house located near a thermal power plant (3-5kms)?	1, Yes | 0, No | 2, Don't know
Pesticide exposure Now we are going to ask you about your exposure to chemicals used in agriculture	Do you live near an agricultural area?	1, Yes | 2, No
	How far is the agricultural area from your house (in metres)?	1, 500 m | 2, 501 - 1000 m | 3, > 1000 m | 4, Not applicable | 5, Don't know
	Are your parents/siblings engaged in agriculture? If yes, specify years	1, Yes _ Specify years | 2, No
	Do you handle pesticides yourself?	1, Yes _ Specify hours per day | 2, No
	If yes, Specify hours	
	Are pesticides stored in your house?	1, Yes | 2, No
	Can you name any pesticide you have come in contact with?	
	Are there any large livestock visible roaming around your house?	1, Yes | 0, No
	Do you work in agricultural areas & deal with animals or birds?	1, Yes | 2, No
	If so, please mention how many hours per day (Max 24)	
	If so, please mention how many days per month (Max 31)	
	If so, how many years (Max 99)	

	Are household insecticides used in your house?	1, Yes _ Specify years | 2, No
	Please specify the years	
	Can you name any such insecticide used in your house?	
Noise	Does any particular noise annoy you on a daily basis?	0, No | 1, Yes
	Please rate the degree of annoyance level from 0 (none) to 10 (highest)	1, 1 | 2, 2 | 3, 3 | 4, 4 | 5, 5 | 6, 6 | 7, 7 | 8, 8 | 9, 9 | 10, 10
	Which of these noises annoy you on a daily basis?	1, Vehicles | 2, People (noisy work early in the morning, e.g., washing utensils) | 3, Animals (dogs, chicken) | 4, Religious places | 5, Household items - washing machines, grinders | 6, Others_Specify | 7, None of the above
	If Others, please specify	
Discrimination	Which of these problems do you encounter due to noise pollution?	1, No disturbance (can tolerate) | 2, General disturbance (irritation) | 3, Headache | 4, Loss of sleep/insomnia | 5, Stress | 6, Others_Specify
	If Others, please specify	
	You are treated with less courtesy or respect than other people at schools, colleges, workplace, restaurants, shops, doctor's office/hospital; community resources like tube well; religious places	1, At least once a week | 2, A few times a month | 3, A few times a year | 4, Less than once a year | 5, Never
	People act as if they are afraid of you	1, At least once a week | 2, A few times a month | 3, A few times a year | 4, Less than once a year | 5, Never

	You are threatened or harassed	1, At least once a week | 2, A few times a month | 3, A few times a year | 4, Less than once a year | 5, Never
	What do you think the reasons might be for you to have had these experiences?	1, Your ethnicity (e.g., north east origin, tribal origin etc.) | 2, Your Gender | 3, Your Age | 4, Your Weight | 5, Your religion | 6, Your sexual orientation | 7, A physical disability | 8, Something else related to your physical appearance | 9, Your income | 10, A mental health issue | 11, Your caste | 12, Others_Specify
	If Others, please specify	
	Do you belong to a particular social group?	1, Scheduled tribe | 2, Scheduled caste | 3, Other backward class | 5, General | 4, Other_Specify
	If Others, please specify	
	Do you have any members in your house in the age group of 15-59 years?	1, Yes | 0, No

ASSIST +	
Thank you for agreeing to take part in this brief interview about alcohol, tobacco products and other drugs. I am going to ask you some questions about your experience of using these substances across your lifetime and in the past three months. These substances can be smoked, swallowed, snorted, inhaled, injected or taken in the form of pills (show drug card). Some of the substances listed may be prescribed by a doctor (like amphetamines, sedatives, pain medications). For this interview, we will not record medications that are used as prescribed by your doctor. However, if you have taken such medications for reasons other than prescription, or taken them more frequently or at higher doses than prescribed, please let me know. While we are also interested in knowing about your use of various illicit drugs, please be assured that information on such use will be treated as strictly confidential.	
Question 1: In your life, which of the following medicines/ substances have you ever used ON YOUR OWN?	
a. Tobacco products (cigarettes, chewing tobacco, cigars, e-cig, etc.)	0, No | 3, Yes
b. Alcoholic drinks (beer, spirits, wine, local drinks etc.)	0, No | 3, Yes
c. Cannabis (marijuana/weed/ganja, hash/charas, bhang etc.)	0, No | 3, Yes
d. Cocaine (coke, crack, etc.)	0, No | 3, Yes
e. Amphetamine type stimulants (shabu, DMT, ecstasy, etc.)	0, No | 3, Yes
f. Inhalants (glue/ Fevicol, Erazex, petrol, paint thinner, etc.)	0, No | 3, Yes
g. Sleeping Pills /Sedatives (Valium, Nitrosun, Alprax, Trika etc.)	0, No | 3, Yes
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0, No | 3, Yes
i. Opioids (heroin- brown sugar, codeine cough syrup, Proxyvon -pain medicines, morphine, Tramadol, etc.)	0, No | 3, Yes
j. Other - specify:	0, No | 3, Yes
If choose Other, please specify:	
Question 2: In the past three months, how often have you used the substances you mentioned	
a. Tobacco products (cigarettes, chewing tobacco, cigars, e-cig, etc.)	1, Never| 2, Once or Twice | 3, Monthly| 4, Weekly | 5, Daily or Almost Daily
b. Alcoholic drinks (beer, spirits, wine, local drinks etc.)	1, Never| 2, Once or Twice | 3, Monthly| 4, Weekly | 5, Daily or Almost Daily
c. Cannabis (marijuana/weed/ganja, hash/charas, bhang etc.)	1, Never| 2, Once or Twice | 3, Monthly| 4, Weekly | 5, Daily or Almost Daily

d. Cocaine (coke, crack, etc.)	1, Never| 2, Once or Twice | 3, Monthly| 4, Weekly | 5, Daily or Almost Daily
e. Amphetamine type stimulants (shabu, DMT, ecstasy, etc.)	1, Never| 2, Once or Twice | 3, Monthly| 4, Weekly | 5, Daily or Almost Daily
f. Inhalants (glue/ Fevicol, Erazex, petrol, paint thinner, etc.)	1, Never| 2, Once or Twice | 3, Monthly| 4, Weekly | 5, Daily or Almost Daily
g. Sleeping Pills /Sedatives (Valium, Nitrosun, Alprax, Trika etc.)	1, Never| 2, Once or Twice | 3, Monthly| 4, Weekly | 5, Daily or Almost Daily
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	1, Never| 2, Once or Twice | 3, Monthly| 4, Weekly | 5, Daily or Almost Daily
i. Opioids (heroin- brown sugar, codeine cough syrup, Proxyvon -pain medicines, morphine, Tramadol, etc.)	1, Never| 2, Once or Twice | 3, Monthly| 4, Weekly | 5, Daily or Almost Daily
j. Other	1, Never| 2, Once or Twice | 3, Monthly| 4, Weekly | 5, Daily or Almost Daily
If choose Other, please specify	
Question 3: In the past three months, how often have you had a strong desire or urge to use	
a. Tobacco products (cigarettes, chewing tobacco, cigars, e-cig, etc.)	1, Never| 2, Once or Twice | 3, Monthly| 4, Weekly | 5, Daily or Almost Daily
b. Alcoholic drinks (beer, spirits, wine, local drinks etc.)	1, Never| 2, Once or Twice | 3, Monthly| 4, Weekly | 5, Daily or Almost Daily
c. Cannabis (marijuana/weed/ganja, hash/charas, bhang etc.)	1, Never| 2, Once or Twice | 3, Monthly| 4, Weekly | 5, Daily or Almost Daily
d. Cocaine (coke, crack, etc.)	1, Never| 2, Once or Twice | 3, Monthly| 4, Weekly | 5, Daily or Almost Daily
e. Amphetamine type stimulants (shabu, DMT, ecstasy, etc.)	1, Never| 2, Once or Twice | 3, Monthly| 4, Weekly | 5, Daily or Almost Daily
f. Inhalants (glue/ Fevicol, Erazex, petrol, paint thinner, etc.)	1, Never| 2, Once or Twice | 3, Monthly| 4, Weekly | 5, Daily or Almost Daily
g. Sleeping Pills /Sedatives (Valium, Nitrosun, Alprax, Trika etc.)	1, Never| 2, Once or Twice | 3, Monthly| 4, Weekly | 5, Daily or Almost Daily
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	1, Never| 2, Once or Twice | 3, Monthly| 4, Weekly | 5, Daily or Almost Daily
i. Opioids (heroin- brown sugar, codeine cough syrup, Proxyvon -pain medicines, morphine, Tramadol, etc.)	1, Never| 2, Once or Twice | 3, Monthly| 4, Weekly | 5, Daily or Almost Daily
j. Other	1, Never| 2, Once or Twice | 3, Monthly| 4, Weekly | 5, Daily or Almost Daily
If choose Other, please specify	
Question 4: In the past three months, how often has your use of (FIRST DRUG, SECOND DRUG, ETC) led to health, social, legal or financial problems?	
a. Tobacco products (cigarettes, chewing tobacco, cigars, e-cig, etc.)	1, Never| 2, Once or Twice | 3, Monthly| 4, Weekly | 5, Daily or Almost Daily
b. Alcoholic drinks (beer, spirits, wine, local drinks etc.)	1, Never| 2, Once or Twice | 3, Monthly| 4, Weekly | 5, Daily or Almost Daily
c. Cannabis (marijuana/weed/ganja, hash/charas, bhang etc.)	1, Never| 2, Once or Twice | 3, Monthly| 4, Weekly | 5, Daily or Almost Daily

d. Cocaine (coke, crack, etc.)	1, Never| 2, Once or Twice | 3, Monthly| 4, Weekly | 5, Daily or Almost Daily
e. Amphetamine type stimulants (shabu, DMT, ecstasy, etc.)	1, Never| 2, Once or Twice | 3, Monthly| 4, Weekly | 5, Daily or Almost Daily
f. Inhalants (glue/ Fevicol, Erazex, petrol, paint thinner, etc.)	1, Never| 2, Once or Twice | 3, Monthly| 4, Weekly | 5, Daily or Almost Daily
g. Sleeping Pills /Sedatives (Valium, Nitrosun, Alprax, Trika etc.)	1, Never| 2, Once or Twice | 3, Monthly| 4, Weekly | 5, Daily or Almost Daily
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	1, Never| 2, Once or Twice | 3, Monthly| 4, Weekly | 5, Daily or Almost Daily
i. Opioids (heroin- brown sugar, codeine cough syrup, Proxyvon -pain medicines, morphine, Tramadol, etc.)	1, Never| 2, Once or Twice | 3, Monthly| 4, Weekly | 5, Daily or Almost Daily
j. Other	1, Never| 2, Once or Twice | 3, Monthly| 4, Weekly | 5, Daily or Almost Daily
If choose Other, please specify	
Question 5: In the past three months, how often have you failed to do what was normally expected of you because of your use of	
b. Alcoholic drinks (beer, spirits, wine, local drinks etc.)	1, Never| 2, Once or Twice | 3, Monthly| 4, Weekly | 5, Daily or Almost Daily
c. Cannabis (marijuana/weed/ganja, hash/charas, bhang etc.)	1, Never| 2, Once or Twice | 3, Monthly| 4, Weekly | 5, Daily or Almost Daily
d. Cocaine (coke, crack, etc.)	1, Never| 2, Once or Twice | 3, Monthly| 4, Weekly | 5, Daily or Almost Daily
e. Amphetamine type stimulants (shabu, DMT, ecstasy, etc.)	1, Never| 2, Once or Twice | 3, Monthly| 4, Weekly | 5, Daily or Almost Daily
f. Inhalants (glue/ Fevicol, Erazex, petrol, paint thinner, etc.)	1, Never| 2, Once or Twice | 3, Monthly| 4, Weekly | 5, Daily or Almost Daily
g. Sleeping Pills /Sedatives (Valium, Nitrosun, Alprax, Trika etc.)	1, Never| 2, Once or Twice | 3, Monthly| 4, Weekly | 5, Daily or Almost Daily
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	1, Never| 2, Once or Twice | 3, Monthly| 4, Weekly | 5, Daily or Almost Daily
i. Opioids (heroin- brown sugar, codeine cough syrup, Proxyvon -pain medicines, morphine, Tramadol, etc.)	1, Never| 2, Once or Twice | 3, Monthly| 4, Weekly | 5, Daily or Almost Daily
j. Other	1, Never| 2, Once or Twice | 3, Monthly| 4, Weekly | 5, Daily or Almost Daily
If choose Other, please specify	
Queston 6: Has a friend or relative or anyone else ever expressed concern about your use of	
a. Tobacco products (cigarettes, chewing tobacco, cigars, e-cig, etc.)	1, No, Never| 2, Yes, in the past 3 months| 3, Yes, but not in the past 3 months
b. Alcoholic drinks (beer, spirits, wine, local drinks etc.)	1, No, Never| 2, Yes, in the past 3 months| 3, Yes, but not in the past 3 months
c. Cannabis (marijuana/weed/ganja, hash/charas, bhang etc.)	1, No, Never| 2, Yes, in the past 3 months| 3, Yes, but not in the past 3 months
d. Cocaine (coke, crack, etc.)	1, No, Never| 2, Yes, in the past 3 months| 3, Yes, but not in the past 3 months

<table>
<tr><td>e. Amphetamine type stimulants (shabu, DMT, ecstasy, etc.)</td><td>1, No, Never| 2, Yes, in the past 3 months|
3, Yes, but not in the past 3 months</td></tr>
<tr><td>f. Inhalants (glue/ Fevicol, Erazex, petrol, paint thinner, etc.)</td><td>1, No, Never| 2, Yes, in the past 3 months|
3, Yes, but not in the past 3 months</td></tr>
<tr><td>g. Sleeping Pills /Sedatives (Valium, Nitrosun, Alprax, Trika etc.)</td><td>1, No, Never| 2, Yes, in the past 3 months|
3, Yes, but not in the past 3 months</td></tr>
<tr><td>h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)</td><td>1, No, Never| 2, Yes, in the past 3 months|
3, Yes, but not in the past 3 months</td></tr>
<tr><td>i. Opioids (heroin- brown sugar, codeine cough syrup, Proxyvon -pain medicines, morphine, Tramadol, etc.)</td><td>1, No, Never| 2, Yes, in the past 3 months|
3, Yes, but not in the past 3 months</td></tr>
<tr><td>j. Other</td><td>1, No, Never| 2, Yes, in the past 3 months|
3, Yes, but not in the past 3 months</td></tr>
<tr><td>If choose Other, please specify</td><td></td></tr>
<tr><td colspan="2">Question 7: Have you <u>ever</u> tried and failed to control, cut down or stop using</td></tr>
<tr><td>a. Tobacco products (cigarettes, chewing tobacco, cigars, e-cig, etc.)</td><td>1, No, Never| 2, Yes, in the past 3 months|
3, Yes, but not in the past 3 months</td></tr>
<tr><td>b. Alcoholic drinks (beer, spirits, wine, local drinks etc.)</td><td>1, No, Never| 2, Yes, in the past 3 months|
3, Yes, but not in the past 3 months</td></tr>
<tr><td>c. Cannabis (marijuana/weed/ganja, hash/charas, bhang etc.)</td><td>1, No, Never| 2, Yes, in the past 3 months|
3, Yes, but not in the past 3 months</td></tr>
<tr><td>d. Cocaine (coke, crack, etc.)</td><td>1, No, Never| 2, Yes, in the past 3 months|
3, Yes, but not in the past 3 months</td></tr>
<tr><td>e. Amphetamine type stimulants (shabu, DMT, ecstasy, etc.)</td><td>1, No, Never| 2, Yes, in the past 3 months|
3, Yes, but not in the past 3 months</td></tr>
<tr><td>f. Inhalants (glue/ Fevicol, Erazex, petrol, paint thinner, etc.)</td><td>1, No, Never| 2, Yes, in the past 3 months|
3, Yes, but not in the past 3 months</td></tr>
<tr><td>g. Sleeping Pills /Sedatives (Valium, Nitrosun, Alprax, Trika etc.)</td><td>1, No, Never| 2, Yes, in the past 3 months|
3, Yes, but not in the past 3 months</td></tr>
<tr><td>h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)</td><td>1, No, Never| 2, Yes, in the past 3 months|
3, Yes, but not in the past 3 months</td></tr>
<tr><td>i. Opioids (heroin- brown sugar, codeine cough syrup, Proxyvon -pain medicines, morphine, Tramadol, etc.)</td><td>1, No, Never| 2, Yes, in the past 3 months|
3, Yes, but not in the past 3 months</td></tr>
<tr><td>j. Other</td><td>1, No, Never| 2, Yes, in the past 3 months|
3, Yes, but not in the past 3 months</td></tr>
<tr><td>If choose Other, please specify</td><td></td></tr>
<tr><td>Have you ever used any drug by injection (NON-MEDICAL USE ONLY)</td><td>1, No, Never| 2, Yes, in the past 3 months|
3, Yes, but not in the past 3 months</td></tr>
<tr><td>PATTERN OF INJECTING</td><td></td></tr>
<tr><td>Prescription Drugs for Non-Medical Reasons</td><td>0, Never
1, Once or Twice
2, Monthly
3, Weekly
4, Daily or Almost Daily</td></tr>
</table>

Select the type of nonmedical prescription drug used	1, Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)
	2, Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)
	3, Sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.)
Now, I would ask you about your Internet use or playing of computer games: During the last year...	
Have there been periods when all you could think of was the moment that you could play a game, even while at school or work?	0, No | 1, Yes
Have you felt the need to continue playing for longer periods of time, or play more often?	0, No | 1, Yes
Have you been feeling restless, angry or frustrated when you were unable to play games?	0, No | 1, Yes
Were you unable to reduce your time playing games, after others had repeatedly told you to play less?	0, No | 1, Yes
Have you played games so that you would not have to think about annoying things? Or to escape negative feelings?	0, No | 1, Yes
Have you skipped work or school so that you could play games? Or, have you played throughout the night, or almost the whole night?	0, No | 1, Yes
Have you hidden the time you spend on games from others? Or have you lied to your parents (or partner) about the time you spent playing games?	0, No | 1, Yes
Have you been spending less time with friends, partner or family in order to play games? ...have you lost interest in hobbies or other activities because gaming is all you wanted to do?	0, No | 1, Yes
Have you experienced serious problems at work or school because of gaming? ...Have you experienced serious conflicts with family, friends or partner because of gaming? ...Have you lost or jeopardized an important friendship or relationship because of gaming?	0, No | 1, Yes

We want to know how kids feel about food and eating. There are no right answers. Every kid is different. We just want to know how you feel about "junk foods" like: 1, Sweets (mithai, candy, ice cream, chocolate, cookies, cake) 2, Carbs (white bread, pasta, noodles, and rice) 3, Salty snacks (chips, namkeen) 4, Fatty foods (French fries, burgers, pizza) 5, Fried foods (fried snacks) 6, Sugary drinks (cold / soft drinks, juice, milkshakes, smoothies, and energy drinks like Red Bull)	
I find myself consuming certain foods even though I am no longer hungry.	0, Never | 1, Once per month | 2, 2-4 times per month | 3, 2-3 times per week
I worry about cutting down on certain foods	0, Never | 1, Once per month | 2, 2-4 times per month | 3, 2-3 times per week
I feel sluggish or fatigued from overeating.	0, Never | 1, Once per month | 2, 2-4 times per month | 3, 2-3 times per week
I have spent time dealing with negative feelings from overeating certain foods, instead of spending time in important activities such as time with family, friends, work, or recreation.	0, Never | 1, Once per month | 2, 2-4 times per month | 3, 2-3 times per week
I have had physical withdrawal symptoms such as agitation and anxiety when I cut down on certain foods. (Do NOT include caffeinated drinks: coffee, tea, cola, energy drinks, etc.)	0, Never | 1, Once per month | 2, 2-4 times per month | 3, 2-3 times per week
My behavior with respect to food and eating causes me significant distress.	0, Never | 1, Once per month | 2, 2-4 times per month | 3, 2-3 times per week
Issues related to food and eating decrease my ability to function effectively (daily routine, job/school, social or family activities, health difficulties).	0, Never | 1, Once per month | 2, 2-4 times per month | 3, 2-3 times per week

Adverse Childhood Effects Questionnaire		
Demographic Information	Sex (as observed)	Male female
	What is your date of birth?	
	How old are you?	
	What is your background? Linguistic group (NK for not known or NR for no response)	
	Religion	
	Caste What is your background? (NK for not known or NR for no response)	
	What is the highest level of education you have completed?	1, No formal schooling | 2, Less than primary school | 3, Primary school completed | 4, Secondary/High school completed |5, College/University completed | 6, Post graduate degree | 7, Does Not Know | 8, Refused
	Which of the following best describes your main work status over the last 12 months?	1, Government employee | 2, Non-government employee | 3, Self-employed | 4, Non-paid | 5, Student | 6, Homemaker | 7, Retired | 8, Unemployed (able to work) | 9, Unemployed (unable to work) | 10, Refused
	What is your civic status?	1, Married | 2, Living as couple | 3, Divorced or separated | 4, Single | 5, Widowed | 6, Other |7, Refused
Marriage	Have you ever been married?	1, Yes | 0, No | 3, Refused
	At what age were you first married?	
	At the time of your first marriage did you yourself choose your husband/wife?	1, Yes | 0, No | 3, Don't know/ Not sure | 4, Refused
	At the time of your first marriage if you did not choose your husband/wife yourself, did you give your consent to the choice?	1, Yes | 0, No | 3, Refused
	If you are a mother or father what was your age when your first child was born?	1, If Applicable, type age | 2, Not apllicable |3, Redused
		4, Always | 3, Most of the time | 2, Sometimes | 1, Rarely | 0, Never | 5 ,Refused
Relationship with Parents/Guardians	Did your parents/guardians understand your problems and worries?	4, Always | 3, Most of the time | 2, Sometimes | 1, Rarely | 0, Never | 5 ,Refused
	Did your parents/guardians really know what	4, Always | 3, Most of the time | 2, Sometimes | 1, Rarely | 0, Never | 5 ,Refused

	you were doing with your free time when you were not at school or work?	
	How often did your parents/guardians not give you enough food even when they could easily have done so?	3, Many times | 2, A few times | 1, Once | 0, Never | 4, Refused
	Were your parents/guardians too drunk or intoxicated by drugs to take care of you?	3, Many times | 2, A few times | 1, Once | 0, Never | 4, Refused
	How often did your parents/guardians not send you to school even when it was available?	3, Many times | 2, A few times | 1, Once | 0, Never | 4, Refused
CRIES_3	Below is a list of comments made by people after stressful life events. Please tick each item showing how frequently these comments were true for you <i>during the past seven days.</i> If they did not occur during that time please tick the 'not at all' box.	
	Do you think about it even when you don't mean to?	0, Not at all | 1, Rarely | 2, Sometimes | 3, Often
	Do you try to remove it from your memory	0, Not at all | 1, Rarely | 2, Sometimes | 3, Often
	Do you have waves of strong feelings about it	0, Not at all | 1, Rarely | 2, Sometimes | 3, Often
	Do you stay away from reminders of it (e.g. places or situations)?	0, Not at all | 1, Rarely | 2, Sometimes | 3, Often
	Do you try not talk about it	0, Not at all | 1, Rarely | 2, Sometimes | 3, Often
	Do pictures about it pop into your mind?	0, Not at all | 1, Rarely | 2, Sometimes | 3, Often
	Do other things keep making you think about it?	0, Not at all | 1, Rarely | 2, Sometimes | 3, Often
	Do you try not to think about it?	0, Not at all | 1, Rarely | 2, Sometimes | 3, Often
FAMILY ENVIRONMENT	When you were growing up, during the first 18 years of your life . . .	
	Did you live with a household member who	1, Yes | 0, No | 3, Refused

	was a problem drinker or alcoholic, or misused street or prescription drugs?	
	Did you live with a household member who was depressed, mentally ill or suicidal?	1, Yes | 0, No | 3, Refused
	Did you live with a household member who was ever sent to jail or prison?	1, Yes | 0, No | 3, Refused
	Were your parents ever separated or divorced?	1, Yes | 0, No | 3, Refused
	Did your mother, father or guardian die?	1, Yes | 0, No | 3, Refused
	These next questions are about certain things you may actually have heard or seen IN YOUR HOME. These are things that may have been done to another household member but not necessarily to you. <i>When you were growing up, during the first 18 years of your life . . .</i>	
	Did you see or hear a parent or household member in your home being yelled at, screamed at, sworn at, insulted or humiliated?	3, Many times | 2, A few times | 1, Once | 0, Never | 4, Refused
	Did you see or hear a parent or household member in your home being slapped, kicked, punched or beaten up?	3, Many times | 2, A few times | 1, Once | 0, Never | 4, Refused
	Did you see or hear a parent or household member in your home being hit or cut with an object, such as a stick (or cane), bottle, club, knife, whip etc.?	3, Many times | 2, A few times | 1, Once | 0, Never | 4, Refused
CRIES_4	Below is a list of comments made by people after stressful life events. Please tick each item showing how frequently these comments were true for you <i>during the past seven days.</i> If they did not occur during that time	

	please tick the ‘not at all’ box.	
	Do you think about it even when you don’t mean to?	0, Not at all | 1, Rarely | 2, Sometimes | 3, Often
	Do you try to remove it from your memory	0, Not at all | 1, Rarely | 2, Sometimes | 3, Often
	Do you have waves of strong feelings about it	0, Not at all | 1, Rarely | 2, Sometimes | 3, Often
	Do you stay away from reminders of it (e.g. places or situations)?	0, Not at all | 1, Rarely | 2, Sometimes | 3, Often
	Do you try not talk about it	0, Not at all | 1, Rarely | 2, Sometimes | 3, Often
	Do pictures about it pop into your mind?	0, Not at all | 1, Rarely | 2, Sometimes | 3, Often
	Do other things keep making you think about it?	0, Not at all | 1, Rarely | 2, Sometimes | 3, Often
	Do you try not to think about it?	0, Not at all | 1, Rarely | 2, Sometimes | 3, Often
	These next questions are about certain things YOU may have experienced. When you were growing up, during the first 18 years of your life . . .	
	Did a parent, guardian or other household member yell, scream or swear at you, insult or humiliate you?	3, Many times | 2, A few times | 1, Once | 0, Never | 4, Refused
	Did a parent, guardian or other household member threaten to, or actually, abandon you or throw you out of the house?	3, Many times | 2, A few times | 1, Once | 0, Never | 4, Refused
	Did a parent, guardian or other household member spank, slap, kick, punch or beat you up?	3, Many times | 2, A few times | 1, Once | 0, Never | 4, Refused
	Did a parent, guardian or other household member hit or cut you with an object, such as a stick (or cane), bottle, club, knife, whip etc?	3, Many times | 2, A few times | 1, Once | 0, Never | 4, Refused
	Did someone touch or fondle you in a sexual way when you did not want them to?	3, Many times | 2, A few times | 1, Once | 0, Never | 4, Refused
	Did someone make you touch their body in a	3, Many times | 2, A few times | 1, Once | 0, Never | 4, Refused

	sexual way when you did not want them to?	
	Did someone attempt oral, anal, or vaginal intercourse with you when you did not want them to?	3, Many times | 2, A few times | 1, Once | 0, Never | 4, Refused
	Did someone actually have oral, anal, or vaginal intercourse with you when you did not want them to?	3, Many times | 2, A few times | 1, Once | 0, Never | 4, Refused
CRIES_5	Below is a list of comments made by people after stressful life events. Please tick each item showing how frequently these comments were true for you <i>during the past seven days.</i> If they did not occur during that time please tick the ‘not at all’ box.	
	Do you think about it even when you don’t mean to?	0, Not at all | 1, Rarely | 2, Sometimes | 3, Often
	Do you try to remove it from your memory	0, Not at all | 1, Rarely | 2, Sometimes | 3, Often
	Do you have waves of strong feelings about it	0, Not at all | 1, Rarely | 2, Sometimes | 3, Often
	Do you stay away from reminders of it (e.g. places or situations)?	0, Not at all | 1, Rarely | 2, Sometimes | 3, Often
	Do you try not talk about it	0, Not at all | 1, Rarely | 2, Sometimes | 3, Often
	Do pictures about it pop into your mind?	0, Not at all | 1, Rarely | 2, Sometimes | 3, Often
	Do other things keep making you think about it?	0, Not at all | 1, Rarely | 2, Sometimes | 3, Often
	Do you try not to think about it?	0, Not at all | 1, Rarely | 2, Sometimes | 3, Often
PEER VIOLENCE	These next questions are about BEING BULLIED when you were growing up. Bullying is when a young person or group of young people say or do bad and unpleasant things to another young person. It is also bullying when a young person is teased a lot in an unpleasant way or when a young person is left out of things on	

	purpose. It is not bullying when two young people of about the same strength or power argue or fight or when teasing is done in a friendly and fun way. When you were growing up, during the first 18 years of your life . . .	
	How often were you bullied?	3, Many times | 2, A few times | 1, Once | 0, Never | 4, Refused
	How were you bullied most often?	1, I was hit, kicked, pushed, shoved around, or locked indoors | 2, I was made fun of because of my race, nationality or colour | 3, I was made fun of because of my religion | 4, I was made fun of with sexual jokes, comments, or gestures | 5, I was left out of activities on purpose or completely ignored | 6, I was made fun of because of how my body or face looked | 6, I was bullied in some other way | 7, Others Specify | 8, Refused
	This next question is about PHYSICAL FIGHTS. A physical fight occurs when two young people of about the same strength or power choose to fight each other. When you were growing up, during the first 18 years of your life . . .	
	How often were you in a physical fight?	3, Many times | 2, A few times | 1, Once | 0, Never | 4, Refused
CRIES_6	Below is a list of comments made by people after stressful life events. Please tick each item showing how frequently these comments were true for you <i>during the past seven days.</i> If they did not occur during that time please tick the 'not at all' box.	
	Do you think about it even when you don't mean to?	0, Not at all | 1, Rarely | 2, Sometimes | 3, Often
	Do you try to remove it from your memory	0, Not at all | 1, Rarely | 2, Sometimes | 3, Often
	Do you have waves of strong feelings about it	0, Not at all | 1, Rarely | 2, Sometimes | 3, Often
	Do you stay away from reminders of it (e.g. places or situations)?	0, Not at all | 1, Rarely | 2, Sometimes | 3, Often
	Do you try not talk about it	0, Not at all | 1, Rarely | 2, Sometimes | 3, Often

	Do pictures about it pop into your mind?	0, Not at all | 1, Rarely | 2, Sometimes | 3, Often
	Do other things keep making you think about it?	0, Not at all | 1, Rarely | 2, Sometimes | 3, Often
	Do you try not to think about it?	0, Not at all | 1, Rarely | 2, Sometimes | 3, Often
WITNESSING COMMUNITY VIOLENCE	These next questions are about how often, when you were a child, YOU may have seen or heard certain things in your NEIGHBOURHOOD OR COMMUNITY (not in your home or on TV, movies, or the radio). When you were growing up, during the first 18 years of your life . . .	
	Did you see or hear someone being beaten up in real life?	3, Many times | 2, A few times | 1, Once | 0, Never | 4, Refused
	Did you see or hear someone being stabbed or shot in real life?	3, Many times | 2, A few times | 1, Once | 0, Never | 4, Refused
	Did you see or hear someone being threatened with a knife or gun in real life?	3, Many times | 2, A few times | 1, Once | 0, Never | 4, Refused
CRIES_7	Below is a list of comments made by people after stressful life events. Please tick each item showing how frequently these comments were true for you <i>during the past seven days.</i> If they did not occur during that time please tick the ‘not at all’ box.	
	Do you think about it even when you don’t mean to?	0, Not at all | 1, Rarely | 2, Sometimes | 3, Often
	Do you try to remove it from your memory	0, Not at all | 1, Rarely | 2, Sometimes | 3, Often
	Do you have waves of strong feelings about it	0, Not at all | 1, Rarely | 2, Sometimes | 3, Often
	Do you stay away from reminders of it (e.g. places or situations)?	0, Not at all | 1, Rarely | 2, Sometimes | 3, Often
	Do you try not talk about it	0, Not at all | 1, Rarely | 2, Sometimes | 3, Often

	Do pictures about it pop into your mind?	0, Not at all | 1, Rarely | 2, Sometimes | 3, Often
	Do other things keep making you think about it?	0, Not at all | 1, Rarely | 2, Sometimes | 3, Often
	Do you try not to think about it?	0, Not at all | 1, Rarely | 2, Sometimes | 3, Often
EXPOSURE TO WAR/COLLECTIVE VIOLENCE	These questions are about whether YOU did or did not experience any of the following events when you were a child. The events are all to do with collective violence, including wars, terrorism, political or ethnic conflicts, genocide, repression, disappearances, torture and organized violent crime such as banditry and gang warfare. When you were growing up, during the first 18 years of your life . . .	
	Were you forced to go and live in another place due to any of these events?	3, Many times | 2, A few times | 1, Once | 0, Never | 4, Refused
	Did you experience the deliberate destruction of your home due to any of these events?	3, Many times | 2, A few times | 1, Once | 0, Never | 4, Refused
	Were you beaten up by soldiers, police, militia, or gangs?	3, Many times | 2, A few times | 1, Once | 0, Never | 4, Refused
	Was a family member or friend killed or beaten up by soldiers, police, militia, or gangs?	3, Many times | 2, A few times | 1, Once | 0, Never | 4, Refused
CRIES_8	Below is a list of comments made by people after stressful life events. Please tick each item showing how frequently these comments were true for you <i>during the past seven days.</i> If they did not occur during that time please tick the ‘not at all’ box.	
	Do you think about it even when you don’t mean to?	0, Not at all | 1, Rarely | 2, Sometimes | 3, Often

	Do you try to remove it from your memory	0, Not at all | 1, Rarely | 2, Sometimes | 3, Often
	Do you have waves of strong feelings about it	0, Not at all | 1, Rarely | 2, Sometimes | 3, Often
	Do you stay away from reminders of it (e.g. places or situations)?	0, Not at all | 1, Rarely | 2, Sometimes | 3, Often
	Do you try not talk about it	0, Not at all | 1, Rarely | 2, Sometimes | 3, Often
	Do pictures about it pop into your mind?	0, Not at all | 1, Rarely | 2, Sometimes | 3, Often
	Do other things keep making you think about it?	0, Not at all | 1, Rarely | 2, Sometimes | 3, Often
	Do you try not to think about it?	0, Not at all | 1, Rarely | 2, Sometimes | 3, Often
CTQ	Did you feel that there was someone to take care of you and protect you?	3, Many times | 2, A few times | 1, Once | 0, Never | 4, Refused
	Did your family make you feel important or special?	3, Many times | 2, A few times | 1, Once | 0, Never | 4, Refused
	Were people in your family close to each other?	3, Many times | 2, A few times | 1, Once | 0, Never | 4, Refused
	Did people in your family look out for each other?	3, Many times | 2, A few times | 1, Once | 0, Never | 4, Refused
	Did you feel that your family was a source of strength and support?	3, Many times | 2, A few times | 1, Once | 0, Never | 4, Refused

School Climate Questionnaire	
The sentences below describe how students feel about their school. Please read each sentence carefully, and choose ONE option that you feel best describe your school.	
I feel safe in this school.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, Refused
It's easy to make new friends in this school.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, Refused
Students with special needs (e.g., physical disability, family difficulties, etc.) get extra attention and care in this school.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, Refused
Teachers in this school let students to do something important.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, Refused
There are groups of students who bully others in this school.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, Refused
Teachers in this school like their students.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, Refused
Rules are enforced fairly to all students in this school.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, Refused
Students in this school are allowed to make suggestions on how to learn in class.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, Refused
There are many fights among students in this school.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, Refused
Teachers in this school believe that I can achieve something.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, Refused
All students in this school have equal opportunities participating in school activities.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, Refused
Teachers in this school let students decide on many things.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, Refused
Students smoke and/ or drink in this school.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, Refused
Students are friendly in this school.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, Refused
Every student in this school has the opportunity participating in group activities.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, Refused
Teachers in this school encourage students to develop innovative solutions to Problems independently.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, Refused
Someone broke or stole something of mine on purpose in this school.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, Refused
This school treats student with respect.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, Refused
This school offers help to any student who is in difficult situation.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, Refused
Students in this school have some free and their own time.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, Refused

<table>
<tr><td>Students in this school have group discussions or team works in class.</td><td>1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, Refused</td></tr>
</table>

Indian Family Violence and Control Scale	
CONTROL SUBSCALE - During your entire married life, has your husband, or his family, tried to control you in any way? Do they give you freedom to do what you want to?	
During my entire married life, without being bothered by my husband or his family, I could…Rest and relax when I wanted to.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, refused
During my entire married life, without being bothered by my husband or his family, I could…Spend my own or self-earned money on my natal family.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, refused
During my entire married life, without being bothered by my husband or his family, I could…Spend my own or self-earned money on my children	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, refused
During my entire married life, without being bothered by my husband or his family, I could…Spend my own or self-earned money on my friends.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, refused
During my entire married life, without being bothered by my husband or his family, I could…Spend my own or self-earned money for my personal things.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, refused
During my entire married life, without being bothered by my husband or his family, I could…Take up a new job or remain in my current job if I wanted to.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, refused
During my entire married life, without being bothered by my husband or his family, I could…Go out of the house.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, refused
During my entire married life, without being bothered by my husband or his family, I could…Visit my natal family, friends, coworkers, relatives, or other acquaintances.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, refused
During my entire married life, without being bothered by my husband or his family, I could…Talk freely on the phone or send SMS (text) messages.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, refused
During my entire married life, without being bothered by my husband or his family, I could…Seek medical care for myself.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, refused
During my entire married life, without being bothered by my husband or his family, I could…Make my own decisions about family-planning such as getting pregnant, using contraception, spacing between children, and permanent sterilization.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, refused
During my entire married life, without being bothered by my husband or his family, I could…Wear any type of dress and have any style that I wanted.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, refused
During my entire married life, without being bothered by my husband or his family, I could…Freely invite my natal family members and friends to visit me in my matrimonial home.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, refused
During my entire married life, without being bothered by my husband or his family, I could…Have sex how and when I wanted to.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, refused

Has your husband, or his family, ever done anything to hurt you psychologically or emotionally?	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, refused
Psychological Violence Subscale Has your husband, or his family, ever done anything to hurt you psychologically or emotionally?	
My husband or a member of his family…Screamed at me when I was alone.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, refused
My husband or a member of his family…Excessively criticized me for my work at home.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, refused
Screamed at me or insulted me in front of others, in a public place, or on a social networking site.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, refused
Threatened that he/they would send me out of the house	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, refused
Forced me to leave the house.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, refused
Threatened to send me to my natal home against my will.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, refused
Sent me to my natal home against my will.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, refused
Harassed me for wedding-related gifts or money such as maanpaan or dowry	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, refused
Harassed my natal family for wedding-related gifts or money such as maanpaan or dowry.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, refused
Taunted me about my poor health	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, refused
Threatened to hurt or hurt my children because he/she was angry with me.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, refused
Threatened to hurt or hurt a member of my natal family because he/she was angry with me	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, refused
Threatened to leave me and get remarried.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, refused
Intentionally spread false rumors about my character and chastity.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, refused
Intentionally ignored me or did not talk to me.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, refused
Intentionally starved me or gave me stale food.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, refused
Intentionally confined me in the house.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, refused
Intentionally left me out of family functions or social events.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, refused
Bothered me for having a girl child.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, refused
Bothered me for being infertile.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, refused
Forced me to become vegetarian or non-vegetarian.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, refused
Forced me to fast (perform upvas) when I did not want to.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, refused
PHYSICAL VIOLENCE SUBSCALE	
Forced me to work excessively against my will.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, refused

Slapped or scratched me.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, refused
Kicked, punched, or beat me.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, refused
Twisted my arm or pulled my hair.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, refused
Pushed me, pulled me, dragged me, shook me, or held me down.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, refused
Tried to strangle or suffocate me.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, refused
Tried to hang me.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, refused
Tried to poison me.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, refused
Threw things in the house when he/she was angry with me.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, refused
Burnt me or threatened to burn me with a cigarette.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, refused
Threatened to burn me using kerosene, chemicals, acid, or some other method.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, refused
Burned me using kerosene, chemicals, acid, or some other method	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, refused
Threatened me with a sharp object such as broken glass, a razor blade, axe, or knife.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, refused
Attacked me with a sharp object such as broken glass, a razor blade, axe, or knife.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, refused
Threatened me with a blunt object such as a belt, stone, broomstick, or rolling pin.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, refused
Attacked me with a blunt object such as a belt, stone, broomstick, or rolling pin.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, refused
Forced me to have sex against my will during my menstrual cycle	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, refused
Forced me to have sex against my will with someone else.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, refused
Purposely made me drunk or high on drugs to force me to have sex against my will.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, refused
Forced me to have sex without a condom against my will	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, refused
Forced me to replicate a sexual behavior from a pornographic film against my will.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, refused
Forced me to engage in vaginal sexual intercourse against my will.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, refused
Forced me to engage in oral sex against my will.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, refused
Forced me to engage in anal sex against my will.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, refused
Videotaped us having sex against my will.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, refused
Intentionally performed forceful sex to hurt me.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, refused
Threatened to sexually abuse someone that I care about if I refused to have sex.	1, Never | 2, Rarely | 3, Sometimes | 4, Often | NA, refused

PMPUQ_SV

Record ID	__________________
Do you have access to a phone?	◯ I own a phone ◯ Use adult's phone ◯ NA
How long have you owned/ using a mobile phone?	◯ Less than 1 year ◯ 1-5 years ◯ More than 5 years ◯ NA
How many calls do you make with your mobile phone per day?	◯ 0-2 ◯ 3-5 ◯ More than 5
How much time do you spend your mobile phone per day? - Screen time (see digital well-being scale)	__________________
Do you consider yourself addicted to your mobile phone?	◯ Yes ◯ No

Physical activity

Are you using any electronic devices to measure your physical activity? (e.g. steps, heart rate)	◯ Yes ◯ No
Please mention the name of the device. (Eg. if its smart watch, mention Samsung smart watch)	__________________
If yes, please tell your step counts?	◯ Daily ◯ Weekly (first check if the available data is for daily/weekly basis)
Mention the step count	__________________ (number)

Sleep

How many hours of sleep do you get? (On an average in the past 2 weeks)	__________________
How long does it take for you to fall asleep? (In the last two weeks)	__________________
How many times do you usually wake up during the night? (In the past two weeks)	__________________

Driving Licence

Do you have a driving licence?

◯ Yes
◯ No

How long have you held DL? (in years)

____

This is a brief interview about your phone use Please read each statement and decide whether you "agree or "disagree" to the statements.

	Strongly Agree	Agree	Disagree	Strongly Disagree	NA
It is easy for me to spend all day not using my mobile phone	◯	◯	◯	◯	◯
I use my mobile phone while driving	◯	◯	◯	◯	◯
I don't use my mobile phone when it is completely forbidden to use it	◯	◯	◯	◯	◯
Is it hard for me not to use my mobile phone when I feel like it	◯	◯	◯	◯	◯
I try to avoid using my mobile phone when driving on the motorway	◯	◯	◯	◯	◯
I don't use my mobile phone in a library	◯	◯	◯	◯	◯
I can easily live without my mobile phone	◯	◯	◯	◯	◯
I use my mobile phone in situations that would qualify as dangerous	◯	◯	◯	◯	◯
I use my mobile phone where it is forbidden to do so	◯	◯	◯	◯	◯
I feel lost without my mobile phone	◯	◯	◯	◯	◯
While driving, I find myself in dangerous situations because of my mobile phone use	◯	◯	◯	◯	◯
When using my mobile phone on public transport, I try not to talk too loud	◯	◯	◯	◯	◯
It is hard for me to turn my mobile phone off	◯	◯	◯	◯	◯
I use my mobile phone while driving, even in situations that require a lot of concentration	◯	◯	◯	◯	◯

I try to avoid using mobile phone where people need silence	○	○	○	○	○

YANTRA

COVID-19 Assessment

Question	Response options
CO1. Did you receive a COVID-19 vaccine?	◯ No ◯ Yes, 1 dose ◯ Yes, 2 doses ◯ Yes, more than 2 doses ◯ I prefer not to say ◯ I don't know
CO2. Did you have a diagnosis of COVID-19? If so, how were you treated? (If you had more than one episode of COVID-19, answer based on your most severe episode) IF response to Q2 is 4, 997 or 998 skip to Q.5, otherwise:	◯ I self-isolated at home ("attention at home") ◯ I was hospitalized, but not in the ICU ◯ I was hospitalized and put in the ICU ◯ I did not have a diagnosis of COVID-19 ◯ I prefer not to say ◯ I don't know
CO3. How long ago did you have COVID-19? (If you had more than one episode of COVID-19, answer based on your most severe episode)	◯ Less than 1 month ◯ 1 to 6 months ◯ 6 months to 1 year ◯ More than 1 year ◯ I prefer not to say ◯ I don't know
CO4. Have you completely recovered from COVID-19? Please choose the answer that best describes you. (Complete recovery means you are feeling completely better, are having no COVID-19-related symptoms, are doing your usual activities and have returned to your usual state of health prior to your COVID-19 illness).	◯ Not recovered at all ◯ Recovered a little ◯ About half recovered ◯ Mostly recovered ◯ Completely recovered ◯ I prefer not to say ◯ I don't know
CO5. Did you have a family member or close friend who died from COVID-19?	◯ No ◯ Yes ◯ I prefer not to say ◯ I do not know
CO6. How did the COVID-19 pandemic affect your job?	◯ I don't work ◯ No effect ◯ I have increased hours ◯ I have reduced hours ◯ I have reduced pay ◯ I lost my job ◯ I prefer not to say ◯ I do not know

For the questions below, think about the worst time of the pandemic How often were you bothered by the following problems?

CO7a. Concern about your health.	◯ not at all ◯ a little ◯ A lot ◯ Don't Know
CO7b. Concern about health of family/friends.	◯ not at all ◯ a little ◯ A lot ◯ Don't Know
CO7c. Isolation.	◯ not at all ◯ a little ◯ A lot ◯ Don't Know
CO7d. Concern about shortage of food or other essential items.	◯ not at all ◯ a little ◯ A lot ◯ Don't Know
CO7e. Economic consequences.	◯ not at all ◯ a little ◯ A lot ◯ Don't Know
CO7f. Pandemic news and information.	◯ not at all ◯ a little ◯ A lot ◯ Don't Know

For the questions below, think about the worst time of the pandemic�How often were you bothered by the following problems?

CO8a. Feeling nervous, anxious, or on edge.	◯ At no moment ◯ Some days ◯ More than half of the days ◯ Almost all days ◯ Don't Know
CO8b. Not being able to stop or control worrying.	◯ At no moment ◯ Some days ◯ More than half of the days ◯ Almost all days ◯ Don't Know
CO8c. Worrying too much about different things.	◯ At no moment ◯ Some days ◯ More than half of the days ◯ Almost all days ◯ Don't Know
CO8d. Trouble relaxing.	◯ At no moment ◯ Some days ◯ More than half of the days ◯ Almost all days ◯ Don't Know
CO8e. Being so restless that it's hard to sit still.	◯ At no moment ◯ Some days ◯ More than half of the days ◯ Almost all days ◯ Don't Know
CO8f. Becoming easily annoyed or irritable.	◯ At no moment ◯ Some days ◯ More than half of the days ◯ Almost all days ◯ Don't Know
CO8g. Feeling afraid as if something awful might happen.	◯ At no moment ◯ Some days ◯ More than half of the days ◯ Almost all days ◯ Don't Know
CO8h. Having little interest or pleasure in doing things.	◯ At no moment ◯ Some days ◯ More than half of the days ◯ Almost all days ◯ Don't Know
CO8i. Feeling down, depressed, or hopeless.	◯ At no moment ◯ Some days ◯ More than half of the days ◯ Almost all days ◯ Don't Know

CO8j. Feeling lonely.

◯ At no moment
◯ Some days
◯ More than half of the days
◯ Almost all days
◯ Don't Know

Pregnancy History Questionnaire

Now I'd like to ask you some questions about your pregnancy and your child's birth and early development. You may not be able to answer all of these questions, but please be patient and answer as many as you can	
(Codes: 0 - no, 1 = yes, - 6 = missing, - 7 = ref, - 8 = DK)	
What is (--------‘s) birth-date?	
How old were you when (he/she) was born?	
Sex - Male, Female	
Before this child, how many times had you been pregnant?	
If one time or more ask:	
How many of these pregnancies ended with live births?	
With stillbirths/ With miscarriages?	
With abortions?	
Others?	
Before this child, had you had any premature or overdue deliveries?	1. yes, 0. No 7, Refused 8, Don't know
If yes ask: How many premature and how many overdue?	
After this child, how many times were you pregnant?	
If one time or more ask:	
How many of these pregnancies ended with live births?	
With stillbirths/ miscarriages/ abortions?	
Others	
After this child, had you had any premature or overdue deliveries?	1. yes, 0. No 7, Refused 8, Don't know
If yes ask: How many premature and how many overdue?	
Prior to your pregnancy with this child, did you have any major health problems requiring medical care?	1. yes, 0. No 7, Refused 8, Don't know
If yes ask: What were they?	
Infections- Did you have any infections requiring medical care?	
If yes ask: What kind of infection? Was it... Tuberculosis HIV/ STDs	checkboxes
Others	

Cardiovascular Problems: Did you have .. . High blood pressure? Excessive fluid in your body? Swelling of your face, hands, or ankles? Protein in your urine? Heart problems	checkboxes
Neurological Problems: Did you have .. . Seizures or convulsions?	
If yes, ask: Was this due to a history of epilepsy that was present before your pregnancy?	
Others	
Psychiatric: Did you have .. .	
Emotional problems which bothered you a lot (for which you may or may not have sought treatment or counselling)?	
Anxiety- Depression	1. yes, 0. No 7, Refused 8, Don't know
Other emotional/ behavioural problems/mental health diagnosis	
Family Problems : Serious family problems which were upsetting to you? Family problems relating to conflict with close family members Problems relating to money, availability of food or other necessities	checkboxes
Anaemia: Did you have anaemia?	1.Yes , 0. No , 7, Refused, 8, Don't know
Endocrinological /Immunological: Did you have any autoimmune diseases? Diabetes Thyroid disorders? Others such as Arthritis/	checkboxes
How many months pregnant were you when you first saw a doctor or went to a clinic about this pregnancy?	
Did you receive a regular antenatal checkup as advised by a doctor? Yes=2/ Irregular=1/ None=1	
Did you have any of the following during your pregnancy with this child?	
Gestational Problems– 1. Bad foetal position such as the baby sitting too high up inside 2. Your water breaking while before it was supposed to?	1.Yes , 0. No , 7, Refused, 8, Don't know

Placental Problems– Spotting or light bleeding Heavy bleeding requiring bed rest or special treatment Problems with your placenta (previa or abruption)? Excessive nausea or vomiting lasting more than 3 months? No Refused Don't know	checkboxes
Maternal Weight Problems: i]Weight gain over >10 kg ? ii] Weight loss over 5 kg (do not count if placed on reducing diet or water pills)	
Infections	
Did you have any infection requiring medical care?	1. Yes 0, No
If yes, what was it :Rubella (German measles) Kidney infection Other, specify Refused Don't know	checkboxes
Cardiovascular: Did you have high blood pressure (Pre-eclampsia) Excessive fluid in your body-Swelling of your face, hands, or ankles/ Protein in your urine? No Refused Don't Know	checkboxes
Neurological	
Did you have Seizures or convulsions? If yes ask:	1.Yes , 0. No , 7, Refused, 8, Don't know
Was this due to a history of epilepsy that was present before your pregnancy?	
Psychiatric	
Did you have Emotional problems for which you sought treatment or counselling?	
Anxiety/ Depression 1] before/during the pregnancy 2] immediately or soon after childbirth	1.Yes , 0. No , 7, Refused, 8, Don't know
Other mood problems/ mental problems 1] before/during the pregnancy 2] immediately or soon after childbirth	1.Yes , 0. No , 7, Refused, 8, Don't know
Immunological/Endocrinological	
Did you have any autoimmune diseases? Diabetes / Any thyroid disorders?	1.Yes , 0. No , 7, Refused, 8, Don't know

If yes, were they any of the following ? : 1, Addison's disease 2, Arthritis 3, Autoimmune hepatitis 4, Autoimmune blood diseases 5, Diabetes 6, Lupus Erythematosus 7, Myasthenia gravis 8, Pemphigus 9, Pernicious Anemia 10, Sjogren's disease 11, Ulcerative colitis 12, other autoimmune diseases, specify 13, Rh incompatibility 14, Any thyroid disorders	checkboxes
Accidents or injuries requiring medical care?	1.Yes , 0. No , 7, Refused, 8, Don't know
Other illnesses requiring medical care?	
For any of these difficulties during pregnancy, did they happen during the first 20 weeks of your pregnancy or during the final 20 weeks?	1, First 20 weeks 2, Final 20 weeks 3, Entire pregnancy 4, Don't remember
Did you receive any treatment for any of the problems during pregnancy that you mentioned?	1.Yes , 0. No , 7, Refused, 8, Don't know
Toxins/Medications	
Did you take any medications during this pregnancy? (1 = any medication other than prenatal vitamins; 2 = prenatal vitamins)	
If yes, ask: What did you take it for? Morning sickness? Pain? High blood pressure? To prevent miscarriage? To prevent weight gain? Health of mother and infant? Other physiological problems? Sleep or anxiety Sadness or depression Other mental problems?	checkboxes
If other physical or mental, specify?	

During your pregnancy, were you exposed to X-rays?	1.Yes , 0. No , 7, Refused, 8, Don't know
Did you smoke/ chew tobacco/ pan parag during your pregnancy?	1.Yes , 0. No , 7, Refused, 8, Don't know
If yes, how many packs per day (write in number of cigarettes)	
If yes, ask: For how many months of your pregnancy?	
Did you drink alcoholic beverages during your pregnancy?	1.Yes , 0. No , 7, Refused, 8, Don't know
If yes, ask: How often? (0 = none; 1 = once a month; 2 = every week; 3 = daily)	
Birth	
How long were you in labour with this child? Prolonged labour (20 hours or more if you are a first-time mother, and 14 hours or more if you have previously given birth)	
Was your child born early, late, or on time? (1 = early; 2 = late; 3 = on time)	
If early or late ask: About how many weeks (early/late)?	
Was your baby larger or smaller than normal? (0 = normal; 1 = smaller; 2 = larger)	
Did (he/she) weigh less than 2.5 kg ?	1.Yes , 0. No , 7, Refused, 8, Don't know
How much did (he/she) weigh? _______________________	
Is there any record of birth weight/ head circumference --	
Did you have any problems when you delivered this child? Umbilical cord complications such as the cord tightly wrapped around the baby's neck? Was there meconium aspiration; that is, did the baby swallow its stool? Was there excess amniotic fluid? Was there a dry sack or too little amniotic fluid? Did the doctor say that there was "fetal distress"? Was the baby's heartbeat slow? No problems	checkboxes
Was (he/she) born a breech (bottom or feet first)?	1.Yes , 0. No , 7, Refused, 8, Don't know
Did you have a caesarean (a C-section)?	1.Yes , 0. No , 7, Refused, 8, Don't know
Was this child a twin or multiple birth?	
If Yes, did one twin weigh much less than the other?	

If yes, ask: Did the doctor say that one twin received more blood and nourishment during the pregnancy than the other?	
Did you receive any form of anaesthesia during the delivery? (0, No ,1, Yes, General anaesthesia, 3, Yes, Local anaesthesia ,4, Both)	
Were forceps or vacuum extraction used during this delivery? (1 = forceps; 2 = vacuum extraction; 3 = both)	
Can you recall any other difficulties with (his/her) delivery?	
If yes specify:	
Neonate	
Did your baby have any of the following problems at birth (read all): Blue at birth/Respiratory Distress Syndrome? Did not breathe at first? Convulsions? Jaundice? Required oxygen? Required blood transfusion? Have bleeding problems? Was it irritable or "hyperexcitable"? NA	
After birth, was (he/she) in an incubator?	
If yes ask: A. For how long?	
Did the baby have to stay in the hospital after you went home?	
If yes ask: A. For how long?	
Did (he/she) have surgery in the first month? (1 = any surgery other than circumcision; 2 = circumcision)	
Did (he/she) have any infections or serious illnesses in the first 12 months?	
Did you notice anything unusual about (child's name) in the first 12 months of life, such as: Having to switch formulas 3 times or more? Crying day and night, never satisfied? Too quiet, "perfect" baby, didn't respond much to care and attention? Floppy or limp when held, didn't cuddle to you? Slower growth than normal? Bleeding problems, that is, bled a lot? Irritable or "hyperexcitable"? Noticeably inactive? Fevers? Anything else unusual in the first 12 months? None of the above, No problem or Specify:	
Developmental-Cognitive History of Child	
Did (child's name) have any of the following when (he/she) was a child, that is, after the first year?	
Learning and developmental difficulties such as: (0 = no; 1 = yes)	

Delayed reading ability?	
If yes ask:	
At what age was (child) when (he/she) learned to read?	
A2. Delayed speech?	
At what age did (child) talk ?	
Delayed walking or other motor skills, such as problems with clumsiness, learning to run, jump, skip, or ride a bicycle?	
At what age did (child) walk?	
Spelling difficulties?	
Mathematical difficulties?	
Difficulties in controlling certain movements, such as having trouble learning how to write or hold a pencil?	
Stuttering difficulties?	
Problems with being very restless or frequently being unable to sit down and pay attention at home or school?	
School conduct difficulties?	
Any (other) delays in developmental milestones?	
If yes, describe:	
Was (child) ever in a special school? (e.g., for a learning disability, or for behavior problems)	
Note type of school:	
Was (he/she) ever in a special academic class in a regular school? (such as a resource room) for learning problems? (1 = learning problems; 2 = gifted classes)	
Did (he/she) ever get special help for academic problems, for example, individual tutoring?	
Did (he/she) ever repeat a grade in school?	
Did (he/she) ever fail a subject more than once?	
Was (he/she) ever described as having a learning disability?	
Has (child) had any serious medical problems?	
If yes, describe:	
At what age did this illness begin?	
Now I'd like to ask you some questions about your diet and food habits during pregnancy and your child's diet during birth and early development.	
How was your weight Weight before pregnancy,	
- Underweight	
- Normal range	
- Overweight	
While you were pregnant did your household ever run out of money to buy food?	
- Yes	

- No	
While you were pregnant, did you ever cut down the size of meals or skip meals because there was not enough food in the house?	
- Yes	
- No	
While you were pregnant, did you ever go to bed hungry because there was not enough money to buy food?	
- Yes	
- No	
Did you breastfeed once your baby was born?	
- Exclusive breast-feeding	
- Partially breast-fed (both formula and breast-feeding)	
- Used formula-feeds/ alternative feeds only	
At what age (in months) did you start to introduce semi-solid and solid foods? …….	
Till what age (in months) was breast-feeding continued until? …….	
Does your child consume any non-vegetarian products (other than dairy products)?	
-No / -Yes	
At what age (in months) was egg introduced into your child's diet? ……..	
At what age (in months) were any of the following meat products introduced into your child's diet? Fish/Chicken/mutton/ beef/ pork	If applicable

PBQ Scoring Sheet

Name ________________________________ Baby's age __________ Date ____________________

Please indicate how often the following are true for you. There are no 'right' or 'wrong' answers. Choose the answer which seems right in your recent experience:

	Always	Very often	Quite often	Some-times	Rarely	Never
I feel close to my baby	0	1	2	3	4	5
I wish the old days when I had no baby would come back	5	4	3	2	1	0
I feel distant from my baby	5	4	3	2	1	0
I love to cuddle my baby	0	1	2	3	4	5
I regret having this baby	5	4	3	2	1	0
The baby doesn't seem to be mine	5	4	3	2	1	0
My baby winds me up	5	4	3	2	1	0
I love my baby to bits	0	1	2	3	4	5
I feel happy when my baby smiles or laughs	0	1	2	3	4	5
My baby irritates me	5	4	3	2	1	0
I enjoy playing with my baby	0	1	2	3	4	5
My baby cries too much	5	4	3	2	1	0
I feel trapped as a mother	5	4	3	2	1	0
I feel angry with my baby	5	4	3	2	1	0
I resent my baby	5	4	3	2	1	0
My baby is the most beautiful baby in the world	0	1	2	3	4	5
I wish my baby would somehow go away	5	4	3	2	1	0
I have done harmful things to my baby	5	4	3	2	1	0
My baby makes me feel anxious	5	4	3	2	1	0
I am afraid of my baby	5	4	3	2	1	0
My baby annoys me	5	4	3	2	1	0
I feel confident when caring for my baby	0	1	2	3	4	5
I feel the only solution is for someone else to look after my baby	5	4	3	2	1	0
I feel like hurting my baby	5	4	3	2	1	0
My baby is easily comforted	0	1	2	3	4	5

http://www.mothersmatter.co.nz/PBQ.htm

Postpartum Bonding Questionnaire Scoring

I feel close to my baby
I wish the old days when I had no baby would come back
The baby doesn't seem to be mine
My baby winds me up
I love my baby to bits
I feel happy when my baby smiles or laughs
My baby irritates me
My baby cries too much
I feel trapped as a mother
I resent my baby
My baby is the most beautiful baby in the world
I wish my baby would somehow go away
Impaired bonding (12=high)

I feel distant from my baby
I love to cuddle my baby
I regret having this baby
I enjoy playing with my baby
I feel angry with my baby
My baby annoys me
I feel the only solution is for someone else to look after my baby
Rejection and pathological anger (13=high)

My baby makes me feel anxious
I am afraid of my baby
I feel confident when caring for my baby
My baby is easily comforted
Infant-focused anxiety (10=high)

I have done harmful things to my baby
I feel like hurting my baby
Incipient abuse (3=high)

Obs: The cutoff for "Rejection and pathological anger" was changed to 13, given the preliminary results of recent research. (The original cutoff value is 17).

AP1.RSV5 < AP2.RSV5 Or (AP1.RSV1 < 12 AND AP1.RSV2 < 13 AND AP1.RSV3 < 10 AND AP1.RSV4 < 3)

Global Scales for
Early Development v1.0

Short Form (caregiver-reported)

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Global Scales for Early Development v1.0

Short Form (caregiver-reported)

WHO/MSD/GSED package v1.0/2023.2

Global Scales for Early Development v1.0 Technical report – Global Scales for Early Development v1.0 Short Form (caregiver-reported) – Global Scales for Early Development v1.0 Short Form (caregiver-reported). Item guide – Global Scales for Early Development v1.0 Short Form (caregiver-reported). User manual – Global Scales for Early Development v 1.0 Long Form (directly administered) – Global Scales for Early Development v 1.0 Long Form (directly administered). Item guide – Global Scales for Early Development v1.0 Long Form (directly administered). User manual – Global Scales for Early Development v1.0 Scoring guide – Global Scales for Early Development v1.0 Adaptation and translation guide

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"The GSED package v1.0 includes open-access measures that provide a standardized method for measuring the development of children up to 36 months of age across diverse cultures and contexts."

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Administration Instructions

1. Complete the following information about the child.

Child ID:	**Child age** (in months):	**Child's birthday** (MM/DD/YYYY):	**SF administration date** (MM/DD/YYYY):

2. Administration instructions

▶ **Start rule:** begin with the first item in the age band that corresponds with the child's age in months (see Table).

- If the caregiver responds "No" or "Don't know" to any of the first three items in the age band that corresponds to the child's age, then go back to the earlier age band and proceed with the administration of those items.
  For example, if the child is 13 months old, the first item will be SF058. If the caregiver responds "No" and/or "Don't know" to any of the items SF058, SF059 or SF060, go to the start item of the previous age band, 9 - 11 months, and begin with the first item in that age band (SF049).
- If the caregiver responds "No" or "Don't know" to any of the first three items in the earlier age band, continue going back until the caregiver answers "Yes" to all of the first three items in the selected age band.

■ **Stop rule:** Once the starting age band has been established (i.e. the first three items have been answered as "Yes"), continue administering the Short Form. The interview should stop when the caregiver provides five "No" and/or "Don't know" responses in a row.

Age band	Start item
0 < 3 months	SF001
3 < 6 months	SF018
6 < 9 months	SF032
9 < 12 months	SF049
12 < 15 months	SF058
15 < 18 months	SF065
18 < 21 months	SF081
21 < 24 months	SF085
24 < 27 months	SF095
27 < 30 months	SF100
30 < 33 months	SF104
33 < 36 months	SF110

3. Read aloud to the caregiver before asking any items

Now I am going to ask you some questions about the things your child can and cannot do. Some of the things I ask about may be very easy for your child, and others may be too difficult. If they are difficult, it is not because your child is not doing well. It is just that I like to ask questions that are a bit harder than what I expect, so I can see what the maximum is that your child can do. It is also important to remember that children develop and learn at different rates. For example, some children learn to walk earlier than others, and this is normal and OK.

The most important thing is that you give honest answers. Please respond to the questions with "Yes" or "No" answers. If you don't understand a question, please let me know so I can repeat the question. Although I would prefer for you to answer with "Yes" or "No", if you feel you do not know the answer or are not able to answer the question, please say "I don't know".

4. After reading the above script, ask, "May I begin?".
When the item is accompanied by a prop (such as "show picture/video" or "play audio") ensure the question is asked first, and the prop is then given, or give the prop while you're asking the question (if you and the caregiver are sitting side-by-side).

			Responses (please check appropriate box):	Yes	No	Don't know
Start for children 0 < 3 m						
SF001		SHOW PICTURE	Does your child smile?	☐ 1	☐ 2	☐ 8
SF002		PLAY VIDEO	When lying on his/her back, does your child move his/her arms and legs?	☐ 1	☐ 2	☐ 8
SF003		SHOW PICTURE	Does your child look at your face when you speak to him/her?	☐ 1	☐ 2	☐ 8
SF004			Does your child cry when he/she is hungry, wet, tired or wants to be held?	☐ 1	☐ 2	☐ 8
SF005		SHOW PICTURE	Does your child grasp your finger if you touch his/her hand?	☐ 1	☐ 2	☐ 8
SF006			Does your child look at and focus on objects in front of him/her?	☐ 1	☐ 2	☐ 8
SF007		SHOW PICTURE	Does your child bring his/her hand to his/her mouth?	☐ 1	☐ 2	☐ 8
SF008		PLAY VIDEO	Does your child try to move his/her head (or eyes) to follow an object or person?	☐ 1	☐ 2	☐ 8
SF009			Does your child smile when you smile at or talk with him/her?	☐ 1	☐ 2	☐ 8
SF010			Does your child look at a person when that person starts talking or making noise?	☐ 1	☐ 2	☐ 8
SF011			Does your child stop crying or calm down when you come into the room after being out of sight, or when you pick him/her up?	☐ 1	☐ 2	☐ 8
SF012			When you talk to your child, does he/she smile, make noises or move arms, legs or trunk in response?	☐ 1	☐ 2	☐ 8
SF013			When you are about to pick up your child, does he/she act happy or excited?	☐ 1	☐ 2	☐ 8
SF014			Does your child turn his/her head towards your voice or some other noise?	☐ 1	☐ 2	☐ 8
SF015		SHOW PICTURE	Does your child grasp onto a small object (e.g. your finger, a spoon) when put it in his/her hand?	☐ 1	☐ 2	☐ 8
SF016		PLAY AUDIO	Does your child make sounds other than crying?	☐ 1	☐ 2	☐ 8
SF017		SHOW PICTURE	Does your child sometimes suck his/her thumb or fingers?	☐ 1	☐ 2	☐ 8

		Responses (please check appropriate box):	**Yes**	**No**	**Don't know**
Start for children 3 < 6 m					
SF018		While your child is on his/her back, can he/she bring his/her hands together such that the hands touch each other?	☐ 1	☐ 2	☐ 8
SF019		Does your child move excitedly, kick legs, move arms or trunk or make cooing noises when a known person enters the room or speaks to him/her?	☐ 1	☐ 2	☐ 8
SF020		Does your child make noise or gestures to get your attention?	☐ 1	☐ 2	☐ 8
SF021	SHOW PICTURE	If you play a game with your child, does he/she respond with interest? For example, if you play *peek-a-boo, pat-a-cake, wave bye-bye*, etc., does your child smile, widen his/her eyes, kick or move arms or vocalize?	☐ 1	☐ 2	☐ 8
SF022		Does your child recognize you or other family members (e.g. smile when someone enters a room or moves towards the child)?	☐ 1	☐ 2	☐ 8
SF023		Does your child laugh?	☐ 1	☐ 2	☐ 8
SF024		Does your child smile or become excited when seeing someone familiar?	☐ 1	☐ 2	☐ 8
SF025	PLAY VIDEO	When your child is on his/her stomach, can he/she turn his/her head to the side?	☐ 1	☐ 2	☐ 8
SF026	PLAY AUDIO	Does your child make sounds (not crying) when LOOKING at toys or people?	☐ 1	☐ 2	☐ 8
SF027		Is your child interested when he/she sees other children playing? Does he/she watch, smile or look excited?	☐ 1	☐ 2	☐ 8
SF028	SHOW PICTURE	Does your child hold his/her hands in fists all the time?	☐ 1	☐ 2	☐ 8
SF029		Can your child hold his/her head steady for at least a few seconds, without it flopping to the side?	☐ 1	☐ 2	☐ 8
SF030	SHOW PICTURE	When held in a sitting position, can your child hold his/her head steady and straight?	☐ 1	☐ 2	☐ 8
SF031	PLAY VIDEO	When your child is on his/her stomach, can he/she hold his/her head up off the ground?	☐ 1	☐ 2	☐ 8

			Responses (please check appropriate box):	**Yes**	**No**	**Don't know**
▼ Start for children 6 < 9 m						
SF032		SHOW PICTURE	Does your child show interest in new objects that are put in front of him/her by reaching out for them?	☐ 1	☐ 2	☐ 8
SF033		SHOW PICTURE	When your child is on his/her tummy, can your child hold his/her head straight up, looking around for more than a few seconds? Your child can rest on his/her arms while doing this.	☐ 1	☐ 2	☐ 8
SF034		PLAY VIDEO	Can your child roll from his/her back to stomach or stomach to side?	☐ 1	☐ 2	☐ 8
SF035		PLAY VIDEO	Can your child reach for AND HOLD an object, at least for a few seconds?	☐ 1	☐ 2	☐ 8
SF036			Can your child eat food from your fingers or off a spoon you hold?	☐ 1	☐ 2	☐ 8
SF037		PLAY AUDIO	Does your child make single sounds such as "buh", "duh" or "muh"?	☐ 1	☐ 2	☐ 8
SF038		SHOW PICTURE	Can your child sit with support, either leaning against something (furniture or person) or by leaning forward on his/her hands?	☐ 1	☐ 2	☐ 8
SF039		SHOW PICTURE	Does your child try to reach for objects that are in front of him/her by extending one or both arms?	☐ 1	☐ 2	☐ 8
SF040		PLAY VIDEO	Can your child pick up a small object (e.g. a piece of food, small toy or small stone) using just one hand?	☐ 1	☐ 2	☐ 8
SF041		SHOW PICTURE	When lying on his/her stomach, can your child hold his/her head and chest off the ground using only his/her hands and arms for support?	☐ 1	☐ 2	☐ 8
SF042		PLAY VIDEO	If an object falls to the ground out of view, does your child look for it?	☐ 1	☐ 2	☐ 8
SF043		SHOW PICTURE	When lying on his/her back, does your child grab his/her feet?	☐ 1	☐ 2	☐ 8
SF044		PLAY VIDEO	Can your child roll from his/her back to stomach or stomach to back, on his/her own?	☐ 1	☐ 2	☐ 8
SF045		PLAY VIDEO	Does your child play by tapping an object on the ground or a table?	☐ 1	☐ 2	☐ 8

			Responses (please check appropriate box):	Yes	No	Don't know
SF046			Does your child look for an object of interest when it is removed from sight or hidden from him/her (e.g. put under a cover, behind another object)?	☐ 1	☐ 2	☐ 8
SF047		SHOW PICTURE	Can your child hold him-/herself in a sitting position without help or support for longer than a few seconds?	☐ 1	☐ 2	☐ 8
SF048		PLAY VIDEO	Does your child intentionally move or change his/her position to get objects that are out of reach?	☐ 1	☐ 2	☐ 8
Start for children 9 < 12 m						
SF049		PLAY AUDIO	Does your child make two similar sounds together such as "baba", "mumu", "pepe", "didi" (single consonant-vowel combinations)?	☐ 1	☐ 2	☐ 8
SF050			When you put your child on the floor, can he/she lean on his/her hands while sitting?	☐ 1	☐ 2	☐ 8
SF051		PLAY VIDEO	Can your child pass a small object from one hand to the other?	☐ 1	☐ 2	☐ 8
SF052		PLAY VIDEO	Can your child bang objects together or bang an object on a table or on the ground?	☐ 1	☐ 2	☐ 8
SF053		SHOW PICTURE	Can your child pick up small bits of food and feed him-/herself using his/her hand?	☐ 1	☐ 2	☐ 8
SF054		SHOW PICTURE	Can your child pick up and drop a small object (e.g. a piece of food, small toy or small stone) into a bucket or bowl while sitting?	☐ 1	☐ 2	☐ 8
SF055		SHOW PICTURE	Can your child maintain a standing position while holding onto a person or object (e.g. wall or furniture)?	☐ 1	☐ 2	☐ 8
SF056		PLAY VIDEO	Can your child pick up a small object (e.g. a piece of food, small toy or small stone) with just his/her thumb and one finger?	☐ 1	☐ 2	☐ 8
SF057		SHOW PICTURE	Can your child pull him-/herself up from the floor while holding onto something? For example, can your child pull him-/herself up using a chair, a person or some other object?	☐ 1	☐ 2	☐ 8

			Responses (please check appropriate box):	Yes	No	Don't know
Start for children 12 < 15 m						
SF058			Does your child stop what he/she is doing when you say "Stop!", even if just for a second?	☐1	☐2	☐8
SF059		SHOW PICTURE	Can your child walk several steps while holding onto a person or object (e.g. wall or furniture)?	☐1	☐2	☐8
SF060		PLAY VIDEO	While holding onto furniture, does your child bend down and pick up a small object from the floor and then return to a standing position?	☐1	☐2	☐8
SF061		PLAY VIDEO	While holding onto furniture, does your child squat with control (without falling or flopping down)?	☐1	☐2	☐8
SF062			Does your child make a gesture to indicate "No" (e.g. shaking head)?	☐1	☐2	☐8
SF063			Even if your child is unable to do singing games, does he/she enjoy them and want to be a part of them?	☐1	☐2	☐8
SF064		SHOW PICTURE	Can your child stand up without holding onto anything, even if just for a few seconds?	☐1	☐2	☐8
Start for children 15 < 18 m						
SF065			Does your child put his/her hands out to have them washed?	☐1	☐2	☐8
SF066		SHOW PICTURE	Can your child maintain a standing position on his/her own, without holding on or receiving support?	☐1	☐2	☐8
SF067			Can your child drink from an open cup without help?	☐1	☐2	☐8
SF068		SHOW PICTURE	Can your child climb onto an object (rock, porch, step, chair, bed, low table, etc.)?	☐1	☐2	☐8
SF069		SHOW PICTURE	Can your child make any light marks on paper or in dirt with a crayon or a stick?	☐1	☐2	☐8
SF070		SHOW PICTURE	Can your child bend down or squat to pick up an object from the floor and then stand up again, without help from a person or object?	☐1	☐2	☐8

		Responses (please check appropriate box):	Yes	No	Don't know
SF071		Can your child follow a simple spoken command or direction without you making a gesture?	☐ 1	☐ 2	☐ 8
SF072		Can your child fetch something when asked?	☐ 1	☐ 2	☐ 8
SF073		Does your child share with others (e.g. food)?	☐ 1	☐ 2	☐ 8
SF074	PLAY VIDEO	Can your child take several steps (3 to 5) forward without holding onto any person or object, even if your child falls down immediately afterwards?	☐ 1	☐ 2	☐ 8
SF075	PLAY VIDEO	While standing, can your child purposefully throw a ball and not just drop it?	☐ 1	☐ 2	☐ 8
SF076	PLAY VIDEO	Can your child stand up from sitting by him-/herself and take several steps forward?	☐ 1	☐ 2	☐ 8
SF077		Can your child break off a piece of food and feed it to him-/herself? [Use local examples of food.]	☐ 1	☐ 2	☐ 8
SF078	SHOW PICTURE	Can your child make a scribble on paper, or in dirt, in a back-and-forth manner? For example, can he/she move a pen, pencil or stick back-and-forth?	☐ 1	☐ 2	☐ 8
SF079		Can your child move around by walking, rather than by crawling on his/her hands and knees?	☐ 1	☐ 2	☐ 8
SF080	PLAY VIDEO	Can your child walk well, with coordination, without falling down often, and with one foot in front of the other (rather than shifting weight side-to-side, stiff-legged)?	☐ 1	☐ 2	☐ 8
▼ Start for children 18 < 21 m					
SF081	SHOW PICTURE	Can your child stack at least 2 objects on top of each other, such as bottle tops, blocks, stones, etc.?	☐ 1	☐ 2	☐ 8
SF082		Can your child greet people either by giving his/her hand or saying "Hello"? [Use local examples of greetings.]	☐ 1	☐ 2	☐ 8
SF083	PLAY VIDEO	Can your child kick a ball or other round object forward using his/her foot?	☐ 1	☐ 2	☐ 8
SF084		Can your child say 5 or more separate words (e.g. names such as "Mama" or objects such as "ball")?	☐ 1	☐ 2	☐ 8

		Responses (please check appropriate box):	Yes	No	Don't know
Start for children 21 < 24 m					
SF085		Can your child follow directions with more than 1 step, for example, "Go to the kitchen and bring me a spoon"?	☐ 1	☐ 2	☐ 8
SF086		Can your child correctly name at least 1 family member other than mom and dad (e.g. name of brother, sister, aunt, uncle)?	☐ 1	☐ 2	☐ 8
SF087		Can your child identify at least 7 objects? For example, when you ask "Where is the ball/spoon/cup/cloth/door/plate/bucket, etc.", does your child look at or point to (or even name) the objects?	☐ 1	☐ 2	☐ 8
SF088		Can your child ask for something (e.g. food, water) by name when he/she wants it?	☐ 1	☐ 2	☐ 8
SF089	SHOW PICTURE	Can your child run well, without falling or bumping into objects?	☐ 1	☐ 2	☐ 8
SF090		Can your child wash hands by him-/herself?	☐ 1	☐ 2	☐ 8
SF091	SHOW PICTURE	While standing, can your child kick a ball by swinging his/her leg forward?	☐ 1	☐ 2	☐ 8
SF092		Does your child dry hands by him-/herself after you have washed them?	☐ 1	☐ 2	☐ 8
SF093		Does your child show independence (e.g. wants to go to visit a friend's house)?	☐ 1	☐ 2	☐ 8
SF094		If you show your child an object he/she knows well (e.g. a cup or animal), can he/she consistently name it?	☐ 1	☐ 2	☐ 8
Start for children 24 < 27 m					
SF095	SHOW PICTURE	Can your child stack 3 or more small objects (e.g. blocks, cups, bottle caps) on top of each other?	☐ 1	☐ 2	☐ 8
SF096		Can your child walk on an uneven surface (e.g. a bumpy or steep road) without falling?	☐ 1	☐ 2	☐ 8
SF097		Does your child usually communicate with words what he/she wants in a way that is understandable to others?	☐ 1	☐ 2	☐ 8
SF098		Can your child say 10 or more words in addition to "Mama" and "Dada"?	☐ 1	☐ 2	☐ 8
SF099		When looking at pictures, if you say to your child, "What is this?", can your child say the name of the object that you point to?	☐ 1	☐ 2	☐ 8

		Responses (please check appropriate box):	Yes	No	Don't know
Start for children 27 < 30 m					
SF100		Can your child speak using short sentences of 2 words that go together (e.g. "Mama go", or "Dada eat")?	☐ 1	☐ 2	☐ 8
SF101	SHOW PICTURE	Can your child unscrew the lid from a bottle or jar?	☐ 1	☐ 2	☐ 8
SF102		Does your child help out around the house with simple chores, even if he/she doesn't do them well? [Use local examples of chores.]	☐ 1	☐ 2	☐ 8
SF103		Is your child able to go poo or pee without having accidents (wetting or soiling him-/herself)?	☐ 1	☐ 2	☐ 8
Start for children 30 < 33 m					
SF104		Can your child speak using sentences of 3 or more words that go together (e.g. "I want water", or "The house is big")?	☐ 1	☐ 2	☐ 8
SF105		Can your child name at least 2 body parts (e.g. arm, eye or nose)?	☐ 1	☐ 2	☐ 8
SF106		Can your child remove an item of clothing (e.g. take off his/her shirt)?	☐ 1	☐ 2	☐ 8
SF107		Can your child say 15 or more separate words (e.g. names such as "Mama", or objects such as "ball")?	☐ 1	☐ 2	☐ 8
SF108	PLAY VIDEO	Can your child jump with both feet leaving the ground?	☐ 1	☐ 2	☐ 8
SF109		Can your child tell you or someone familiar his/her own name (or nickname) when asked?	☐ 1	☐ 2	☐ 8
Start for children 33 < 36 m					
SF110		Can your child correctly ask questions using any of the words "What", "Which", "Where" or "Who"?	☐ 1	☐ 2	☐ 8
SF111		Does your child show respect around elders? [Example can be added.]	☐ 1	☐ 2	☐ 8
SF112		Can your child correctly use any of the words "I", "you", "she" or "he" (e.g. "I go to store", or "He eats rice")?	☐ 1	☐ 2	☐ 8
SF113		Can your child sing a short song or repeat parts of a rhyme from memory by him-/herself?	☐ 1	☐ 2	☐ 8

		Responses (please check appropriate box):	Yes	No	Don't know
SF114		Does your child know the difference between the words "big" and "small"? For example, if you ask, "Give me the big spoon" can your child understand which item to give if there are 2 different sizes?	☐ 1	☐ 2	☐ 8
SF115		Does your child pronounce most of his/her words correctly?	☐ 1	☐ 2	☐ 8
SF116		Can your child go to the toilet by him-/herself?	☐ 1	☐ 2	☐ 8
SF117		If you point to an object, can your child correctly use the words "on", "in" or "under" to describe where it is (e.g. "The cup is on the table" instead of, "The cup is in the table").	☐ 1	☐ 2	☐ 8
SF118		Can your child put on at least 1 piece of clothing by him-/herself?	☐ 1	☐ 2	☐ 8
SF119		Can your child explain in words what common objects such as a cup or chair are used for?	☐ 1	☐ 2	☐ 8
SF120		Can your child draw a straight line?	☐ 1	☐ 2	☐ 8
SF121		Can your child say what he/she likes or dislikes (e.g. "I like sweets")?	☐ 1	☐ 2	☐ 8
SF122		If you show your child 2 objects or people of different sizes, can he/she tell you which one is the bigger one and which is the smaller one?	☐ 1	☐ 2	☐ 8
SF123		Does your child regularly use describing words such as "fast", "short", "hot", "fat" or "beautiful" correctly?	☐ 1	☐ 2	☐ 8
SF124		Does your child know to keep quiet when the situation requires it (e.g. at ceremonies, when someone is asleep)?	☐ 1	☐ 2	☐ 8
SF125		Does your child ask "Why" questions (e.g. "Why are you tall?")?	☐ 1	☐ 2	☐ 8
SF126	SHOW PICTURE	Can your child stand on one foot WITHOUT any support for at least a few seconds?	☐ 1	☐ 2	☐ 8
SF127		If you ask your child to give you 3 objects (e.g. stones, beans), does your child give you the correct number?	☐ 1	☐ 2	☐ 8

		Responses (please check appropriate box):	Yes	No	Don't know
SF128	SHOW PICTURE	Does your child understand the term "longest"? For example, if you ask your child to choose "which is the longest of 3 objects (e.g. 3 spoons or sticks), would he/she be able to choose the longest?	☐ 1	☐ 2	☐ 8
SF129		Can your child talk about things that have happened in the past using correct language (e.g. "Yesterday I played with my friend", or "Last week she went to the market")?	☐ 1	☐ 2	☐ 8
SF130		Can your child tell a story?	☐ 1	☐ 2	☐ 8
SF131		Can your child tell you when he/she is happy, angry or sad?	☐ 1	☐ 2	☐ 8
SF132		Can your child name at least 1 colour (e.g. red, blue, yellow)?	☐ 1	☐ 2	☐ 8
SF133		Can your child count up to 5 objects (e.g. fingers, people)?	☐ 1	☐ 2	☐ 8
SF134		If you draw a circle, can your child do it just as you did?	☐ 1	☐ 2	☐ 8
SF135		Can your child tell you when others are happy, angry or sad?	☐ 1	☐ 2	☐ 8
SF136		Can your child talk about things that will happen in the future using correct language (e.g. "Tomorrow he will attend school", or "Next week we will go to the market")?	☐ 1	☐ 2	☐ 8
SF137		Can your child fasten and unfasten buttons without help?	☐ 1	☐ 2	☐ 8
SF138		Can your child dress him-/herself completely (except for shoelaces, buttons and zippers)?	☐ 1	☐ 2	☐ 8
SF139		Can your child say what others like or dislike (e.g. "Mama doesn't like fruit", or "Papa likes football")?	☐ 1	☐ 2	☐ 8

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Annex

When using the GSED SF paper format, and an electronic support (through PowerPoint or other) is not available, at a minimum print the following pictures and video animation sequences, and show them to the caregiver when asking the appropriate item.

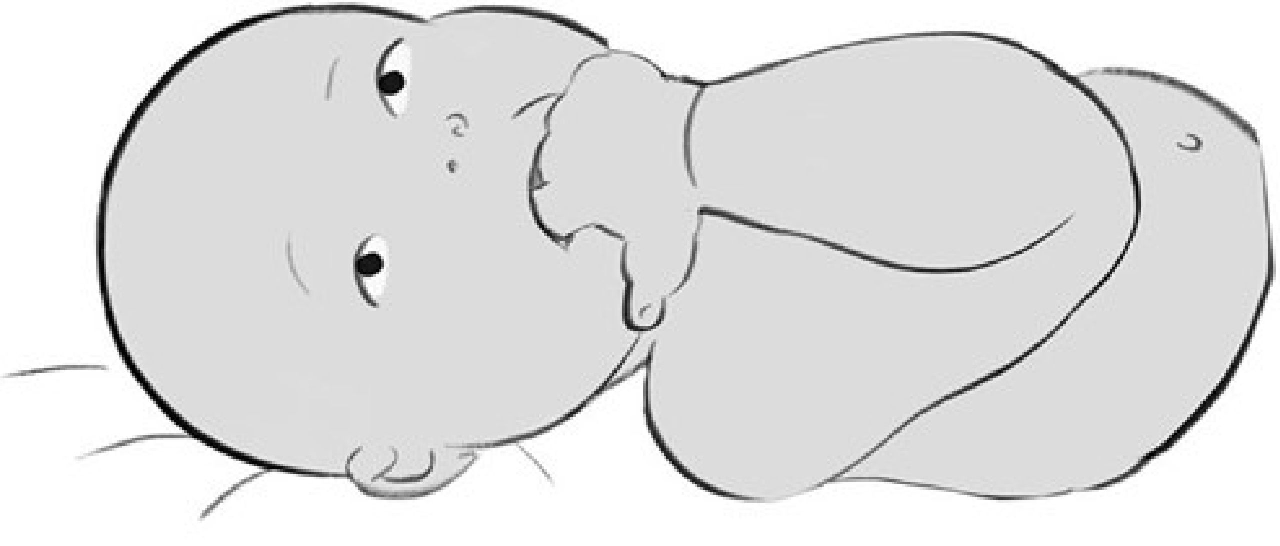
SF001

SF002

SF003

SF005

SF007



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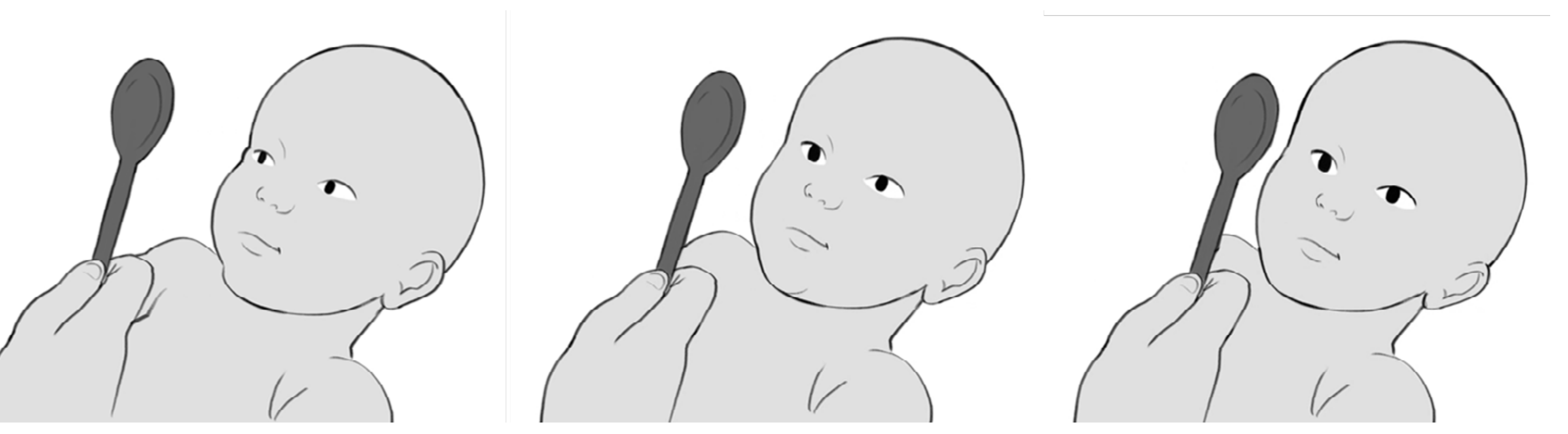

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SF017

SF021

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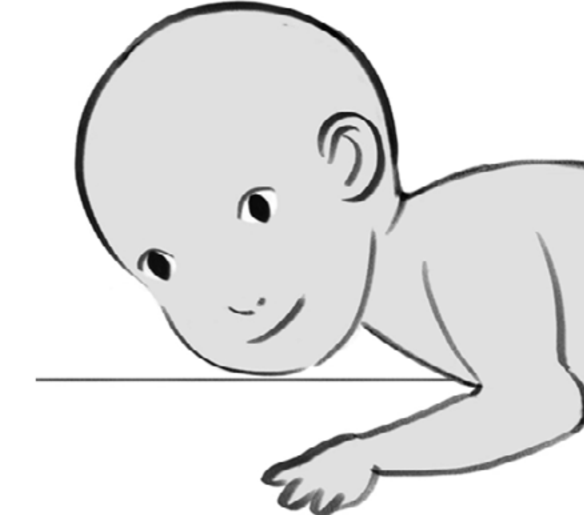

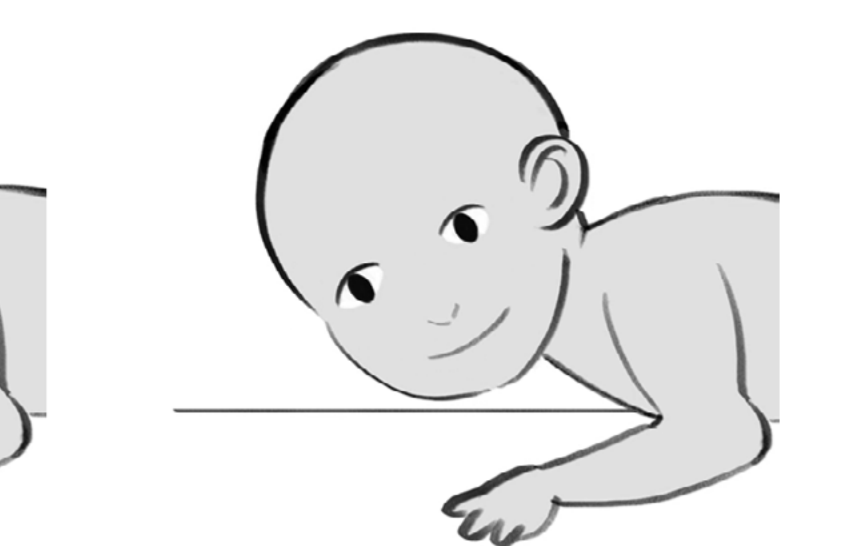

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SF030

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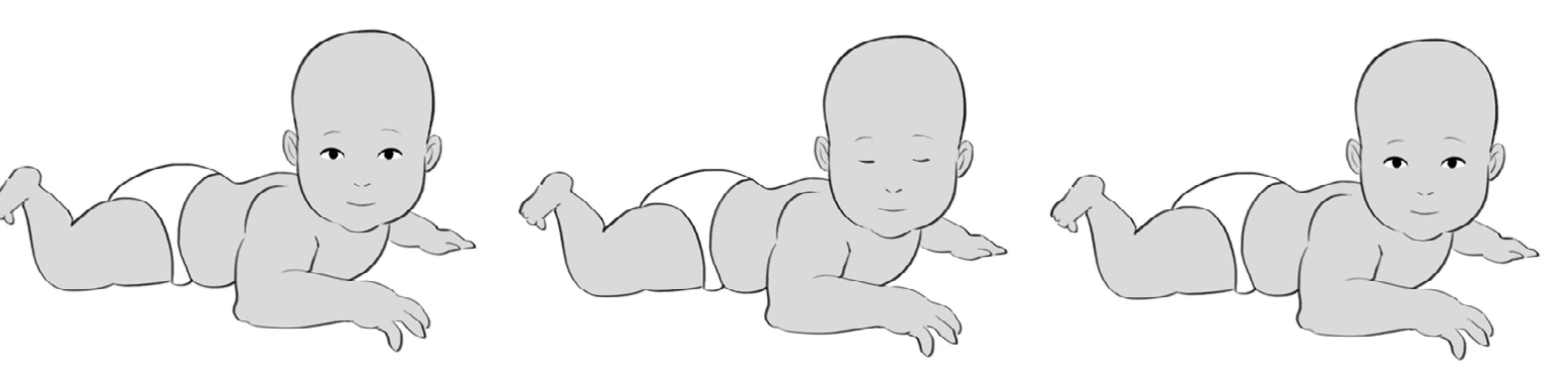

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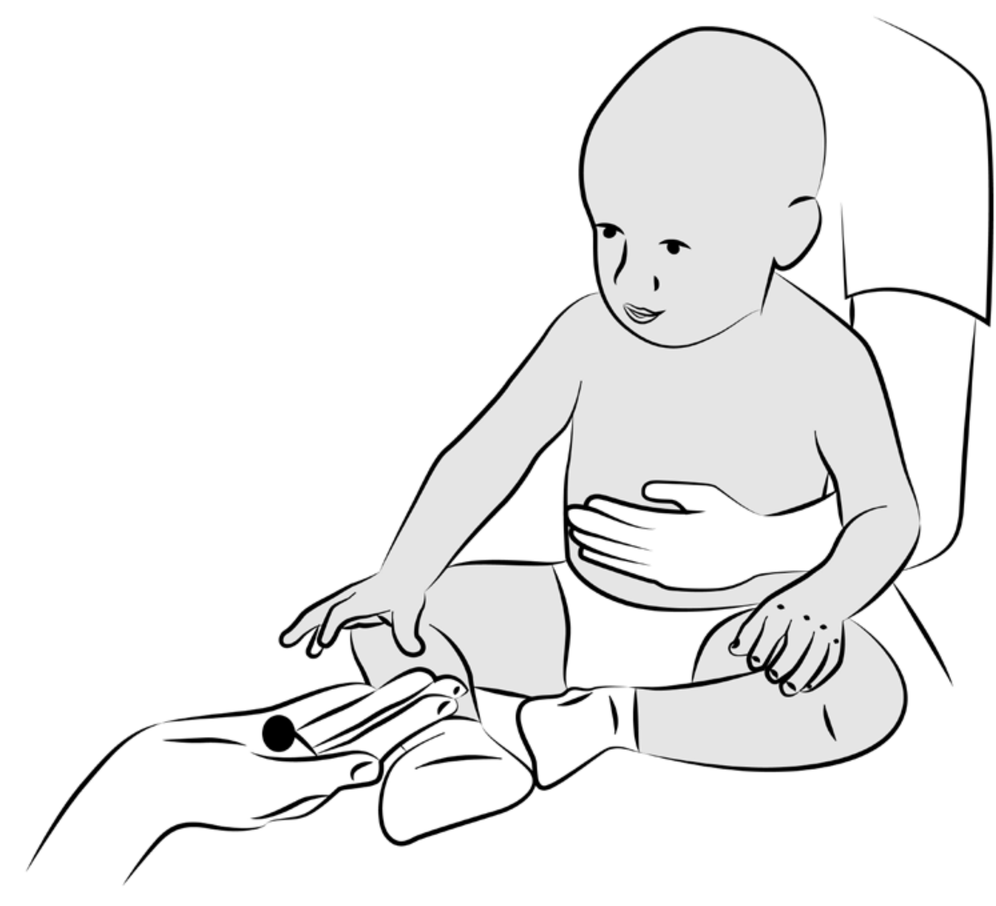

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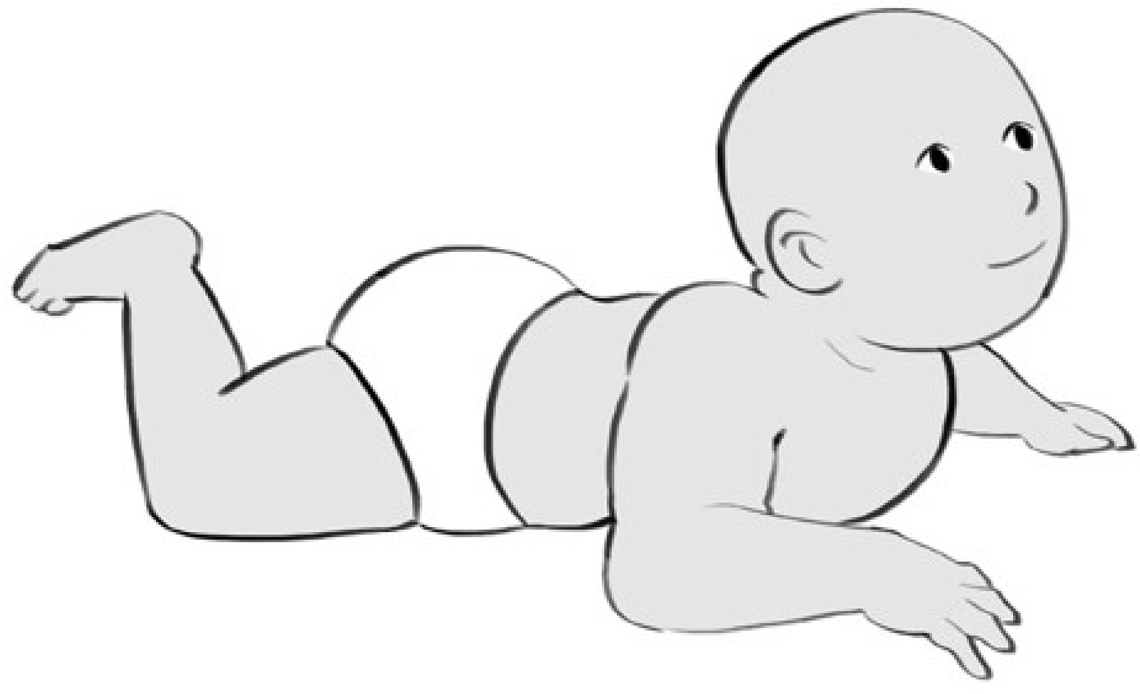

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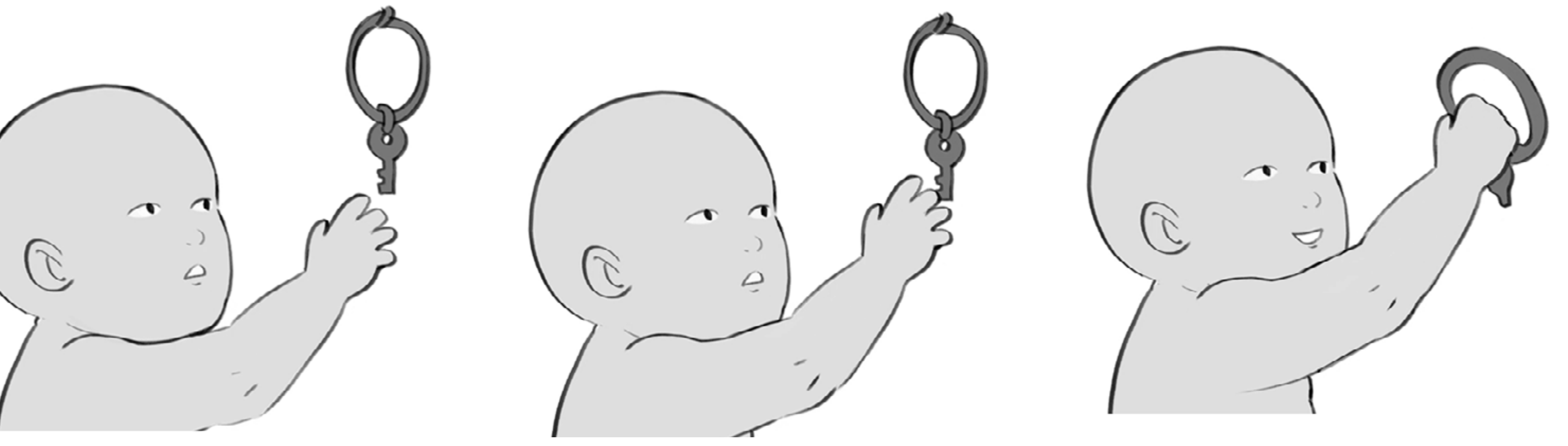

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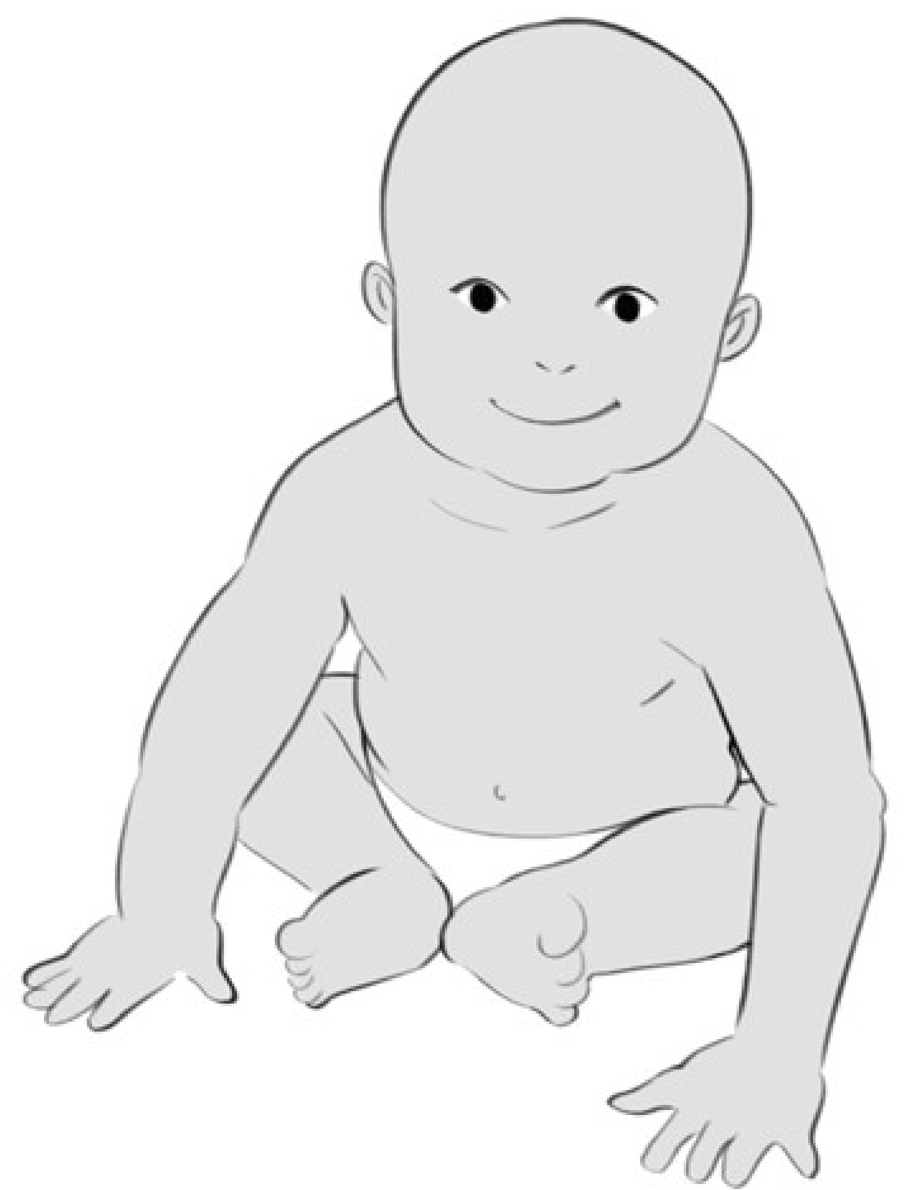

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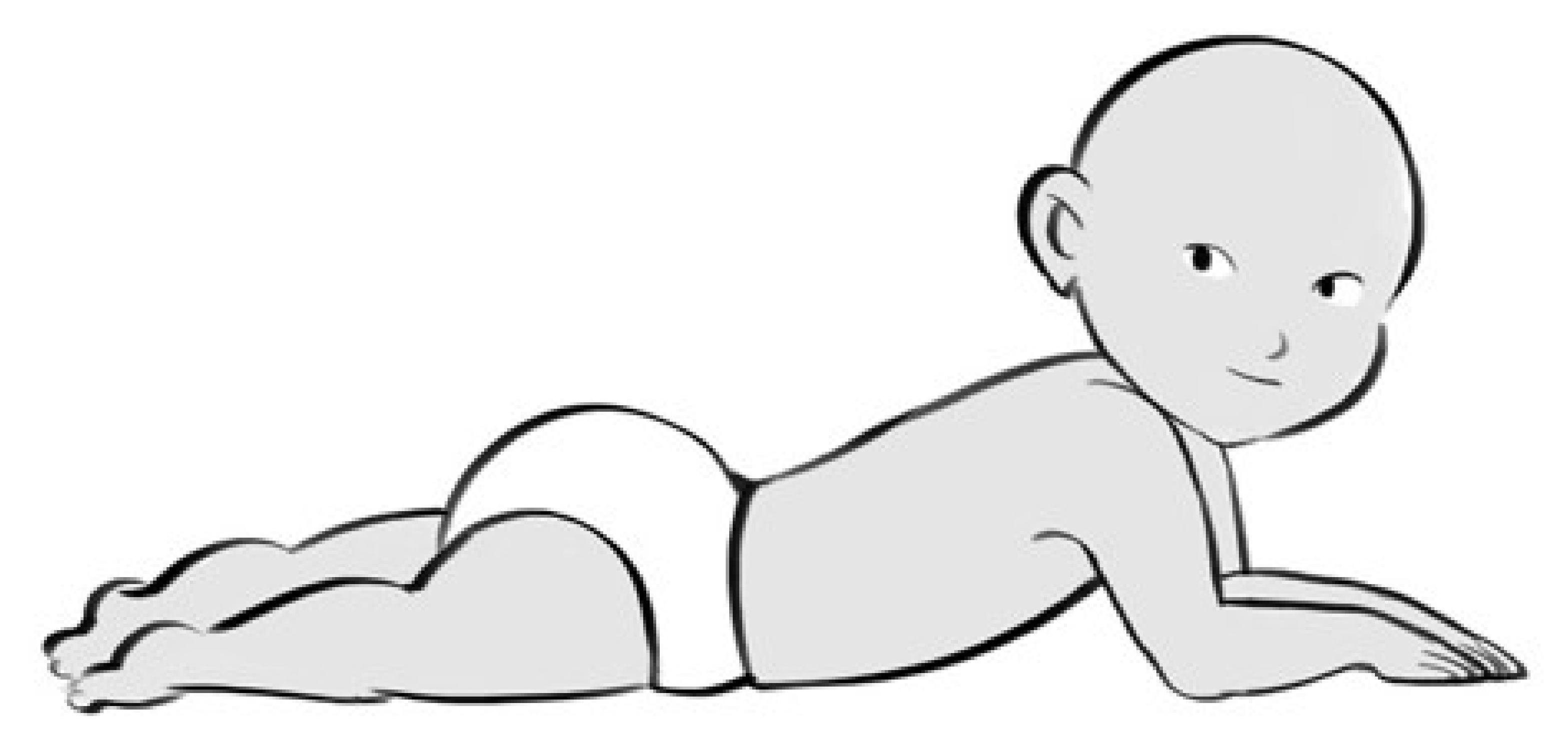

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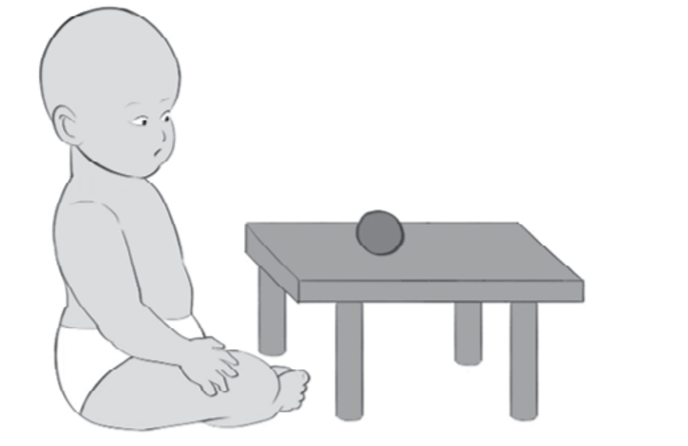

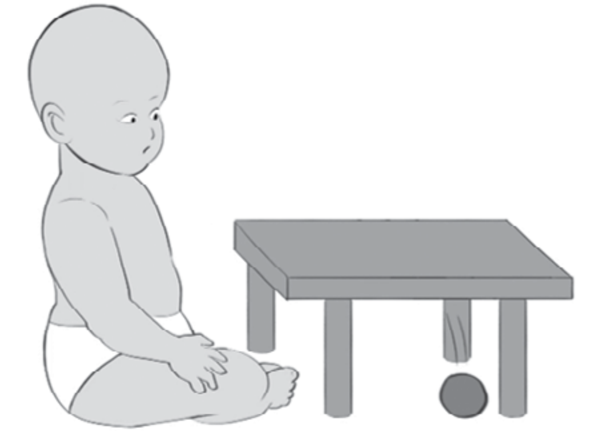

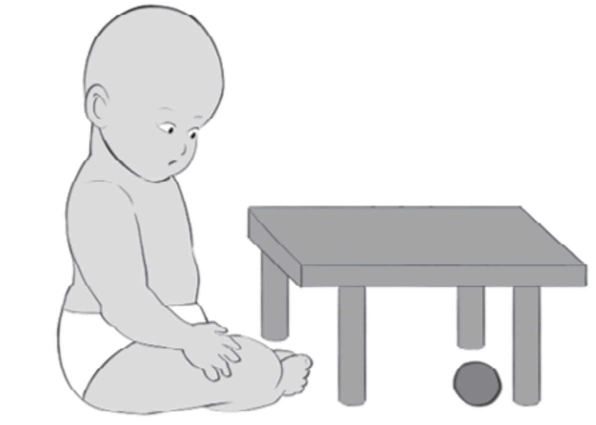

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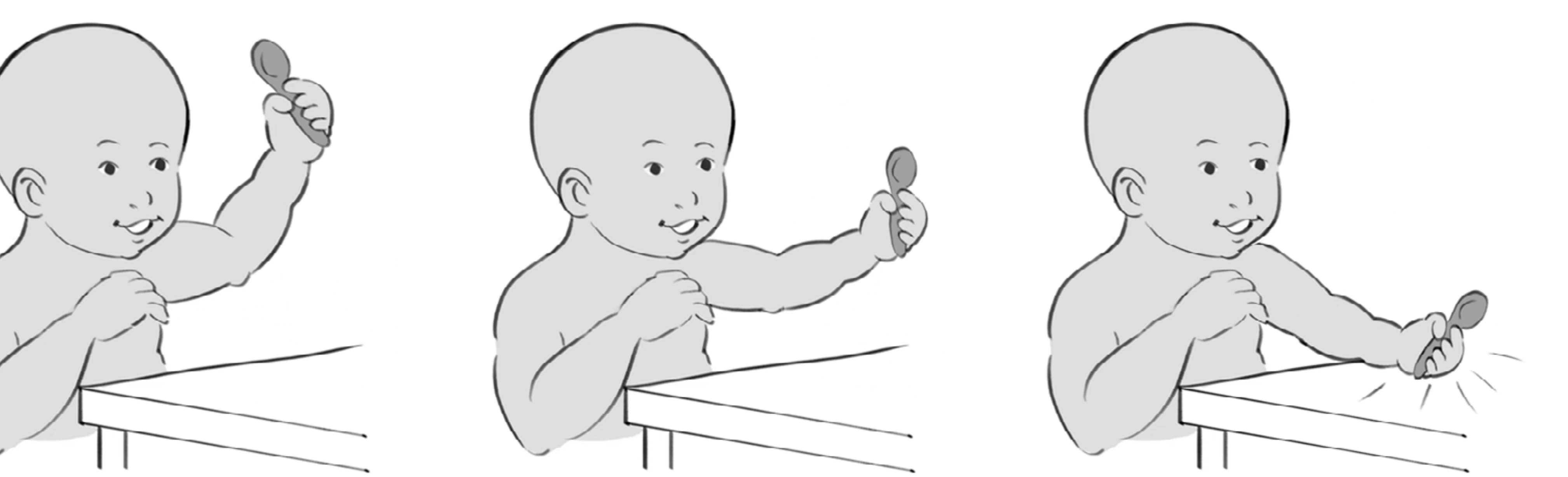

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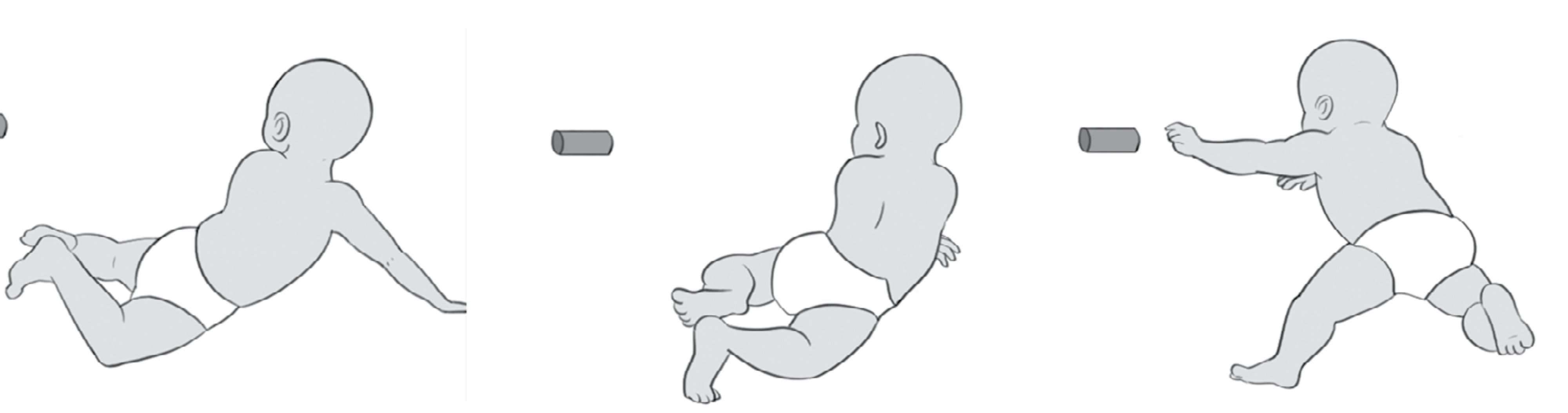

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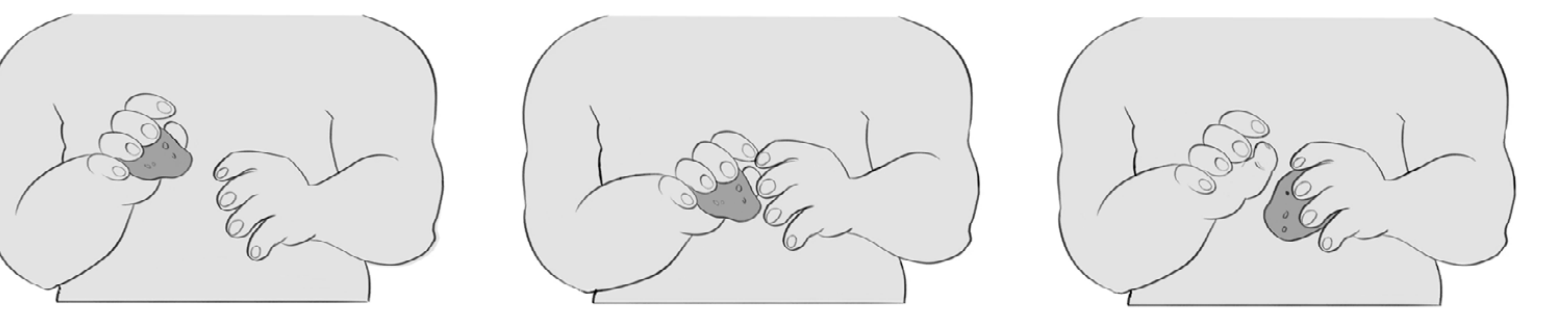

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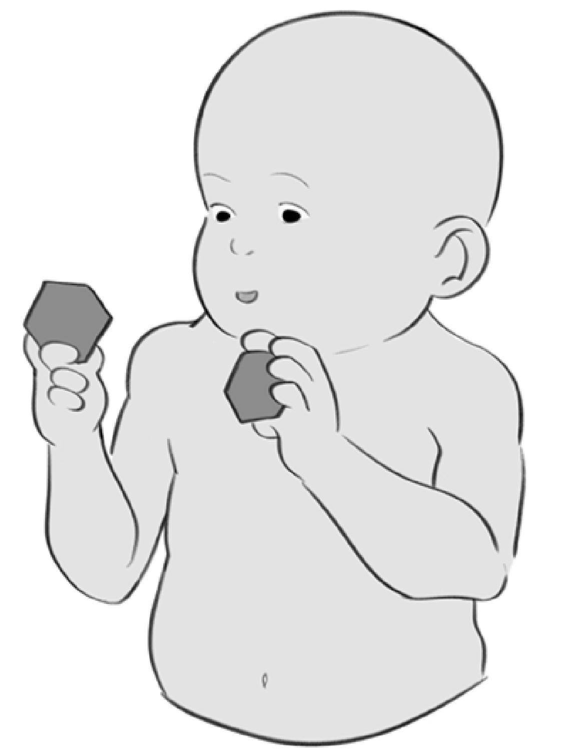

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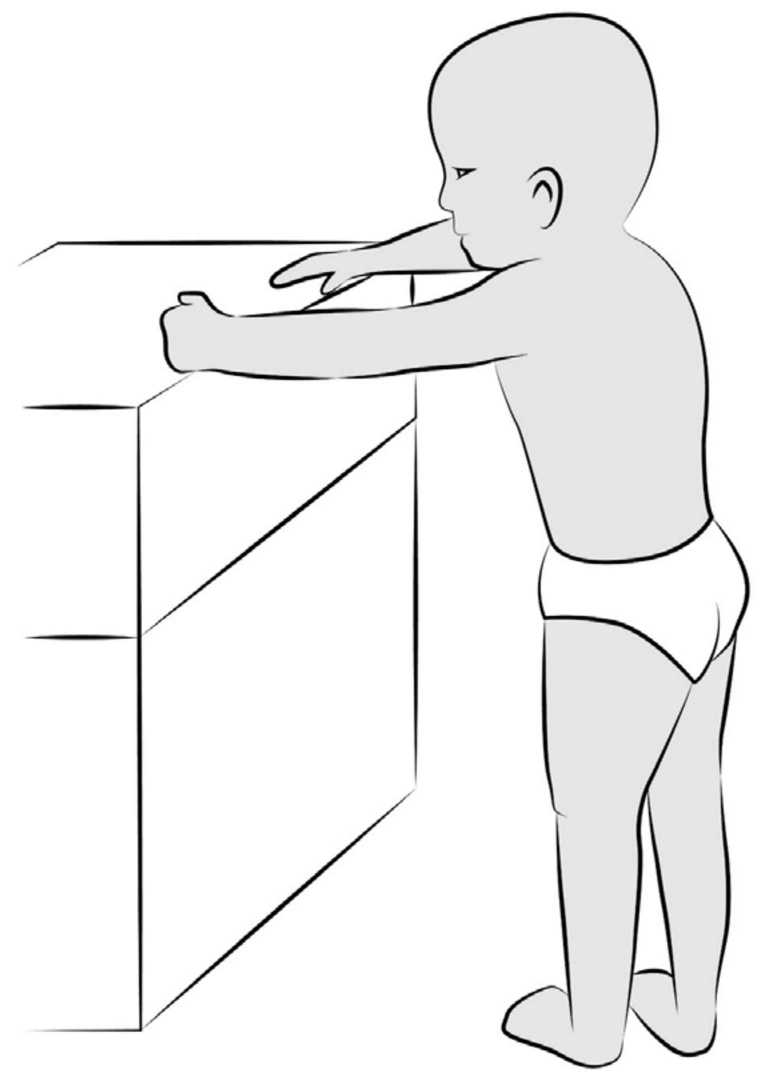

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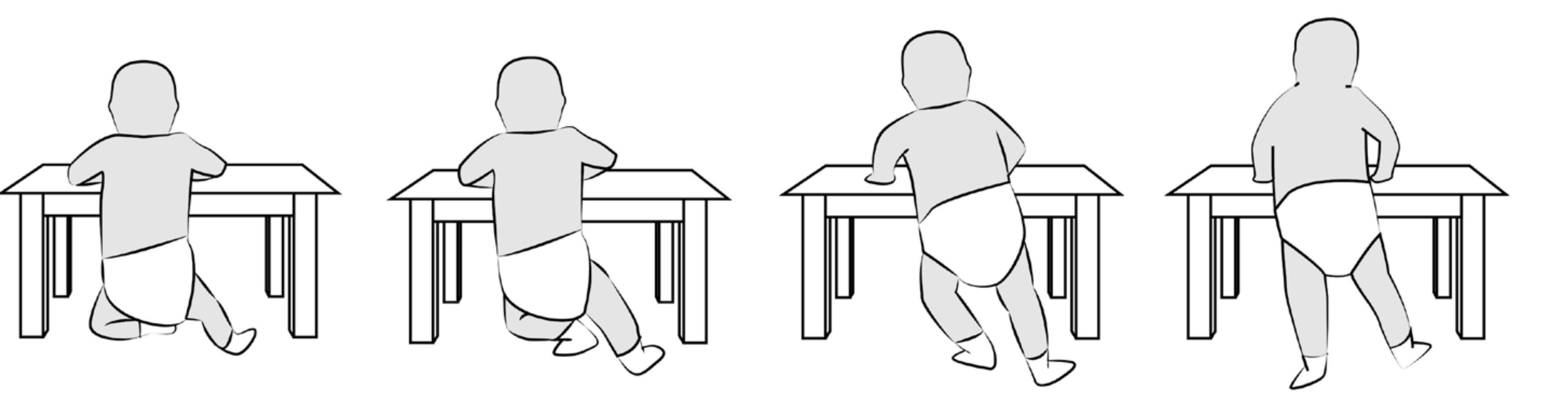

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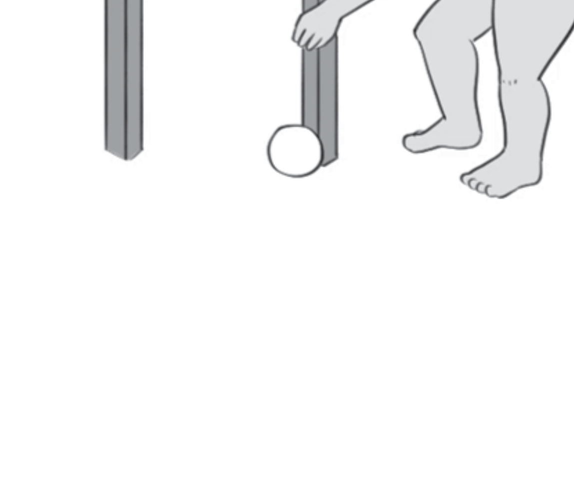

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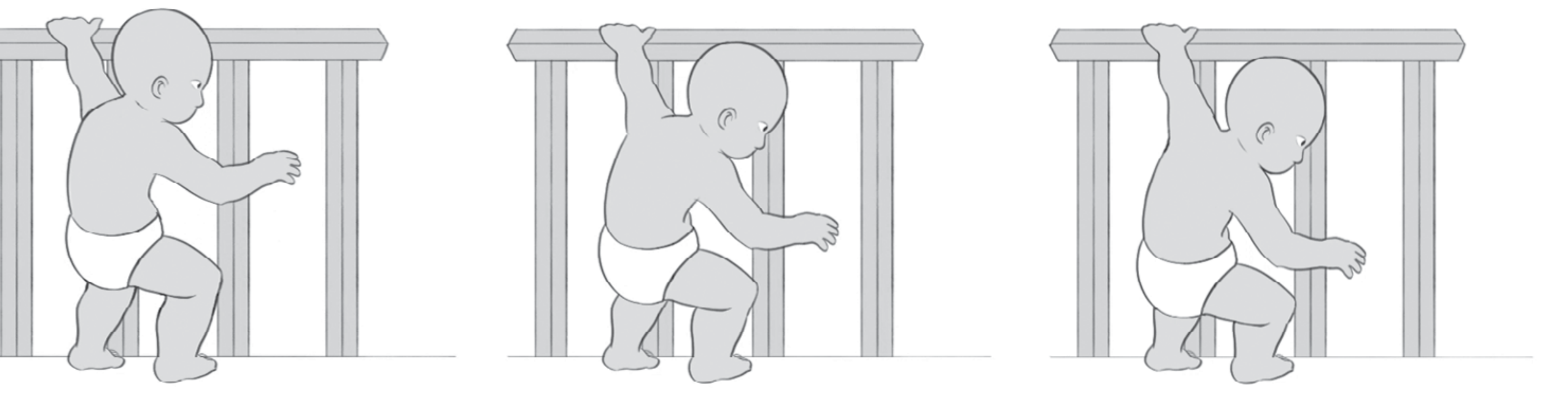

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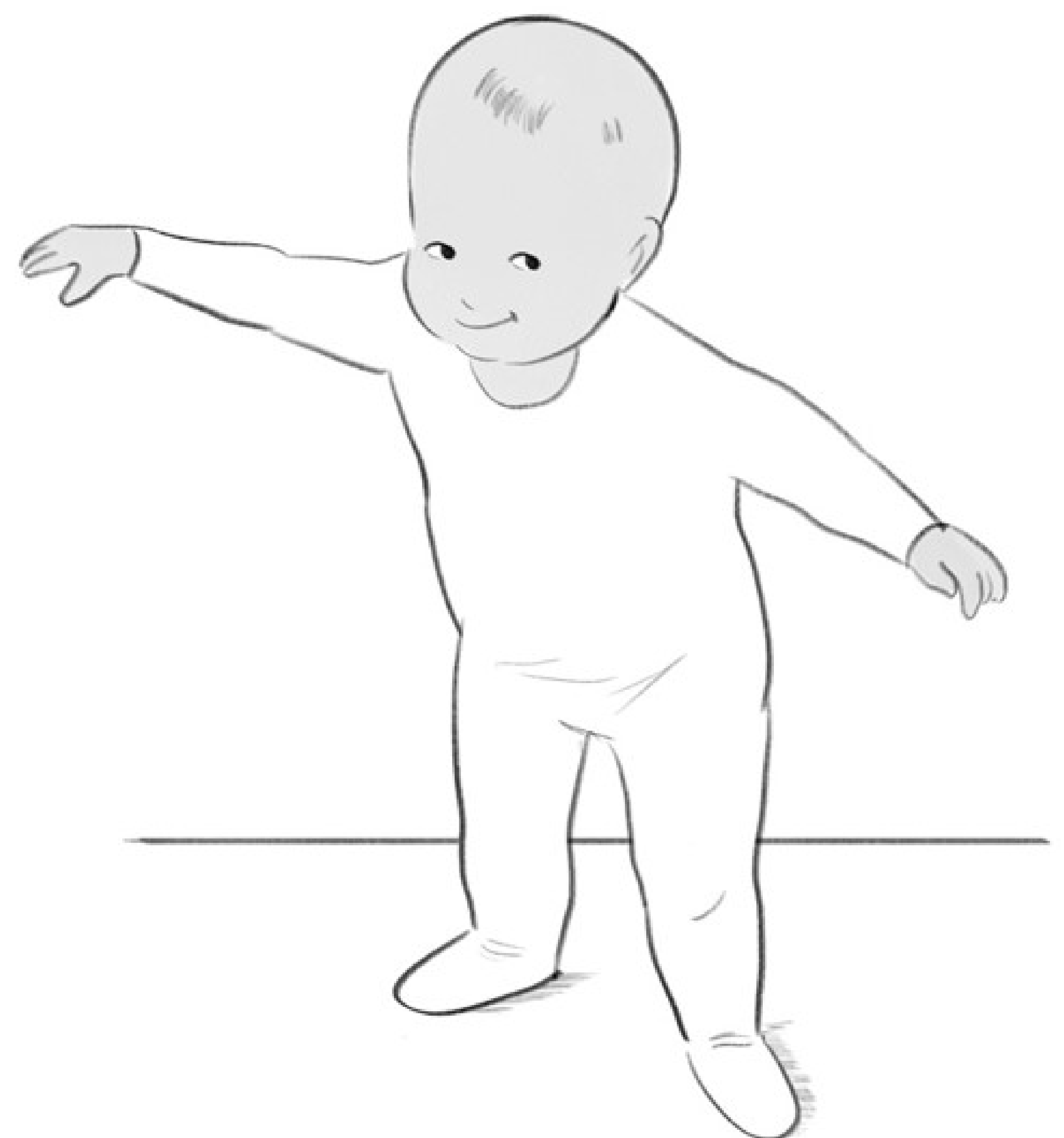

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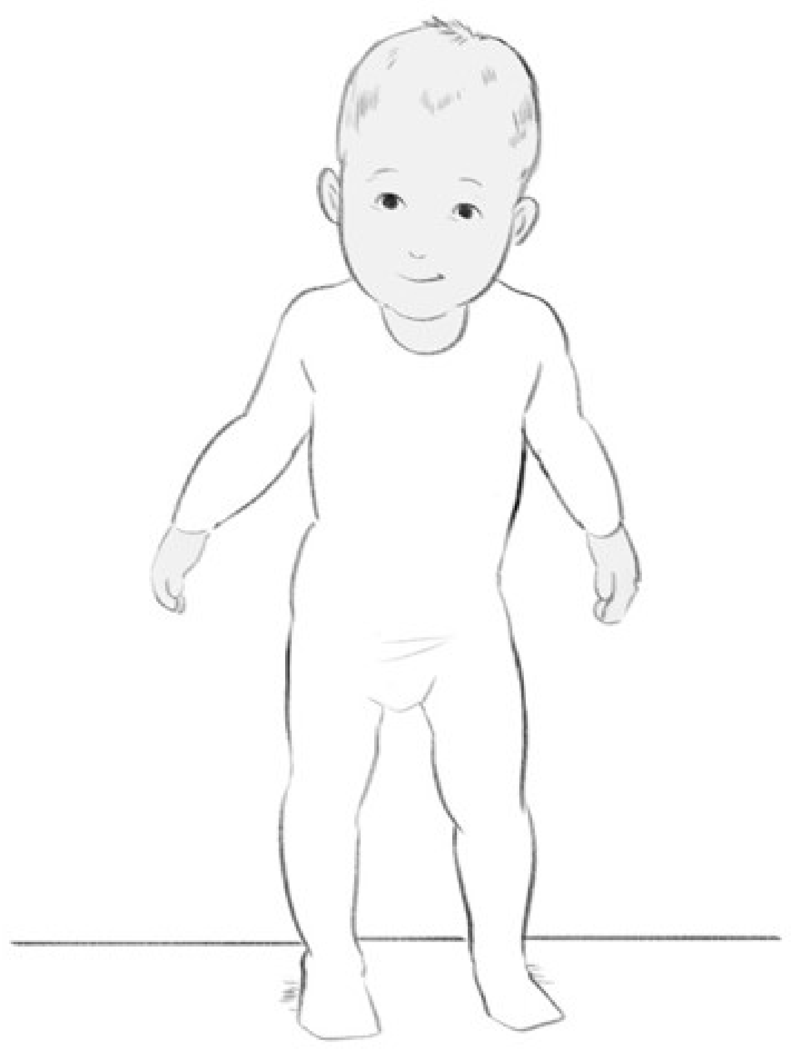

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SF070

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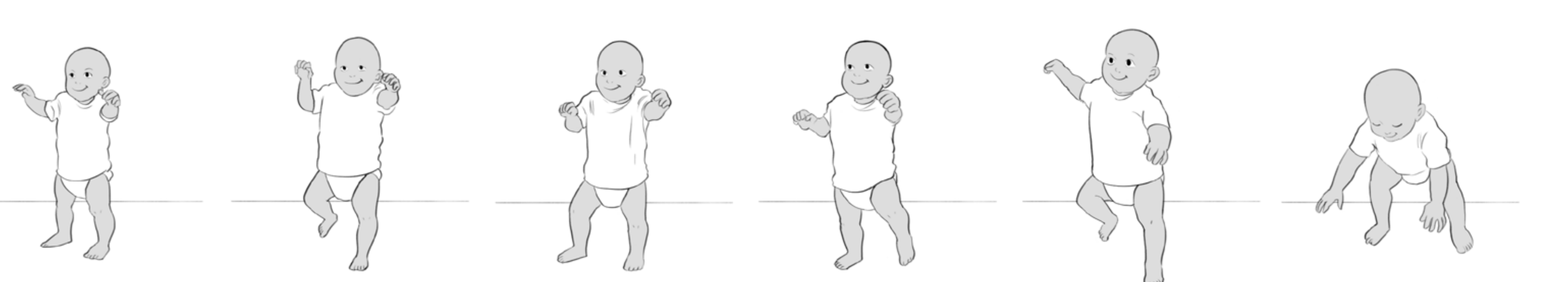

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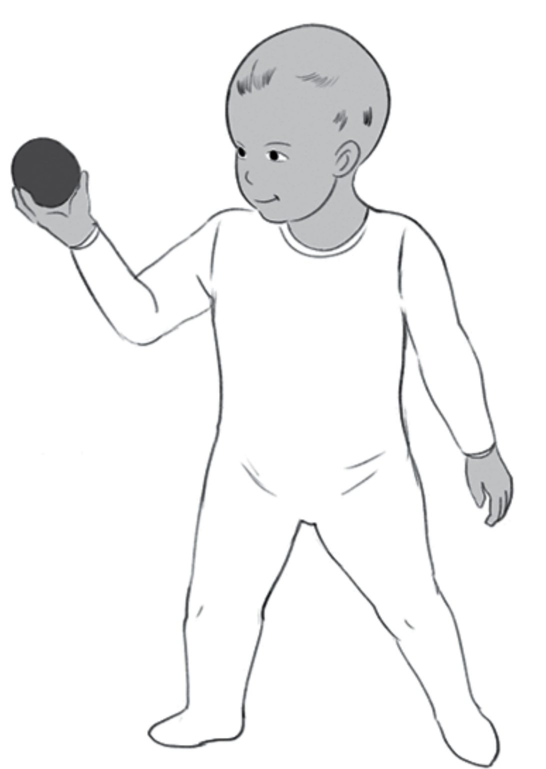

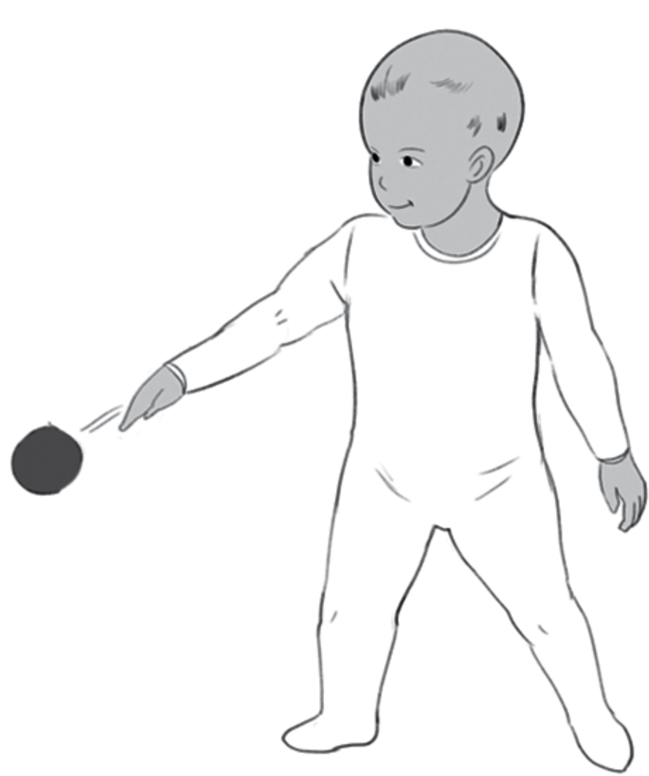

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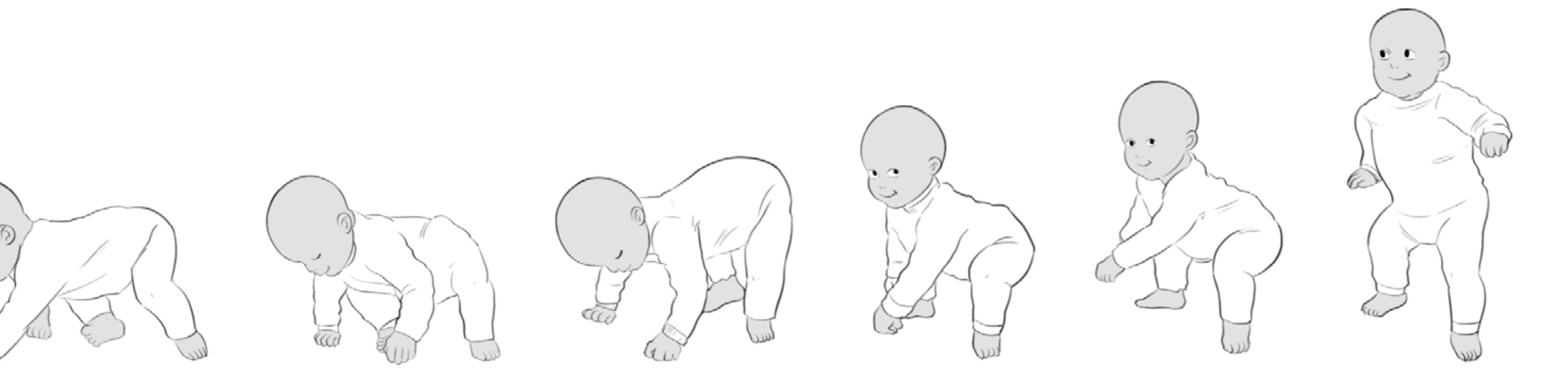

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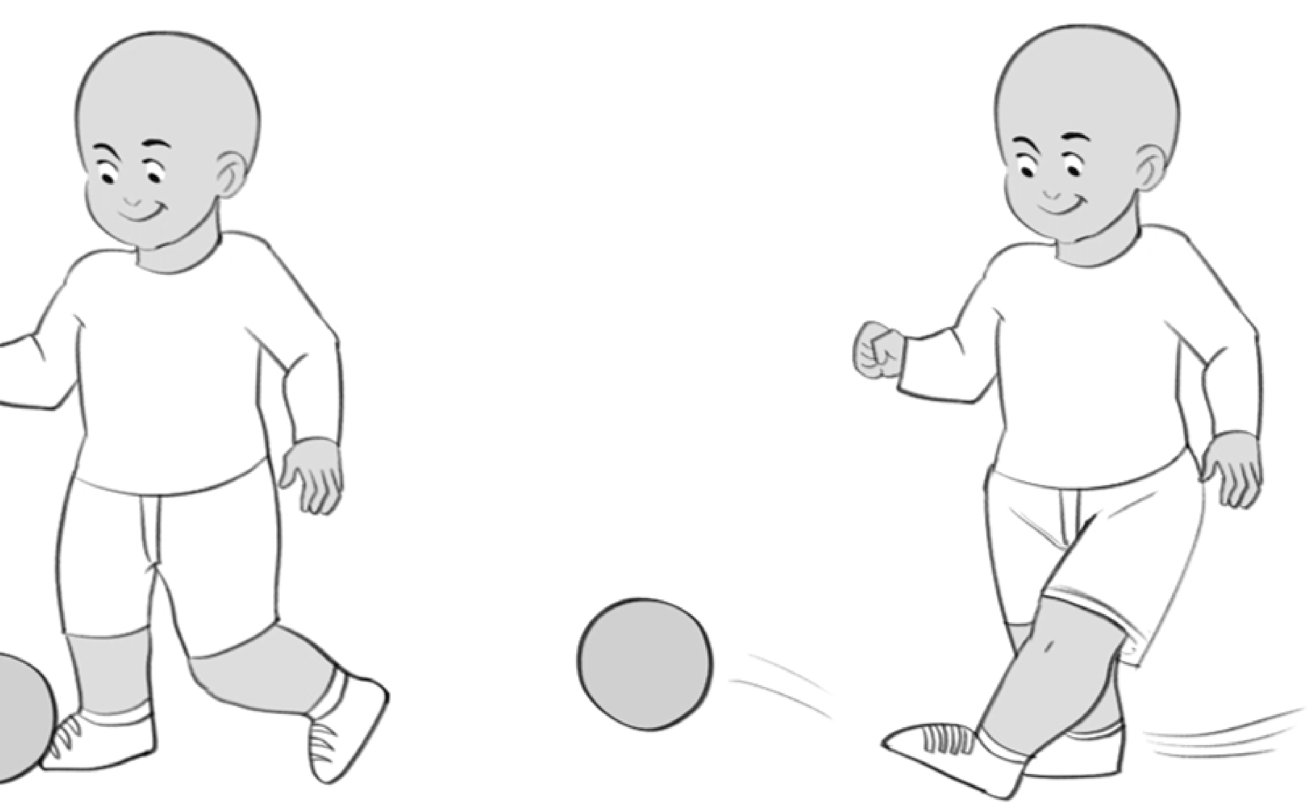

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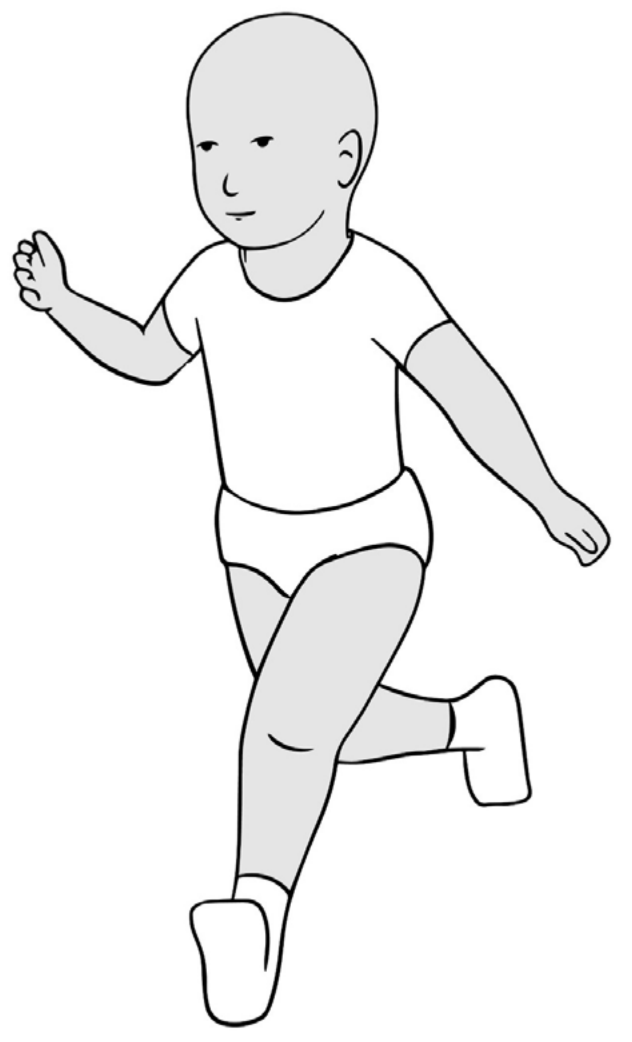

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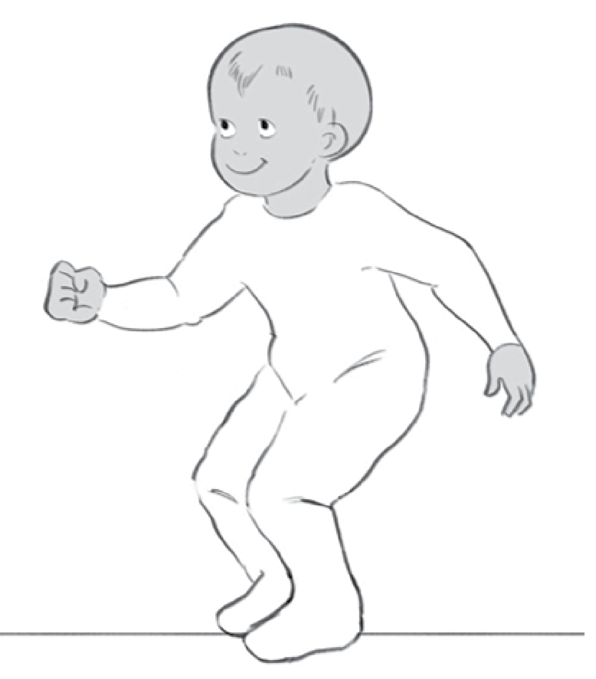

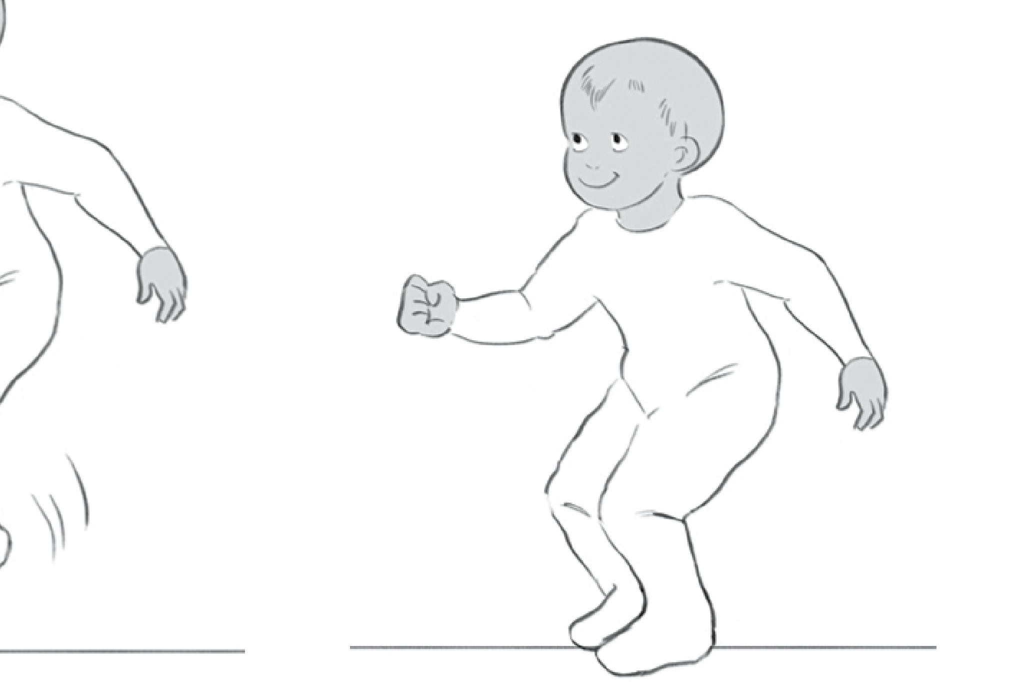

SF126

SF128

FOR MORE INFORMATION PLEASE CONTACT:

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APPENDIX - C

VINELAND SOCIAL MATURITY SCALE

Indian Adaptation by Dr. A.J. Malin

The Vineland Social Maturity Scale (VSMS) measures the differential social capacities of an individual. It provides an estimate of Social Age (SA) and Social Quotient (SQ), and shows high correlation (0.80) with intelligence. It is designed to measure social maturation in eight social areas: Self-help General (SHG), Self-help Eating (SHE), Self-help Dressing (SHD), Self direction (SD), Occupation (OCC), Communication (COM), Locomotion (LOM), and Socialization (SOC). The scale consists of 89 test items grouped into year levels. For details of the complete VSMS one should refer to VSMS manual. VSMS can be used for the age group of 0-15 years.

The examiner should collect information on VSMS test items regarding child's abilities through direct observation and supplement it by interviewing the mother.

Recording

Use Record Sheet for noting the child's responses. Mark the item pass (✓) if the child is able to perform correct and fail (×) if otherwise. Half credits may be given if it can be presumed that the child could have passed the item if the opportunity was present. These half credits receive full credit if they lie between two passed items.

Scoring

Add up passed scores (full and half). Find out the Social Age (SA) from Appendix-11 of VSMS manual. Compute Social Quotient (SQ) by dividing SA by CA and multiplying by 100. Assess maturity levels both in terms of SA and SQ for each of the eight social areas by referring VSMS norms and enter in the columns of social maturity constellation record.

VINELAND SOCIAL MATURITY SCALE RECORD SHEET

S. No. Test Items	S. No. Test Items
0-1 Year	29. Goes about hours or yard
1. "Crows", Laugh	30. Discriminates edible substances from non-edibles
2. Balance head	31. Uses names of familiar objects
3. Grasps objects within reach	32. Walks upstairs unassisted
4. Reaches for familiar persons	33. Unwraps sweets, chocolates
5. Rolls over, (unassisted)	34. Talks in short sentences
6. Reaches for nearby objects	**2-3 Years**
7. Occupies self-upright	35. Signals to go to toilet
8. Sits unsupported	36. Initiates own play activities
9. Pulls self upright	37. Removes shirt to or frock if unbuttoned
10. "Talks", imitates sounds	38. Eats with spoon/hands (food)
11. Drinks from cup or glass assisted	39. Gets drink (water) unassisted
12. Moves about on floor (creeping, crawling)	40. Dries own hands
13. Grasps with thumb and finger	41. Avoids simple hazards
14. Demands personal attention	42. Puts on short or frock unassisted (need not button)
15. Stands alone	43. Can do paper folding
16. Does not drool	44. Relates experience
17. Follows simple instructions	**3-4 Years**
1-2 Year	45. Walks downstairs, one step at a time
18. Walks about room unattended	46. Plays co-operatively at kindergarten level.
19. Marks with pencil or crayon or chalk	47. Buttons shirt or frock
20. Masticates (chews) solid or semi-solid food	48. Helps at little household tasks
21. Pulls off clothes	49. "Performs" for others
22. Transfers objects	50. Washes hands unaided
23. Overcomes simple obstacles	**4-5 Years**
24. Fetches or carries familiar objects	51. Cares for self at toilet
25. Drinks from cup or glass	52. Washes face unassisted
26. Walks without support	53. Goes about neighborhood Unattended
27. Plays with other children	
28. Eats with own hands (biscuits, bread, etc.)	

S. No.	Test Items
54.	Dresses self expect for trying
55.	Uses pencil or crayon or chalk for drawing
56.	Plays competitive exercise games
	5-6 Years
57.	Uses hoops, flies kites, or uses knife
58.	Prints (writes) simple words
59.	Plays simple games which require talking turns
60.	Is trusted with money
61.	Goes to school unattended
	6-7 Years
62.	Mixex rice "properly unassisted
63.	Use pencil or chalk for waiting
64.	Bathes self assisted
65.	Goes to bed unassisted
	7-8 Years
66.	Can differentiate between AM & PM
67.	Helps himself during meals
68.	Understands and keeps family secrets
69.	Participants in pre-adolescent
70.	Combs or burses hair
	8-9 Year
71.	Uses tools or utensils
72.	Does routine household tasks
73.	Reads on own initiative
74.	Bathes self unaided
	9-10 Years
75.	Cares for self at meals
76.	Makes minor purchase
77.	Goes about home town freely
	10-11 Years
78.	Distinguishes between friends any play mates
79.	Makes independent choice of shops
80.	Does small remunerative work; makes articles
81.	Follows local current events
	11-12 Years
82.	Does simple creative work
83.	Is left to care for self or others
84.	Enjoys reading books, newspapers and magazines
	12-15 Years
85.	Plays difficult games
86.	Exercises complete care of dress
87.	Buys own clothing accessories
88.	Engages of adolescent group activities
89.	Performs responsible routine chores

VINELAND SOCIAL MATURITY SCALE

Explanation of some items

1. Vocalizes inarticulately (other than crying or fretting). Spontaneously gargles or coos. Laughs spontaneously or when simulated.
6. Attempts to obtain nearby but beyond reach
7. Plays with rattle or simple objects for quarter hour or longer without need of attention.
14. Indicates desire to be "talked" to or beyond mere handling, or care for physical needs.
16. Has established control of saliva so that mouth or chin does not require wiping except while eating.
17. Comes when called, points to particular objects in pictures when asked; in general cooperages on verbal request in very simple activities.
22. Pours from one vessel to another without messing; removes, transfers, or replaces objects in somewhat purposeful manner.
23. Opens closed doors; climbs up on chair; uses stools for reaching; removes simple impediments.
26. Walks by pushing a cart on wheels or a walker.
27. Activity is individual rather that cooperative, but he "gets along" with other children.
28. Eats things like biscuit or bread holding in his own hand or uses spoon to eat from a bow, a cup, or a plate.
35. By actions or speech expresses to go to urinate or care himself; may be assisted at the same.
36. Occupies self at play such as drawing or coloring with pencil, looking at books or pictures.
41. Comes in out of rain. Shows some caution regarding strangers. Is careful as regards falling on stairs.

44. Gives simple accounts of experience or tells stories.
46. Participates in coordinated group activity as kindergarten circle games, cooking or group play.
49. Entertains others by reciting, singing, or dancing.
55. Draws forms like man, house, tree, animal etc.
56. Engages in tag, hide and seek, jumping, rope, tops, skipping, or marbles.
57. Hoops-ring pushed by hand or stick, cycle tyre.
59. Games with others requiring taking turns, observing rules without undue dissension; caroms, snake, and ladder, trade etc.
60. Is responsible with small sums of money when sent to make payments of explicit purchases.
63. Writes (not prints) legibly with a pencil a dozen or more simple words with correct spelling.
65. Performs bedtime operation without help; goes to room alone, changes dress and turns out-light.
67. After the meals is served first, helps himself more according to the need.
69. Boys: games not requiring definite skill and with only less rules such as unorganized hockey, football, kho-kho and follow the leader. Takes hikes or bicycle rides.

    Girls: engages in dramatic play symbolizing domestic or social situation such as playing house, school, doctor-nurses etc.,

    (Note: Sex differentiation in play is noted at this stage and there is a shift in girls play to more sedentary ones. However, credit item regardless of sex if this differentiation has yet established.
71. Makes practical use of hammer, screwdriver and household articles. Sews. Uses garden tools etc.
72. Helps effectively at simple tasks for which some continuous responsibility is assumed; dusting; arranging; cleaning; washing dishes, making bet etc.
73. Reads comic strips, movie titles, simple stories, notes simple instructions, elementary news item for own entertainment or information.

76. Buys useful articles, exercise some choice or discretion in doing so and is responsible for safety of articles, money and correct change.
79. Able to decide for self, which shop to go for purchasing different articles.
80. Makes articles for self use, e.g. making simple gardens, stitching buttons, preparing tea for self, doing small repairs, talking care of own cabinet, table and room or performs occasional work on own initiative such as odd jobs, housework, helping in care of children, sewing, selling magazines, carrying newspapers for which some money is paid.
81. Writes letters to get information regarding some books, magazine or toys.
82. Makes useful articles; cooks, raises pets, writes simple stories or poems; produce simple drawings or painting.
83. Is sometimes left along and is successful in looking after own immediate needs or hose of others who may be left in his care.
85. Participates in skilled games and sports as card games, basketball, tennis, hockey, badminton, understands rules and methods of scoring.
86. Includes washing and drying hair, care of nails, proper selection of clothing according to occasion and weather.
87. Selects and purchases minor articles of personal clothing with regard for appropriateness, such as ribbons, underwear, linen, shoes etc.
88. Is an active member of a cooperative group, athletic team, club, social or literary organization. Plans or participates in picnic trips, outdoor sports, etc.
90. Such an assisting in house work, caring for garden, cleaning car-washing window, waiting at table, bringing water etc.

VINELAND SOCIAL MATURITY SCALE-NORMS FOR PROFILE ANALYSIS

Maturity Levels (Years)	Months	SHG	SHE	SHD	SD	OCC	COM	LOC	SOC
XV	180					89			
	168				87				88
	156			86			84		85
XII	144				83	82			
	140								
	136								
XI	132					80	81		
	128				79				
	124								78
X	120								
	116								
	112		75	74	76			77	
IX	108								
	104			70		72	73		
	100			70		71			
VII	96								
	92								69
	88	66	67	65					68
VII	84			64					
	80						63		
	76		62					61	
VI	72								
	68				60				59
	64					57	58		56
V	60			54		55			
	56			52					
	52	51		50				53	

(Contd......)

IV	48							
	44				48			49
	40			47		44	45	46
III	36			42	43			
	32	41	39	40	36			
	28	35	38	37				
II	24.0		33			34		
	21.6	26	30		24	31	32	
	19.2	23	28		22		29	27
	10.8		25	21	19	17	18	
	14.4		20					
I	12.0	15						
	10.5	13						
	9.0	9	16		7	10	12	14
	7.5	8	11			1		4
	6.0	6						
	4.5	5						
	3.0	3						
	1.5	2						

SHG- Self Help General

SHE- Self Help Eating

SHD- Self Help Dressing

SD- Self-Direction

OCC- Occupation

COM- Communication

LOC- Locomotion

SOC- Socialization

VINELAND SOCIAL MATURITY SCALE
ANSWER AND SCORING SHEET

0-1 Year

1. 0.7 months
2. 1.4 months
3. 2.1 months
4. 2.8 months
5. 3.5 months
6. 4.2 months
7. 4.9 months
8. 5.6 months
9. 6.3 months
10. 7.0 months
11. 7.7 months
12. 8.4 months
13. 9.1 months
14. 9.8 months
15. 10.6 months
16. 11.3 months
17. 12.0 months

1 Year

18. 0.7 months
19. 1.4 months
20. 2.1 months
21. 2.8 months
22. 3.5 months
23. 4.2 months
24. 4.9 months
25. 5.6 months
26. 6.3 months
27. 7.0 months
28. 7.7 months
29. 8.4 months
30. 9.2 months
31. 9.9 months
32. 10.6 months
33. 11.3 months
34. 12.0 months

2 Year

35. 1.2 months
36. 2.4 months
37. 3.6 months
38. 4.8 months
39. 6.0 months
40. 7.2 months
41. 8.4 months
42. 9.6 months
43. 10.8 months
44. 12.0 months

3 Year

45. 2 months
46. 4 months
47. 6 months
48. 8 months
49. 10 months
50. 12 months

4 Year

51. 2 months
52. 4 months
53. 6 months
54. 8 months
55. 10 months
56. 12 months

5 Year

57. 1.4 months
58. 4.8 months
59. 7.2 months
60. 9.6 months
61. 12.0 months

6 Years

62. 3 months
63. 6 months
64. 9 months
65. 12 months

7 Years

66. 2.4 months
67. 4.8 months
68. 7.2 months
69. 9.6 months
70. 12.0 months

8 Years

71. 3 months
72. 6 months
73. 9 months
74. 12 months

9 Years

75. 4 months
76. 8 months
77. 12 months

10 years

78. 3 months
79. 6 months
80. 9 months
81. 12 months

11 Years

82. 4 months
83. 8 months
84. 12 months

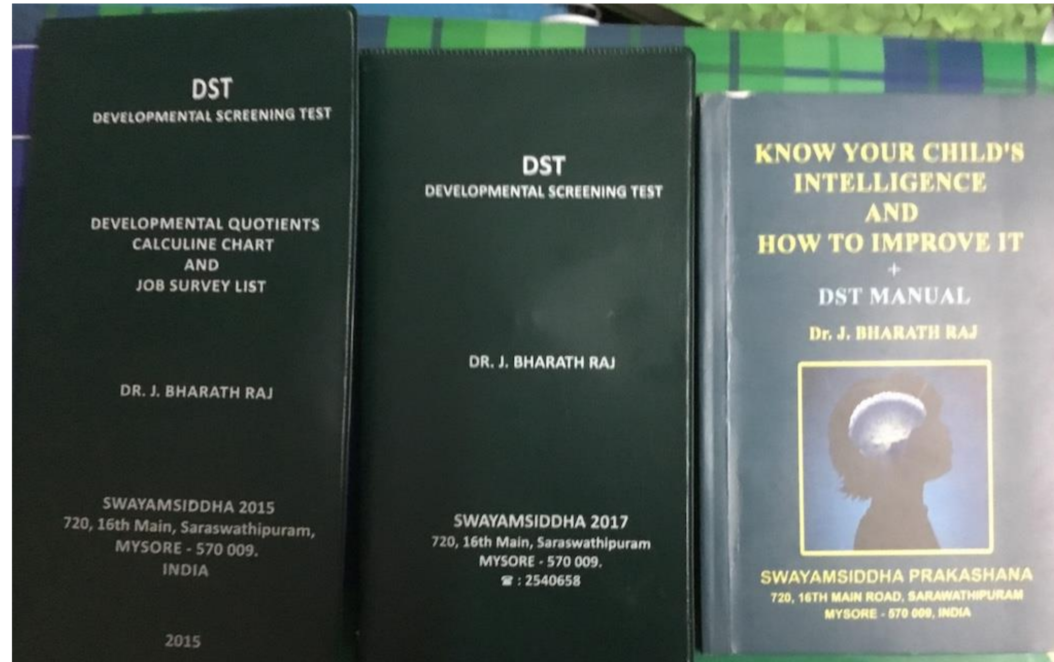
12 Years

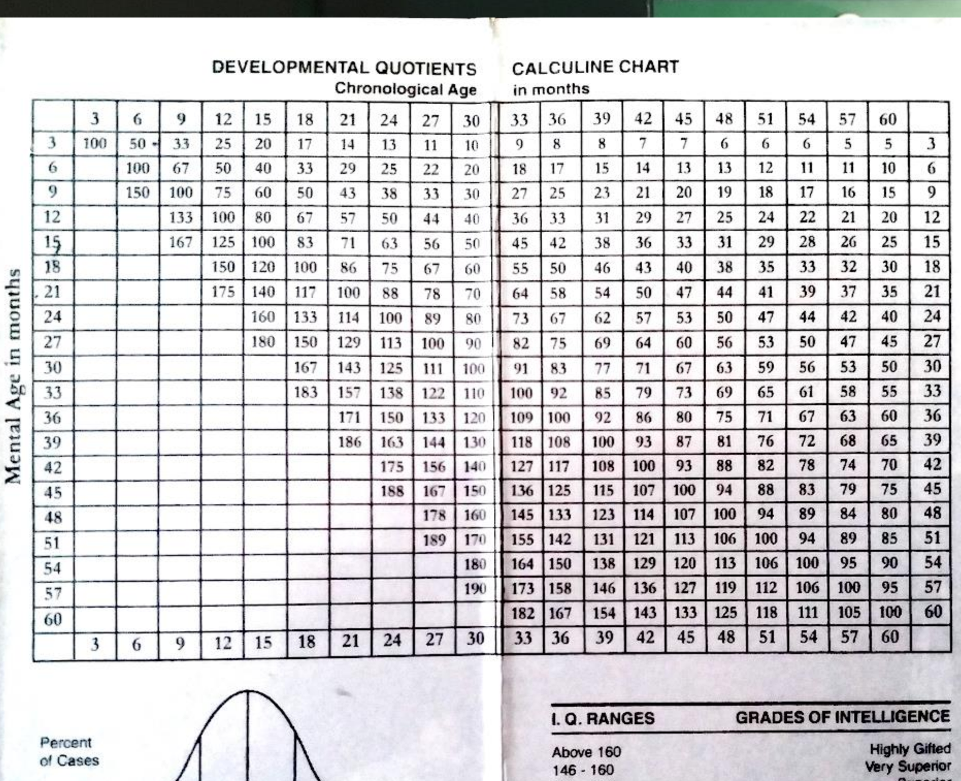
85. 7.2 months
86. 14.4 months
87. 21.6 months
88. 28.8 months
89. 36.0 months

APPENDIX IV

BHARATHRAJ DEVELOPMENTAL SCREENING TEST

		M	D
	birth cry present*		13
	equal bilateral movements		26
	responds to bell		39
	vocalises sounds*		52
	smiles spontaneously		65
	eyes follow moving object		78
3 M	head steady		90
	reaches for objects		15
	laughs aloud*		30
	recognises mother		45
	vocalises for pleasure/babbles*		60
	carried objects to mouth		75
6 M	rolls over		90
	imitates speech sounds*		23
	sits by self		46
	thumb finger grasp		68
9 M	shows curiosity		90
	says 3 words, 'dada','mama' etc*		23
	stands alone well		46
	follows simple instructions*		68
1 Y	cooperates for dressing		90
	many intelligible words*	1	15
	walks, runs well	3	
	indicates wants	4	15
1 Y	scribbles spontaneously	6	
	says sentences of 2/3 words*	1	15
	points out objects in pictures	3	
	shows body parts	4	15
2 Y	participates in play	6	
	copies 0	2	
	relates experiences*	4	
	knows names, uses of common objects	6	
	begins to ask 'why'?*	8	
	takes food by self	10	
3 Y	toilet control present	12	
	buttons up	2	12
	comprehends 'hunger','cold'*	4	24
	plays cooperatively with children	7	6
	repeats 3 digits*	9	18
4 Y	tells stories*	12	
	defines words*	2	
	makes simple drawings	4	
	dresses with no supervision	6	
	describes actions in pictures*	8	
	gives sensible answers to questions*	10	
5 Y	goes about neighbourhood	12	
	can name primary colour	2	12
	plays games governed by rules	4	24
	writes simple words*	7	6
	gains admission to school	9	18
6 Y	enjoys constructive play	12	
	adapts to home, school	2	12
	tells differences of objects	4	24
	spells, reads, writes simple words	7	6
	enjoys group play	9	18
7 Y	knows comparative value of coins	12	
	combs hair by self	3	
	makes small purchases	6	
	competition in school/play	9	
8 Y	tells time	12	
	tells day, month, year*	2	
	reads on own initiative*	4	
	recognises property rights	6	
	favourite of fairy tales*	8	
	muscle coordination games (marbles)	10	
9 Y	bathes self unaided	12	
	cooperates keenly with companions	2	12
	has various hobbies, collections	4	24
	goes about town freely	7	6
	sex differences in play become marked	9	18
10 Y	can stay away from home	12	
	writes occasional short letters*	3	
	comprehends social situations	6	
	physical feats liked	9	
11 Y	able to discuss problems*	12	
	enjoys books, newspapers, magazines*	4	
	more independent in spending	8	
12 Y	capable of self criticism	12	
	shows foresight, planning, judgement	2	12
	learns from experience	4	24
	plays difficult games	7	6
	interested in dressing up	9	18
13 Y	understands abstract ideas (Justice)	12	
	makes sensible plans for future (job)	4	24
	follows current events*	9	18
	buys own clothing	1Y 2	12
	systematises own work	1Y 7	6
15 Y	purchases for others	2Y	

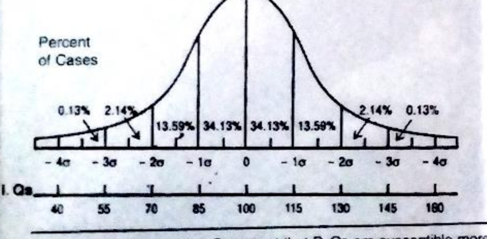




DEVELOPMENTAL QUOTIENTS CALCULINE CHART

Chronological Age in months (columns); Mental Age in months (rows)

	3	6	9	12	15	18	21	24	27	30	33	36	39	42	45	48	51	54	57	60	
3	100	50	33	25	20	17	14	13	11	10	9	8	8	7	7	6	6	6	5	5	3
6		100	67	50	40	33	29	25	22	20	18	17	15	14	13	13	12	11	11	10	6
9		150	100	75	60	50	43	38	33	30	27	25	23	21	20	19	18	17	16	15	9
12			133	100	80	67	57	50	44	40	36	33	31	29	27	25	24	22	21	20	12
15			167	125	100	83	71	63	56	50	45	42	38	36	33	31	29	28	26	25	15
18				150	120	100	86	75	67	60	55	50	46	43	40	38	35	33	32	30	18
21				175	140	117	100	88	78	70	64	58	54	50	47	44	41	39	37	35	21
24					160	133	114	100	89	80	73	67	62	57	53	50	47	44	42	40	24
27					180	150	129	113	100	90	82	75	69	64	60	56	53	50	47	45	27
30						167	143	125	111	100	91	83	77	71	67	63	59	56	53	50	30
33						183	157	138	122	110	100	92	85	79	73	69	65	61	58	55	33
36							171	150	133	120	109	100	92	86	80	75	71	67	63	60	36
39							186	163	144	130	118	108	100	93	87	81	76	72	68	65	39
42								175	156	140	127	117	108	100	93	88	82	78	74	70	42
45								188	167	150	136	125	115	107	100	94	88	83	79	75	45
48									178	160	145	133	123	114	107	100	94	89	84	80	48
51									189	170	155	142	131	121	113	106	100	94	89	85	51
54										180	164	150	138	129	120	113	106	100	95	90	54
57										190	173	158	146	136	127	119	112	106	100	95	57
60											182	167	154	143	133	125	118	111	105	100	60
	3	6	9	12	15	18	21	24	27	30	33	36	39	42	45	48	51	54	57	60	



I. Q. RANGES	GRADES OF INTELLIGENCE
Above 160	Highly Gifted
146 - 160	Very Superior
131 - 145	Superior
116 - 130	Above Average
85 - 115	Normal / Average
70 - 84	Borderline Deficiency
55 - 69	Mild MR
Below 40	Severe / Profound MR

D. Qs are synonymous with I. Qs except that D. Qs are susceptible more frequently for fluctuations due to maturation and learning

Brief Infant Sleep Questionnaire – Revised Short Form

Please answer a few questions about your family.

1. What is your relationship to your child?

☐ Mother ☐ Grandparent

☐ Father ☐ Other

2. What is the highest degree that you completed?

☐ Less than high school/secondary

☐ High school/secondary

☐ College/university

☐ Graduate (e.g., MS, MD, JD, Ph.D.)

☐ Prefer not to answer

3. How old is your child (in months)?

________months

4. Was your child premature (born before 37 weeks' gestation)?

☐ Yes

☐ No

☐ I don't know

5. My child's biological sex is

☐ Male

☐ Female

☐ Intersex

6. In which country/region do you currently reside?

Country/region: ___________________________

7. How many nights per week are you involved with your child at bedtime and/or overnight?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 nights

Please think about your child's sleep during the past two weeks in answering the following questions.

1. What time do you usually start your child's bedtime routine (start getting your child ready for bed)?

Example: 7:45 PM would be written as _____7_:_45_PM

I start getting my child ready for bed at _______:_______

2. In a typical week, how often does your child have the exact same bedtime routine?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 nights

3. Where does your child usually fall asleep at bedtime?

☐ Crib
☐ Own bed (any size)
☐ Parents' bed
☐ Co-sleeper (attached to parents' bed)
☐ Bassinet/infant seat
☐ Swing/stroller
☐ Parent's/adult's arms
☐ Other

4. How does your child usually fall asleep at bedtime?

☐ While being held or rocked
☐ With an adult in the room, but not being held or rocked
☐ On own (without an adult in the room)

5. At bedtime, does your child usually fall asleep while breastfeeding, bottle feeding, or drinking from a sippy cup?

☐ Yes
☐ No

6. What time do you usually put your child to bed at night (lights out)?

Example: 8:30 PM would be written as ____8__:_30_PM

I put my child to bed at _______:_______

7. Typically, how difficult is bedtime?

☐ Very easy
☐ Somewhat easy
☐ Neither easy nor difficult
☐ Somewhat difficult
☐ Very difficult

8. How long does it usually take your child to fall asleep?

Example: If you put your child to bed at 6:30 pm and your child falls asleep at 8:00 pm, it takes 1 hour and 30 minutes for your child to fall asleep.

_________ hours
_________ minutes

9. In what room does your child sleep for most of the night?

☐ In his/her own room
☐ In parents' room
☐ In sibling's or other bedroom
☐ In another room of the house

10. Where does your child sleep for most of the night?

☐ Crib
☐ Own bed (any size)
☐ Parents' bed
☐ Co-sleeper (attached to parents' bed)
☐ Bassinet/infant seat
☐ Swing/stroller
☐ Other

11. How many times does your child usually wake during the night?

_______ times per night

12. When your child wakes up during the night, what do you usually do? (check all that apply)

☐ Pick up my child and put him/her back down while still awake
☐ Bottle feed or give a sippy cup to put my child back to sleep
☐ Breastfeed/nurse my child back to sleep
☐ Play with my child, watch TV, or use/show smartphone/tablet
☐ None of these

13. How much total time during the NIGHT is your child usually awake (between when your child goes to bed and wakes for the day)?

Example: If your child wakes up 2 times and is awake for about 15 minutes each time, your child's total time spent awake is 30 minutes. In that case, write "0 hours, 30 minutes."

________ hours
________ minutes

14. What is the <u>longest stretch</u> of time that your child is asleep during the NIGHT without waking up?

________ hours
________ minutes

15. What time does your child wake up in the morning?

My child wakes up at _______:_______

16. How much total time does your child spend sleeping during the NIGHT (between when your child goes to bed and wakes for the day)?

Example: If your child sleeps for 3 hours, wakes up, then sleeps for 5 hours and 30 minutes more, your child sleeps for 8 hours and 30 minutes total.

________ hours
________ minutes

17. How well does your child usually sleep at night?

☐ Very well
☐ Well
☐ Fairly well
☐ Poorly
☐ Very poorly

18. On a typical DAY, how many naps does your child take (between when your child wakes for the day and goes to bed at night)?

________ naps

19. How much total time does your child spend sleeping during the DAY (between when your child wakes for the day and goes to bed at night)?

Example: If your child took 2 naps and slept 1 hour each time, your child's total time spent sleeping during the day is 2 hours.

________ hours
________ minutes

20. Do you consider your child's sleep a problem?

☐ Not a problem at all
☐ A very small problem
☐ A small problem
☐ A moderate problem
☐ A serious problem

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Infant Behavior Questionnaire – Revised
Very Short Form

Subject No. _______________ Date of Baby's Birth ______ ____ _____
month. day year

Today's Date _______________ Age of Child _____ _____
mos. weeks

Sex of Child _______________

INSTRUCTIONS:
Please read carefully before starting:

As you read each description of the baby's behavior below, please indicate how often the baby did this during the LAST WEEK (the past seven days) by circling one of the numbers in the left column. These numbers indicate how often you observed the behavior described during the last week.

1	2	3	4	5	6	7	NA
Never	**Very Rarely**	**Less Than Half the Time**	**About Half the Time**	**More Than Half the Time**	**Almost Always**	**Always**	**Does Not Apply**

The "Does Not Apply" (X) column is used when you did not see the baby in the situation described during the last week. For example, if the situation mentions the baby having to wait for food or liquids and there was no time during the last week when the baby had to wait, circle the (X) column. "Does Not Apply" is different from "Never" (1). "Never" is used when you saw the baby in the situation but the baby never engaged in the behavior listed during the last week. For example, if the baby did have to wait for food or liquids at least once but never cried loudly while waiting, circle the (1) column.

Please be sure to circle a number for <u>every</u> item.

1	2	3	4	5	6	7	NA
Never	**Very Rarely**	**Less Than Half the Time**	**About Half the Time**	**More Than Half the Time**	**Almost Always**	**Always**	**Does Not Apply**

1. When being dressed or undressed during the last week, how often did the baby squirm and/or try to roll away?

1 2 3 4 5 6 7 NA

2. When tossed around playfully how often did the baby laugh?

1 2 3 4 5 6 7 NA

3. When tired, how often did your baby show distress?

1 2 3 4 5 6 7 NA

4. When introduced to an unfamiliar adult, how often did the baby cling to a parent?

1 2 3 4 5 6 7 NA

5. How often during the last week did the baby enjoy being read to?

1 2 3 4 5 6 7 NA

6. How often during the last week did the baby play with one toy or object for 5-10 minutes?

1 2 3 4 5 6 7 NA

7. How often during the week did your baby move quickly toward new objects?

1 2 3 4 5 6 7 NA

8. When put into the bath water, how often did the baby laugh?

1 2 3 4 5 6 7 NA

9. When it was time for bed or a nap and your baby did not want to go, how often did s/he whimper or sob?

1 2 3 4 5 6 7 NA

10. After sleeping, how often did the baby cry if someone doesn’t come within a few minutes?

1 2 3 4 5 6 7 NA

1	2	3	4	5	6	7	NA
Never	**Very Rarely**	**Less Than Half the Time**	**About Half the Time**	**More Than Half the Time**	**Almost Always**	**Always**	**Does Not Apply**

11. In the last week, while being fed in your lap, how often did the baby seem eager to get away as soon as the feeding was over?

1 2 3 4 5 6 7 NA

12. When singing or talking to your baby, how often did s/he soothe immediately?

1 2 3 4 5 6 7 NA

13. When placed on his/her back, how often did the baby squirm and/or turn body?

1 2 3 4 5 6 7 NA

14. During a peekaboo game, how often did the baby laugh?

1 2 3 4 5 6 7 NA

15. How often does the infant look up from playing when the telephone rings?

1 2 3 4 5 6 7 NA

16. How often did the baby seem angry (crying and fussing) when you left her/him in the crib?

1 2 3 4 5 6 7 NA

17. How often during the last week did the baby startle at a sudden change in body position (e.g., when moved suddenly)?

1 2 3 4 5 6 7 NA

18. How often during the last week did the baby enjoy hearing the sound of words, as in nursery rhymes?

1 2 3 4 5 6 7 NA

19. How often during the last week did the baby look at pictures in books and/or magazines for 5 minutes or longer at a time?

1 2 3 4 5 6 7 NA

1	2	3	4	5	6	7	NA
Never	**Very Rarely**	**Less Than Half the Time**	**About Half the Time**	**More Than Half the Time**	**Almost Always**	**Always**	**Does Not Apply**

20. When visiting a new place, how often did your baby get excited about exploring new surroundings?

1 2 3 4 5 6 7 NA

21. How often during the last week did the baby smile or laugh when given a toy?

1 2 3 4 5 6 7 NA

22. At the end of an exciting day, how often did your baby become tearful?

1 2 3 4 5 6 7 NA

23. How often during the last week did the baby protest being placed in a confining place (infant seat, play pen, car seat, etc.)?

1 2 3 4 5 6 7 NA

24. When being held, in the last week, did your baby seem to enjoy him/herself?

1 2 3 4 5 6 7 NA

25. When showing the baby something to look at, how often did s/he soothe immediately?

1 2 3 4 5 6 7 NA

26. When hair was washed, how often did the baby vocalize?

1 2 3 4 5 6 7 NA

27. How often did your baby notice the sound of an airplane passing overhead?

1 2 3 4 5 6 7 NA

28. When introduced to an unfamiliar adult, how often did the baby refuse to go to the unfamiliar person?

1 2 3 4 5 6 7 NA

29. When you were busy with another activity, and your baby was not able to get your attention, how often did s/he cry?

1 2 3 4 5 6 7 NA

1	2	3	4	5	6	7	NA
Never	**Very Rarely**	**Less Than Half the Time**	**About Half the Time**	**More Than Half the Time**	**Almost Always**	**Always**	**Does Not Apply**

30. How often during the last week did the baby enjoy gentle rhythmic activities, such as rocking or swaying?

1 2 3 4 5 6 7 NA

31. How often during the last week did the baby stare at a mobile, crib bumper or picture for 5 minutes or longer?

1 2 3 4 5 6 7 NA

32. When the baby wanted something, how often did s/he become upset when s/he could not get what s/he wanted?

1 2 3 4 5 6 7 NA

33. When in the presence of several unfamiliar adults, how often did the baby cling to a parent?

1 2 3 4 5 6 7 NA

34. When rocked or hugged, in the last week, did your baby seem to enjoy him/herself?

1 2 3 4 5 6 7 NA

35. When patting or gently rubbing some part of the baby's body, how often did s/he soothe immediately?

1 2 3 4 5 6 7 NA

36. How often did your baby make talking sounds when riding in a car?

1 2 3 4 5 6 7 NA

37. When placed in an infant seat or car seat, how often did the baby squirm and turn body?

1 2 3 4 5 6 7 NA

Early Childhood Behavior Questionnaire
Very Short Form

Child's name: ______________________ Child's birthdate: Mo:____ Day:____ Yr:____

Today's date: Month:____ Day:____ Yr:____ Child's age: ______Yrs, ______Months

Relation to child: ______________________ Sex of child (circle one): Male Female

INSTRUCTIONS: **Please read carefully before starting**.

As you read each description of the child's behavior below, please indicate how often the child did this during the last two weeks by circling one of the numbers in the right column. These numbers indicate how often you observed the behavior described during the last two weeks.

never	very rarely	less than half the time	about half the time	more than half the time	almost always	always	does not apply
1	**2**	**3**	**4**	**5**	**6**	**7**	**NA**

The "Does Not Apply" column (NA) is used when you did not see the child in the situation described during the last two weeks. For example, if the situation mentions the child going to the doctor and there was no time during the last two weeks when the child went to the doctor, circle the (NA) column. "Does Not Apply" (NA) is different from "NEVER" (1). "Never" is used when you saw the child in the situation but the child never engaged in the behavior mentioned in the last two weeks. Please be sure to circle a number or NA for every item.

When approached by an unfamiliar person in a public place (for example, the grocery store), how often did your child

1. cling to a parent? 1 2 3 4 5 6 7 NA

While having trouble completing a task (e.g., building, drawing, dressing), how often did your child

2. get easily irritated? 1 2 3 4 5 6 7 NA

When a familiar child came to your home, how often did your child

3. seek out the company of the child? 1 2 3 4 5 6 7 NA

When offered a choice of activities, how often did your child

4. decide what to do very quickly and go after it? 1 2 3 4 5 6 7 NA

During daily or evening quiet time with you and your child, how often did your child

5. enjoy just being quietly sung to? 1 2 3 4 5 6 7 NA

While playing outdoors, how often did your child

6. choose to take chances for the fun and excitement of it? 1 2 3 4 5 6 7 NA

When engaged in play with his/her favorite toy, how often did your child

7. play for more than 10 minutes? 1 2 3 4 5 6 7 NA
8. continue to play while at the same time responding to your remarks or questions? 1 2 3 4 5 6 7 NA

When told that loved adults would visit, how often did your child

9. get very excited? 1 2 3 4 5 6 7 NA

During quiet activities, such as reading a story, how often did your child

10. fiddle with his/her hair, clothing, etc.? 1 2 3 4 5 6 7 NA

While playing indoors, how often did your child

11. like rough and rowdy games? 1 2 3 4 5 6 7 NA

When being gently rocked or hugged, how often did your child

12. seem eager to get away? 1 2 3 4 5 6 7 NA

When encountering a new activity, how often did your child

13. get involved immediately? 1 2 3 4 5 6 7 NA

When engaged in an activity requiring attention, such as building with blocks, how often did your child

14. tire of the activity relatively quickly? 1 2 3 4 5 6 7 NA

During everyday activities, how often did your child

15. pay attention to you right away when you called to him/her? 1 2 3 4 5 6 7 NA
16. seem to be irritated by tags in his/her clothes? 1 2 3 4 5 6 7 NA
17. become bothered by sounds while in noisy environments? 1 2 3 4 5 6 7 NA
18. seem full of energy, even in the evening? 1 2 3 4 5 6 7 NA

While in a public place, how often did your child

19. seem afraid of large, noisy vehicles? 1 2 3 4 5 6 7 NA

When playing outdoors with other children, how often did your child

20. seem to be one of the most active children? 1 2 3 4 5 6 7 NA

When told "no", how often did your child

21. stop the forbidden activity? 1 2 3 4 5 6 7 NA
22. become sadly tearful? 1 2 3 4 5 6 7 NA

Following an exciting activity or event, how often did your child

23. seem to feel down or blue? 1 2 3 4 5 6 7 NA

While playing indoors, how often did your child

24. run through the house? 1 2 3 4 5 6 7 NA

Before an exciting event (such as receiving a new toy), how often did your child

25. get very excited about getting it? 1 2 3 4 5 6 7 NA

When s/he asked for something and you said "no", how often did your child

26. have a temper tantrum? 1 2 3 4 5 6 7 NA

When asked to wait for a desirable item (such as ice cream), how often did your child

27. wait patiently? 1 2 3 4 5 6 7 NA

When being gently rocked, how often did your child

28. smile? 1 2 3 4 5 6 7 NA

While being held on your lap, how often did your child

29. mold to your body? 1 2 3 4 5 6 7 NA

When a familiar adult, such as a relative or friend, visited your home, how often did your child

30. want to interact with the adult? 1 2 3 4 5 6 7 NA

When asked to do so, how often was your child able to

31. be careful with something breakable? 1 2 3 4 5 6 7 NA

When visiting a new place, how often did your child

32. not want to enter? 1 2 3 4 5 6 7 NA

When s/he was upset, how often did your child

33. cry for more than 3 minutes, even when being comforted?	1	2	3	4	5	6	7	NA
34. become easily soothed?	1	2	3	4	5	6	7	NA

When you were busy, how often did your child

35. find another activity to do when asked?	1	2	3	4	5	6	7	NA

When around large gatherings of familiar adults or children, how often did your child

36. enjoy playing with a number of different people?	1	2	3	4	5	6	7	NA

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Children's Behavior Questionnaire
Version l

Subject No. _____________

Today's Date ____________

Sex of Child ____________

Date of Child's Birth:

______ ______ ______
Month Day Year

Age of Child ______ ______
Years months

Instructions: Please read carefully before starting:

On the next pages you will see a set of statements that describe children's reactions to a number of situations. We would like you to tell us what your child's reaction is likely to be in those situations. There are of course no "correct" ways of reacting; children differ widely in their reactions, and it is these differences we are trying to learn about. Please read each statement and decide whether it is a "true" or "untrue" description of your child's reaction within the past six months. Use the following scale to indicate how well a statement describes your child:

Circle #	If the statement is:
l	extremely untrue of your child
2	quite untrue of your child
3	slightly untrue of your child
4	neither true nor false of your child
5	slightly true of your child
6	quite true of your child
7	extremely true of your child

If you cannot answer one of the items because you have never seen the child in that situation, for example, if the statement is about the child's reaction to your singing and you have never sung to your child, then circle NA (not applicable).

Please be sure to circle a number or NA for every item.

1	2	3	4	5	6	7	NA
extremely untrue	quite untrue	slightly untrue	neither true nor untrue	slightly true	quite true	extremely true	not applicable

My child:

1. Seems always in a big hurry to get from one place to another.
   1 2 3 4 5 6 7 NA

2. Gets quite frustrated when prevented from doing something s/he wants to do.
   1 2 3 4 5 6 7 NA

3. When drawing or coloring in a book, shows strong concentration.
   1 2 3 4 5 6 7 NA

4. Likes going down high slides or other adventurous activities.
   1 2 3 4 5 6 7 NA

5. Is quite upset by a little cut or bruise.
   1 2 3 4 5 6 7 NA

6. Prepares for trips and outings by planning things s/he will need.
   1 2 3 4 5 6 7 NA

7. Often rushes into new situations.
   1 2 3 4 5 6 7 NA

8. Tends to become sad if the family's plans don't work out.
   1 2 3 4 5 6 7 NA

9. Likes being sung to.
   1 2 3 4 5 6 7 NA

10. Seems to be at ease with almost any person.
    1 2 3 4 5 6 7 NA

11. Is afraid of burglars or the "boogie man."
    1 2 3 4 5 6 7 NA

12. Notices it when parents are wearing new clothing.
    1 2 3 4 5 6 7 NA

13. Prefers quiet activities to active games.
    1 2 3 4 5 6 7 NA

14. When angry about something, s/he tends to stay upset for ten minutes or longer.
    1 2 3 4 5 6 7 NA

15. When building or putting something together, becomes very involved in what s/he is doing, and works for long periods.
    1 2 3 4 5 6 7 NA

1	2	3	4	5	6	7	NA
extremely untrue	quite untrue	slightly untrue	neither true nor untrue	slightly true	quite true	extremely true	not applicable

My child:

16. Likes to go high and fast when pushed on a swing.
1 2 3 4 5 6 7 NA

17. Seems to feel depressed when unable to accomplish some task.
1 2 3 4 5 6 7 NA

18. Is good at following instructions.
1 2 3 4 5 6 7 NA

19. Takes a long time in approaching new situations.
1 2 3 4 5 6 7 NA

20. Hardly ever complains when ill with a cold.
1 2 3 4 5 6 7 NA

21. Likes the sound of words, such as nursery rhymes.
1 2 3 4 5 6 7 NA

22. Is sometimes shy even around people s/he has known a long time.
1 2 3 4 5 6 7 NA

23. Is very difficult to soothe when s/he has become upset.
1 2 3 4 5 6 7 NA

24. Is quickly aware of some new item in the living room.
1 2 3 4 5 6 7 NA

25. Is full of energy, even in the evening.
1 2 3 4 5 6 7 NA

26. Is not afraid of the dark.
1 2 3 4 5 6 7 NA

27. Sometimes becomes absorbed in a picture book and looks at it for a long time.
1 2 3 4 5 6 7 NA

28. Likes rough and rowdy games.
1 2 3 4 5 6 7 NA

29. Is not very upset at minor cuts or bruises.
1 2 3 4 5 6 7 NA

30. Approaches places s/he has been told are dangerous slowly and cautiously.
1 2 3 4 5 6 7 NA

1	2	3	4	5	6	7	NA
extremely untrue	quite untrue	slightly untrue	neither true nor untrue	slightly true	quite true	extremely true	not applicable

My child:

31. Is slow and unhurried in deciding what to do next.
1 2 3 4 5 6 7 NA

32. Gets angry when s/he can't find something s/he wants to play with.
1 2 3 4 5 6 7 NA

33. Enjoys gentle rhythmic activities such as rocking or swaying.
1 2 3 4 5 6 7 NA

34. Sometimes turns away shyly from new acquaintances.
1 2 3 4 5 6 7 NA

35. Becomes upset when loved relatives or friends are getting ready to leave following a visit.
1 2 3 4 5 6 7 NA

36. Comments when a parent has changed his/her appearance.
1 2 3 4 5 6 7 NA

Please check back to make sure you have completed all items by marking a number or "NA".

Thank you very much for your help!

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Temperament in Middle Childhood Questionnaire (Version 3.0)

Today's Date ________________ **Sex of Child** M F (circle one)

Child's Height ______/______ **Child's Date of Birth** ______________________
Feet / Inches Month Day Year

Staff Use: Subj. No. ________________ **Age of Child** ______ Years / ______ Months

Race/Ethnicity of Child: European American/White ___ Hispanic ___

African-American ___ Asian/Pacific Islander ___ Native American/Indian ___

Multiracial ___ Other (please specify) ______________________________

Your Relationship to Child:
Mother _____ **Father** _____
Other: (please indicate relationship**)** ______________________________
______

Instructions: **Please read carefully before starting**:

On the next pages you will see a set of statements that describe children's reactions to a number of situations. We would like you to tell us what your child's reaction is likely to be in those situations. There are of course no "correct" ways of reacting; children differ widely in their reactions, and it is these differences we are trying to learn about. Please read each statement and decide whether it is a "true" or "untrue" description of your child's reaction within the past six months. Use the following scale to indicate how well a statement describes your child:

Circle #	If the statement is:
1	Almost always untrue of your child
2	Usually untrue of your child
3	Sometimes true, sometimes untrue of your child
4	Usually true of your child
5	Almost always true of your child

If you cannot answer one of the items because you have never seen the child in that situation, for example, if the statement is about the child playing wildly and recklessly and you have never seen your child play that way, then circle NA (not applicable).

Please be sure to respond by circling a number or NA for every item. If you find an item objectionable or upsetting, you may make an exception to this instruction and skip the item.

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	My Child…	Almost always untrue	Usually untrue	Sometimes true, sometimes untrue	Usually true	Almost always true	Does Not Apply
1	Likes poems.	1	2	3	4	5	NA
2	Likes to be physically active.	1	2	3	4	5	NA
3	Likes going down high slides or other adventurous activities.	1	2	3	4	5	NA
4	Greatly enjoys playing games where s/he can win.	1	2	3	4	5	NA
5	Is bothered by pain when s/he falls down.	1	2	3	4	5	NA
6	Can stop him/herself when s/he is told to stop.	1	2	3	4	5	NA
7	Is easily distracted when listening to a story.	1	2	3	4	5	NA
8	Has a hard time settling down after an exciting activity.	1	2	3	4	5	NA
9	Likes rough and rowdy games.	1	2	3	4	5	NA
10	Likes the crunching sound of leaves in the fall.	1	2	3	4	5	NA
11	Is afraid of fire.	1	2	3	4	5	NA
12	Likes to think of new ideas.	1	2	3	4	5	NA
13	Is afraid of heights.	1	2	3	4	5	NA
14	Can't help touching things without getting permission.	1	2	3	4	5	NA
15	Is always on the move.	1	2	3	4	5	NA
16	Tends to say the first thing that comes to mind, without stopping to think about it.	1	2	3	4	5	NA
17	Looks around the room when doing homework.	1	2	3	4	5	NA
18	Would like to be friends with lots of people.	1	2	3	4	5	NA
19	Is very difficult to soothe when s/he has become upset.	1	2	3	4	5	NA
20	Can make him/herself do homework, even when s/he wants to play.	1	2	3	4	5	NA
21	Prefers playing outdoors to indoors when weather permits.	1	2	3	4	5	NA
22	Interrupts others when they are talking.	1	2	3	4	5	NA
23	Would rather play a sport than watch TV.	1	2	3	4	5	NA
24	Tends to become sad if plans don't work out.	1	2	3	4	5	NA
25	Says the first thing that comes to mind.	1	2	3	4	5	NA
26	Can say hello to a new child in class, even when feeling shy.	1	2	3	4	5	NA
27	Sometimes appears to be downcast for no reason.	1	2	3	4	5	NA
28	Has a hard time speaking when scared to answer a question.	1	2	3	4	5	NA
29	Cheers up quickly.	1	2	3	4	5	NA
30	Cries when given an injection.	1	2	3	4	5	NA
31	Becomes sad when told to do something s/he does not want to do.	1	2	3	4	5	NA

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	My Child…	Almost always untrue	Usually untrue	Sometimes true, sometimes untrue	Usually true	Almost always true	Does Not Apply
32	Likes to play quiet games.	1	2	3	4	5	NA
33	Would like to spend time with a good friend every day.	1	2	3	4	5	NA
34	Likes the sound of poems.	1	2	3	4	5	NA
35	Cries sadly when a favorite toy gets lost or broken.	1	2	3	4	5	NA
36	Notices the color of people's eyes.	1	2	3	4	5	NA
37	Likes to get out of the house and do something physical.	1	2	3	4	5	NA
38	Becomes quite uncomfortable when cold or wet.	1	2	3	4	5	NA
39	Can take a Band-Aid® off when needed, even when painful.	1	2	3	4	5	NA
40	Can stop him/herself from doing things too quickly.	1	2	3	4	5	NA
41	Enjoys exciting and suspenseful TV shows.	1	2	3	4	5	NA
42	Usually stops and thinks things over before deciding to do something.	1	2	3	4	5	NA
43	Likes to run.	1	2	3	4	5	NA
44	Notices the sound of birds.	1	2	3	4	5	NA
45	Likes exploring new places.	1	2	3	4	5	NA
46	Can make him/herself run fast, even when tired.	1	2	3	4	5	NA
47	Becomes self conscious when around people.	1	2	3	4	5	NA
48	Likes to make up stories.	1	2	3	4	5	NA
49	Becomes tearful when tired.	1	2	3	4	5	NA
50	Enjoys making her/his own decisions.	1	2	3	4	5	NA
51	Is warm and friendly.	1	2	3	4	5	NA
52	Would find moving to a new, big city exciting.	1	2	3	4	5	NA
53	Gets very angry when another child takes his/her toy away.	1	2	3	4	5	NA
54	Likes reading or listening to make believe stories.	1	2	3	4	5	NA
55	Is shy with new people.	1	2	3	4	5	NA
56	Has an easy time waiting to open a present.	1	2	3	4	5	NA
57	Notices odors like perfume, smoke, and cooking smells.	1	2	3	4	5	NA
58	Likes to make others feel good.	1	2	3	4	5	NA
59	Can generally think of something to say, even with strangers.	1	2	3	4	5	NA
60	Is followed by other children.	1	2	3	4	5	NA
61	Gets angry when called in from play before s/he is ready to quit.	1	2	3	4	5	NA
62	Can tell if another person is sad or angry by the look on their face.	1	2	3	4	5	NA
63	Is scared of injections by the doctor.	1	2	3	4	5	NA
64	When s/he cries, tends to cry for more than a couple of minutes at a time.	1	2	3	4	5	NA

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	My Child…	Almost always <u>untrue</u>	Usually <u>untrue</u>	Sometimes <u>true,</u> sometimes <u>untrue</u>	Usually <u>true</u>	Almost always <u>true</u>	Does Not Apply
65	Enjoys exciting places with big crowds.	1	2	3	4	5	NA
66	Is energetic.	1	2	3	4	5	NA
67	Likes listening to music.	1	2	3	4	5	NA
68	Remains upset for hours when someone hurts his/her feelings.	1	2	3	4	5	NA
69	Is bothered by loud or scratchy sounds.	1	2	3	4	5	NA
70	Has a hard time making him/herself clean own room.	1	2	3	4	5	NA
71	Enjoys drawing pictures.	1	2	3	4	5	NA
72	Calls out answers before being called on by a teacher or group leader.	1	2	3	4	5	NA
73	Enjoys looking at books.	1	2	3	4	5	NA
74	Makes up mind suddenly.	1	2	3	4	5	NA
75	Is afraid of burglars or the "boogie man."	1	2	3	4	5	NA
76	When a child is left out, can ask that child to play.	1	2	3	4	5	NA
77	Touches fabric or other soft material.	1	2	3	4	5	NA
78	When working on an activity, has a hard time keeping her/his mind on it.	1	2	3	4	5	NA
79	Has a hard time waiting his/her turn to talk when excited.	1	2	3	4	5	NA
80	Has a hard time paying attention.	1	2	3	4	5	NA
81	Is bothered by light or color that is too bright.	1	2	3	4	5	NA
82	Needs to be told by teacher to pay attention.	1	2	3	4	5	NA
83	Often rushes into doing new things.	1	2	3	4	5	NA
84	Is first to speak up in a group.	1	2	3	4	5	NA
85	Is afraid of sleeping over at someone's house.	1	2	3	4	5	NA
86	Likes quiet reading time.	1	2	3	4	5	NA
87	Gets angry when s/he can't find something s/he is looking for.	1	2	3	4	5	NA
88	Is very careful and cautious when crossing the street.	1	2	3	4	5	NA
89	Has a hard time working on an assignment s/he finds boring.	1	2	3	4	5	NA
90	Is afraid of loud noises.	1	2	3	4	5	NA
91	Goes to school nurse's office for very minor complaints.	1	2	3	4	5	NA
92	Likes the feel of warm water in a bath or shower.	1	2	3	4	5	NA
93	Does a fun activity when s/he is supposed to do homework instead.	1	2	3	4	5	NA
94	Gets angry when s/he has trouble with a task.	1	2	3	4	5	NA
95	Likes to look at trees.	1	2	3	4	5	NA
96	Likes to play so wildly and recklessly that s/he might get hurt.	1	2	3	4	5	NA

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	My Child …	Almost always untrue	Usually untrue	Sometimes true, sometimes untrue	Usually true	Almost always true	Does Not Apply
97	Is told by others to "cheer up" and be happier.	1	2	3	4	5	NA
98	When with other children, is the one to choose activities or games.	1	2	3	4	5	NA
99	Gets angry when s/he makes a mistake.	1	2	3	4	5	NA
100	Her/his feelings are easily hurt.	1	2	3	4	5	NA
101	Can make him/herself get out of bed, even when tired.	1	2	3	4	5	NA
102	Likes active games.	1	2	3	4	5	NA
103	Can apologize or shake hands after a fight.	1	2	3	4	5	NA
104	Has a big imagination.	1	2	3	4	5	NA
105	When angry about something, s/he tends to stay upset for five minutes or longer.	1	2	3	4	5	NA
106	Places great importance on friends.	1	2	3	4	5	NA
107	Seems to feel down when unable to accomplish a task.	1	2	3	4	5	NA
108	Gets into trouble because s/he does things without thinking first.	1	2	3	4	5	NA
109	Notices small changes in the environment, like lights getting brighter in a room.	1	2	3	4	5	NA
110	Has temper tantrums when s/he doesn't get what s/he wants.	1	2	3	4	5	NA
111	Notices things others don't notice.	1	2	3	4	5	NA
112	Has a hard time going back to sleep after waking in the night.	1	2	3	4	5	NA
113	Likes to sit under a blanket.	1	2	3	4	5	NA
114	Notices even little specks of dirt on objects.	1	2	3	4	5	NA
115	Enjoys playing chase.	1	2	3	4	5	NA
116	Likes to pretend.	1	2	3	4	5	NA
117	Gets nervous about going to the dentist.	1	2	3	4	5	NA
118	Is shy.	1	2	3	4	5	NA
119	Likes to go high and fast on the swings.	1	2	3	4	5	NA
120	Needs to be told to pay attention.	1	2	3	4	5	NA
121	Would think that skiing or snowboarding fast sounds scary.	1	2	3	4	5	NA
122	Usually wins arguments with other children.	1	2	3	4	5	NA
123	Likes to run his/her hand over things to see if they are smooth or rough.	1	2	3	4	5	NA
124	Grabs what s/he wants.	1	2	3	4	5	NA
125	Becomes upset when hair is combed.	1	2	3	4	5	NA
126	Enjoys riding bicycle fast and recklessly.	1	2	3	4	5	NA
127	Likes to run around outside.	1	2	3	4	5	NA
128	Decides what s/he wants very quickly and then goes after it.	1	2	3	4	5	NA

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	My Child…	Almost always untrue	Usually untrue	Sometimes true, sometimes untrue	Usually true	Almost always true	Does Not Apply
129	Would like to confide in others.	1	2	3	4	5	NA
130	Usually rushes into an activity without thinking about it.	1	2	3	4	5	NA
131	Likes to be in charge.	1	2	3	4	5	NA
132	Can make him/herself take medicine or eat food that s/he knows tastes bad.	1	2	3	4	5	NA
133	Feels sad frequently.	1	2	3	4	5	NA
134	Likes hugs and kisses.	1	2	3	4	5	NA
135	Likes to plan carefully before doing something.	1	2	3	4	5	NA
136	Acts insecure with others.	1	2	3	4	5	NA
137	Feels nervous for a long time after being scared.	1	2	3	4	5	NA
138	Is quite upset by a little cut or bruise.	1	2	3	4	5	NA
139	Can make him/herself pick up something dirty in order to throw it away.	1	2	3	4	5	NA
140	Is afraid of the dark.	1	2	3	4	5	NA
141	Is able to keep secrets.	1	2	3	4	5	NA
142	Is bothered by bath water that is too hot or too cold.	1	2	3	4	5	NA
143	Has a hard time slowing down when rules say to walk.	1	2	3	4	5	NA
144	Tends to feel sad even when others are happy.	1	2	3	4	5	NA
145	Loves pets and other small animals.	1	2	3	4	5	NA
146	Gets mad when provoked by other children.	1	2	3	4	5	NA
147	When s/he sees a toy or a game s/he wants, is eager to have it right away.	1	2	3	4	5	NA
148	Likes to feel close to other people.	1	2	3	4	5	NA
149	Gets distracted when trying to pay attention in class.	1	2	3	4	5	NA
150	Notices when parents are wearing new clothing.	1	2	3	4	5	NA
151	Likes to make things.	1	2	3	4	5	NA
152	Has a hard time getting moving when tired.	1	2	3	4	5	NA
153	Is very frightened by nightmares.	1	2	3	4	5	NA
154	Is likely to cry when even a little bit hurt.	1	2	3	4	5	NA
155	Enjoys winning arguments.	1	2	3	4	5	NA
156	Likes just being with other people.	1	2	3	4	5	NA
157	Can make him/herself smile at someone, even when s/he dislikes them.	1	2	3	4	5	NA

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Early Adolescent Temperament Questionnaire - Revised
Short Form

Directions

On the following page you will find a series of statements that people might use to describe themselves. The statements refer to a wide number of activities and attitudes.

For each statement, please circle the answer that best describes how true each statement is **for you**. There are no best answers. People are very different in how they feel about these statements. Please circle the first answer that comes to you.

You will use the following scale to describe how true or false a statement is about you:

Circle number:	If the statement is:
1	Almost always untrue of you
2	Usually untrue of you
3	Sometimes true, sometimes untrue of you
4	Usually true of you
5	Almost always true of you

NOTE: Please make certain to answer all questions on BOTH SIDES of the page.

Please tell us:

Your date of birth: ___________

Your gender: M / F

Family ID code: __________

How true is each statement for you?	Almost always untrue	Usually untrue	Sometimes true, sometimes untrue	Usually true	Almost always true
1) It is easy for me to really concentrate on homework problems.	1	2	3	4	5
2) I feel pretty happy most of the day.	1	2	3	4	5
3) I think it would be exciting to move to a new city.	1	2	3	4	5
4) I like to feel a warm breeze blowing on my face.	1	2	3	4	5
5) If I'm mad at somebody, I tend to say things that I know will hurt their feelings.	1	2	3	4	5
6) I notice even little changes taking place around me, like lights getting brighter in a room.	1	2	3	4	5
7) I have a hard time finishing things on time.	1	2	3	4	5
8) I feel shy with kids of the opposite sex.	1	2	3	4	5
9) When I am angry, I throw or break things.	1	2	3	4	5
10) It's hard for me not to open presents before I'm supposed to.	1	2	3	4	5
11) My friends seem to enjoy themselves more than I do.	1	2	3	4	5
12) I tend to notice little changes that other people do not notice.	1	2	3	4	5
13) If I get really mad at someone, I might hit them.	1	2	3	4	5
14) When someone tells me to stop doing something, it is easy for me to stop.	1	2	3	4	5
15) I feel shy about meeting new people.	1	2	3	4	5
16) I enjoy listening to the birds sing.	1	2	3	4	5
17) I want to be able to share my private thoughts with someone else.	1	2	3	4	5
18) I do something fun for a while before starting my homework, even when I'm not supposed to.	1	2	3	4	5
19) I wouldn't like living in a really big city, even if it was safe.	1	2	3	4	5
20) It often takes very little to make me feel like crying.	1	2	3	4	5
21) I am very aware of noises.	1	2	3	4	5
22) I tend to be rude to people I don't like.	1	2	3	4	5
23) I like to look at the pattern of clouds in the sky.	1	2	3	4	5
24) I can tell if another person is angry by their expression.	1	2	3	4	5
25) It bothers me when I try to make a phone call and the line is busy.	1	2	3	4	5
26) The more I try to stop myself from doing something I shouldn't, the more likely I am to do it.	1	2	3	4	5
27) I enjoy exchanging hugs with people I like.	1	2	3	4	5
28) Skiing fast down a steep slope sounds scary to me.	1	2	3	4	5
29) I get sad more than other people realize.	1	2	3	4	5
30) If I have a hard assignment to do, I get started right away.	1	2	3	4	5
31) I will do most anything to help someone I care about.	1	2	3	4	5
32) I get frightened riding with a person who likes to speed.	1	2	3	4	5

33) I like to look at trees and walk amongst them.	1	2	3	4	5
34) I find it hard to shift gears when I go from one class to another at school.	1	2	3	4	5
35) I worry about my family when I'm not with them.	1	2	3	4	5
36) I get very upset if I want to do something and my parents won't let me.	1	2	3	4	5
37) I get sad when a lot of things are going wrong.	1	2	3	4	5
38) When trying to study, I have difficulty tuning out background noise and concentrating.	1	2	3	4	5
39) I finish my homework before the due date.	1	2	3	4	5
40) I worry about getting into trouble.	1	2	3	4	5
41) I am good at keeping track of several different things that are happening around me.	1	2	3	4	5
42) I would not be afraid to try a risky sport, like deep-sea diving.	1	2	3	4	5
43) It's easy for me to keep a secret.	1	2	3	4	5
44) It is important to me to have close relationships with other people.	1	2	3	4	5
45) I am shy.	1	2	3	4	5
46) I am nervous of some of the kids at school who push people into lockers and throw your books around.	1	2	3	4	5
47) I get irritated when I have to stop doing something that I am enjoying.	1	2	3	4	5
48) I wouldn't be afraid to try something like mountain climbing.	1	2	3	4	5
49) I put off working on projects until right before they're due.	1	2	3	4	5
50) When I'm really mad at a friend, I tend to explode at them.	1	2	3	4	5
51) I worry about my parent(s) dying or leaving me.	1	2	3	4	5
52) I enjoy going places where there are big crowds and lots of excitement.	1	2	3	4	5
53) I am not shy.	1	2	3	4	5
54) I am quite a warm and friendly person.	1	2	3	4	5
55) I feel sad even when I should be enjoying myself, like at Christmas or on a trip.	1	2	3	4	5
56) It really annoys me to wait in long lines.	1	2	3	4	5
57) I feel scared when I enter a darkened room at home.	1	2	3	4	5
58) I pick on people for no real reason.	1	2	3	4	5
59) I pay close attention when someone tells me how to do something.	1	2	3	4	5
60) I get very frustrated when I make a mistake in my school work.	1	2	3	4	5
61) I tend to get in the middle of one thing, then go off and do something else.	1	2	3	4	5
62) It frustrates me if people interrupt me when I'm talking.	1	2	3	4	5
63) I can stick with my plans and goals.	1	2	3	4	5
64) I get upset if I'm not able to do a task really well.	1	2	3	4	5
65) I like the crunching sound of autumn leaves.	1	2	3	4	5

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Early Adolescent Temperament Questionnaire - Revised
Parent Report

Directions

On the following pages you will find a series of statements that people might use to describe their child. The statements refer to a wide number of activities and attitudes.

For each statement, please circle the answer which best describes how true each statement is for your child. There are no best answers. People are very different in how they feel about these statements. Please circle the first answer that comes to you.

You will use the following scale to describe how true or false a statement is about your child:

Circle number:	If the statement is:
1	Almost always untrue of your child
2	Usually untrue of your child
3	Sometimes true, sometimes untrue of your child
4	Usually true of your child
5	Almost always true of your child

NOTE: Please make certain to answer all questions on BOTH SIDES of the pages.

Please tell us:

Your child's date of birth: ____________

Your child's gender: M / F

Family ID code __________(please leave blank)

Your son or daughter:	Almost always untrue	Usually untrue	Sometimes true, sometimes untrue	Usually true	Almost always true
1) Worries about getting into trouble.	1	2	3	4	5
2) When angry at someone, says thing s/he knows will hurt that person's feelings.	1	2	3	4	5
3) Has a hard time finishing things on time.	1	2	3	4	5
4) Thinks traveling to Africa or India would be exciting and fun.	1	2	3	4	5
5) If having a problem with someone, usually tries to deal with it right away.	1	2	3	4	5
6) Has a hard time waiting his/her turn to speak when excited.	1	2	3	4	5
7) Often does not seem to enjoy things as much as his/her friends.	1	2	3	4	5
8) Opens presents before s/he is supposed to.	1	2	3	4	5
9) Would be frightened by the thought of skiing fast down a steep slope.	1	2	3	4	5
10) Feels like crying over very little on some days.	1	2	3	4	5
11) If very angry, might hit someone.	1	2	3	4	5
12) Likes taking care of other people.	1	2	3	4	5
13) Likes to be able to share his/her private thoughts with someone else.	1	2	3	4	5
14) Usually does something fun for awhile before starting her/his homework, even though s/he is not supposed to.	1	2	3	4	5
15) Finds it easy to really concentrate on a problem.	1	2	3	4	5
16) Thinks it would be exciting to move to a new city.	1	2	3	4	5
17) When asked to do something, does it right away, even if s/he doesn't want to.	1	2	3	4	5
18) Would like to be able to spend time with a good friend every day.	1	2	3	4	5
19) Tends to be rude to people s/he doesn't like.	1	2	3	4	5
20) Is annoyed by little things other kids do.	1	2	3	4	5
21) Gets very irritated when someone criticizes her/him.	1	2	3	4	5
22) When interrupted or distracted, forgets what s/he was about to say.	1	2	3	4	5
23) Is more likely to do something s/he shouldn't do the more s/he tries to stop her/himself.	1	2	3	4	5
24) Enjoys exchanging hugs with people s/he likes.	1	2	3	4	5

25) Tends to try to blame mistakes on someone else.	1	2	3	4	5
26) Is sad more often than other people realize.	1	2	3	4	5
27) Can generally think of something to say, even with strangers.	1	2	3	4	5
28) Wouldn't be afraid to try a risky sport like deep sea diving.	1	2	3	4	5
29) Expresses a desire to travel to exotic places when s/he hears about them.	1	2	3	4	5
30) Worries about our family when s/he is not with us.	1	2	3	4	5
31) Gets irritated when I will not take her/him someplace s/he wants to go.	1	2	3	4	5
32) Slams doors when angry.	1	2	3	4	5
33) Is hardly ever sad, even when lots of things are going wrong.	1	2	3	4	5
34) Would like driving a racing car.	1	2	3	4	5
35) Has a difficult time tuning out background noise and concentrating when trying to study.	1	2	3	4	5
36) Usually finishes her/his homework before it’s due.	1	2	3	4	5
37) Likes it when something exciting and different happens at school.	1	2	3	4	5
38) Usually gets started right away on difficult assignments.	1	2	3	4	5
39) Is good at keeping track of several different things that are happening around her/him.	1	2	3	4	5
40) Is energized by being in large crowds of people.	1	2	3	4	5
41) Makes fun of how other people look.	1	2	3	4	5
42) Doesn't criticize others.	1	2	3	4	5
43) Wants to have close relationships with other people.	1	2	3	4	5
44) Is shy.	1	2	3	4	5
45) Gets irritated when s/he has to stop doing something s/he is enjoying.	1	2	3	4	5
46) Usually puts off working on a project until it is due.	1	2	3	4	5
47) Is able to stop him/herself from laughing at inappropriate times.	1	2	3	4	5
48) Is afraid of the idea of me dying or leaving her/him.	1	2	3	4	5
49) Is often in the middle of doing one thing and then goes off to do something else without finishing it.	1	2	3	4	5
50) Is not shy.	1	2	3	4	5
51) Is quite a warm and friendly person.	1	2	3	4	5

52) Sometimes seems sad even when s/he should be enjoying her/himself like at Christmas, or on a trip.	1	2	3	4	5
53) Doesn't enjoy playing softball or baseball because s/he is afraid of the ball.	1	2	3	4	5
54) Likes meeting new people.	1	2	3	4	5
55) Feels scared when entering a darkened room at night.	1	2	3	4	5
56) Wouldn't want to go on the frightening rides at the fair.	1	2	3	4	5
57) Hates it when people don't agree with him/her.	1	2	3	4	5
58) Gets very frustrated when s/he makes a mistake in her/his school work.	1	2	3	4	5
59) Is usually able to stick with his/her plans and goals.	1	2	3	4	5
60) Pays close attention when someone tells her/him how to do something.	1	2	3	4	5
61) Is nervous being home alone.	1	2	3	4	5
62) Feels shy about meeting new people.	1	2	3	4	5

Please provide the following information by checking the appropriate response or filling in the blank.

Sex: **Male** ______ **Female** ______

Is English your first language? **Yes** ______ **No** ______

Age: ______

Country of Origin: ______________________________

ADULT TEMPERAMENT QUESTIONNAIRE (VERSION 1.3)

Directions

On the following pages you will find a series of statements that individuals can use to describe themselves. There are no correct or incorrect responses. All people are unique and different, and it is these differences which we are trying to learn about. Please read each statement carefully and give your best estimate of how well it describes you. Circle the appropriate number below to indicate how well a given statement describes you.

circle #:	if the statement is:
1	extremely untrue of you
2	quite untrue of you
3	slightly untrue of you
4	neither true nor false of you
5	slightly true of you
6	quite true of you
7	extremely true of you

If one of the statements does not apply to you (for example, if it involves driving a car and you don't drive), then circle "X" (not applicable). Check to make sure that you have answered every item.

1	2	3	4	5	6	7	X
extremely untrue	quite untrue	slightly untrue	neither true nor false	slightly true	quite true	extremely true	not applicable

1. I become easily frightened.

   1 2 3 4 5 6 7 X

2. I am often late for appointments.

   1 2 3 4 5 6 7 X

3. Sometimes minor events cause me to feel intense happiness.

   1 2 3 4 5 6 7 X

4. I find loud noises to be very irritating.

   1 2 3 4 5 6 7 X

5. It's often hard for me to alternate between two different tasks.

   1 2 3 4 5 6 7 X

6. I rarely become annoyed when I have to wait in a slow moving line.

   1 2 3 4 5 6 7 X

7. I would not enjoy the sensation of listening to loud music with a laser light show.

   1 2 3 4 5 6 7 X

8. I often make plans that I do not follow through with.

   1 2 3 4 5 6 7 X

9. I rarely feel sad after saying goodbye to friends or relatives.

   1 2 3 4 5 6 7 X

10. Barely noticeable visual details rarely catch my attention.

    1 2 3 4 5 6 7 X

11. Even when I feel energized, I can usually sit still without much trouble if it's necessary.

    1 2 3 4 5 6 7 X

12. Looking down at the ground from an extremely high place would make me feel uneasy.

    1 2 3 4 5 6 7 X

13. When I am listening to music, I am usually aware of subtle emotional tones.

    1 2 3 4 5 6 7 X

1 extremely untrue	2 quite untrue	3 slightly untrue	4 neither true nor false	5 slightly true	6 quite true	7 extremely true	X not applicable

14. I would not enjoy a job that involves socializing with the public.

    1 2 3 4 5 6 7 X

15. I can keep performing a task even when I would rather not do it.

    1 2 3 4 5 6 7 X

16. I sometimes seem to be unable to feel pleasure from events and activities that I should enjoy.

    1 2 3 4 5 6 7 X

17. I find it very annoying when a store does not stock an item that I wish to buy.

    1 2 3 4 5 6 7 X

18. I tend to notice emotional aspects of paintings and pictures.

    1 2 3 4 5 6 7 X

19. I usually like to talk a lot.

    1 2 3 4 5 6 7 X

20. I seldom become sad when I watch a sad movie.

    1 2 3 4 5 6 7 X

21. I'm often aware of the sounds of birds in my vicinity.

    1 2 3 4 5 6 7 X

22. When I am enclosed in small places such as an elevator, I feel uneasy.

    1 2 3 4 5 6 7 X

23. When listening to music, I usually like turn up the volume more than other people.

    1 2 3 4 5 6 7 X

24. I sometimes seem to understand things intuitively.

    1 2 3 4 5 6 7 X

25. Sometimes minor events cause me to feel intense sadness.

    1 2 3 4 5 6 7 X

26. It is easy for me to hold back my laughter in a situation when laughter wouldn't be appropriate.

1 extremely untrue	2 quite untrue	3 slightly untrue	4 neither true nor false	5 slightly true	6 quite true	7 extremely true	X not applicable

27. I can make myself work on a difficult task even when I don't feel like trying.

    1 2 3 4 5 6 7 X

28. I rarely ever have days where I don't at least experience brief moments of intense happiness.

    1 2 3 4 5 6 7 X

29. When I am trying to focus my attention, I am easily distracted.

    1 2 3 4 5 6 7 X

30. I would probably enjoy playing a challenging and fast paced video-game that makes lots of noise and has lots of flashing, bright lights.

    1 2 3 4 5 6 7 X

31. Whenever I have to sit and wait for something (e.g., a waiting room), I become agitated.

    1 2 3 4 5 6 7 X

32. I'm often bothered by light that is too bright.

    1 2 3 4 5 6 7 X

33. I rarely notice the color of people's eyes.

    1 2 3 4 5 6 7 X

34. I seldom become sad when I hear of an unhappy event.

    1 2 3 4 5 6 7 X

35. When interrupted or distracted, I usually can easily shift my attention back to whatever I was doing before.

    1 2 3 4 5 6 7 X

36. I find certain scratchy sounds very irritating.

    1 2 3 4 5 6 7 X

37. I like conversations that include several people.

    1 2 3 4 5 6 7 X

38. I am usually a patient person.

    1 2 3 4 5 6 7 X

1 extremely untrue	2 quite untrue	3 slightly untrue	4 neither true nor false	5 slightly true	6 quite true	7 extremely true	X not applicable

39. When I am resting with my eyes closed, I sometimes see visual images.

    1 2 3 4 5 6 7 X

40. It is very hard for me to focus my attention when I am distressed.

    1 2 3 4 5 6 7 X

41. Sometimes my mind is full of a diverse array of loosely connected thoughts and images.

    1 2 3 4 5 6 7 X

42. Very bright colors sometimes bother me.

    1 2 3 4 5 6 7 X

43. I can easily resist talking out of turn, even when I'm excited and want to express an idea.

    1 2 3 4 5 6 7 X

44. I would probably not enjoy a fast, wild carnival ride.

    1 2 3 4 5 6 7 X

45. I sometimes feel sad for longer than an hour.

    1 2 3 4 5 6 7 X

46. I rarely enjoy socializing with large groups of people.

    1 2 3 4 5 6 7 X

47. If I think of something that needs to be done, I usually get right to work on it.

    1 2 3 4 5 6 7 X

48. It doesn't take very much to make feel frustrated or irritated.

    1 2 3 4 5 6 7 X

49. It doesn't take much to evoke a happy response in me.

    1 2 3 4 5 6 7 X

50. When I am happy and excited about an upcoming event, I have a hard time focusing my attention on tasks that require concentration.

    1 2 3 4 5 6 7 X

1 extremely untrue	2 quite untrue	3 slightly untrue	4 neither true nor false	5 slightly true	6 quite true	7 extremely true	X not applicable

51. Sometimes, I feel a sense of panic or terror for no apparent reason.

1 2 3 4 5 6 7 X

52. I often notice mild odors and fragrances.

1 2 3 4 5 6 7 X

53. I often have trouble resisting my cravings for food drink, etc.

1 2 3 4 5 6 7 X

54. Colorful flashing lights bother me.

1 2 3 4 5 6 7 X

55. I usually finish doing things before they are actually due (for example, paying bills, finishing homework, etc.).

1 2 3 4 5 6 7 X

56. I often feel sad.

1 2 3 4 5 6 7 X

57. I am often aware how the color and lighting of a room affects my mood.

1 2 3 4 5 6 7 X

58. I usually remain calm without getting frustrated when things are not going smoothly for me.

1 2 3 4 5 6 7 X

59. Loud music is unpleasant to me.

1 2 3 4 5 6 7 X

60. When I'm excited about something, it's usually hard for me to resist jumping right into it before I've considered the possible consequences.

1 2 3 4 5 6 7 X

61. Loud noises sometimes scare me.

1 2 3 4 5 6 7 X

1 extremely untrue	2 quite untrue	3 slightly untrue	4 neither true nor false	5 slightly true	6 quite true	7 extremely true	X not applicable

62. I sometimes dream of vivid, detailed settings that are unlike anything that I have experienced when awake.

1 2 3 4 5 6 7 X

63. When I see an attractive item in a store, it's usually very hard for me to resist buying it.

1 2 3 4 5 6 7 X

64. I would enjoy watching a laser show with lots of bright, colorful flashing lights.

1 2 3 4 5 6 7 X

65. When I hear of an unhappy event, I immediately feel sad.

1 2 3 4 5 6 7 X

66. When I watch a movie, I usually don't notice how the setting is used to convey the mood of the characters.

1 2 3 4 5 6 7 X

67. I usually like to spend my free time with people.

1 2 3 4 5 6 7 X

68. It does not frighten me if I think that I am alone and suddenly discover someone close by.

1 2 3 4 5 6 7 X

69. I am often consciously aware of how the weather seems to affect my mood.

1 2 3 4 5 6 7 X

70. It takes a lot to make me feel truly happy.

1 2 3 4 5 6 7 X

71. I am rarely aware of the texture of things that I hold.

1 2 3 4 5 6 7 X

1 extremely untrue	2 quite untrue	3 slightly untrue	4 neither true nor false	5 slightly true	6 quite true	7 extremely true	X not applicable

72. When I am afraid of how a situation might turn out, I usually avoid dealing with it.

1 2 3 4 5 6 7 X

73. I especially enjoy conversations where I am able to say things without thinking first.

1 2 3 4 5 6 7 X

74. Without applying effort, creative ideas sometimes present themselves to me.

1 2 3 4 5 6 7 X

75. When I try something new, I am rarely concerned about the possibility of failing.

1 2 3 4 5 6 7 X

76. It is easy for me to inhibit fun behavior that would be inappropriate.

1 2 3 4 5 6 7 X

77. I would not enjoy the feeling that comes from yelling as loud as I can.

1 2 3 4 5 6 7 X

Pubertal Developmental Scale

Now, I'm going to ask you some questions about physical development.

1. Would you say that your growth in height has not yet begun to spurt, has barely started, is definitely underway, or does growth seem completed? (if asked spurt = more growth than usual)

1	2	3	4
No	Yes (Barely)	Yes (Definitely)	Development Completed

2. And how about the growth of body hair? Would you say that your body hair has not yet started growing, has barely started growing, or does growth seem completed? (if asked body hair = underarm or pubic hair)

1	2	3	4
No	Yes (Barely)	Yes (Definitely)	Development Completed

3. Have you noticed any skin changes, especially pimples?

1	2	3	4
No	Yes (Barely)	Yes (Definitely)	Development Completed

[Boys only]

4. Have you noticed a deepening of your voice?

1	2	3	4
No	Yes (Barely)	Yes (Definitely)	Development Completed

[Boys only]

5. Have you begun to grow hair on your face?

1	2	3	4
No	Yes (Barely)	Yes (Definitely)	Development Completed

[Girls only]

6. Have your breasts begun to grow?

1	2	3	4
No	Yes (Barely)	Yes (Definitely)	Development Completed

[Girls only]

7. Have you begun to menstruate (get your period)?

1	2	3
No	Yes (Barely)	Yes (Definitely)

IF YES:

7a. What was the date of your first period: _______ ______

Month year

7a1. If you don't know the date, how old were you? _______(age)

8. How tall are you? ______(feet)______(inches)

9. How much do you weigh? _________Kg

10. Do you think your development is earlier or later than most other boys/girls your age?

1. much earlier
2. somewhat earlier
3. about the same
4. somewhat later
5. much later

Supplementary Table 1

Table 1. The premenstrual symptoms screening tool

Do you experience some or any of the following premenstrual symptoms which start before your period and stop within a few days of bleeding?				
Symptoms	Not at all	Mild	Moderate	Severe
1. Anger/irritability				
2. Anxiety/tension				
3. Tearful/Increased sensitivity to rejection				
4. Decreased mood/hopelessness				
5. Decreased interest in work activities				
6. Decreased interest in home activities				
7. Decreased interest in social activities				
8. Difficulty concentrating				
9. Fatigue/lack of energy				
10. Overeating/food cravings				
11. Insomnia				
12. Hypersomnia(needing more sleep)				
13. Feeling overwhelmed or out of control				
14. Physical symptoms: breast tenderness, headaches, joint/muscle pain, bloating, weight gain				
Have your symptoms, as listed above, interfered with:				
	Not at all	Mild	Moderate	Severe
A. Your word efficiency or productivity				
B. Your relationships with coworkers				
C. Your relationships with your family				
D. Your home responsibilities				
Scoring				
The following criteria must be presented for a diagnosis of PMDD				
1) at least one of #1, #2, #3, #4 is severe				
2) in addition at least four of #1-#14 area moderate to severe				
3) at least one of A, B, C, D, E is severe				
The following criteria must be presented for a diagnosis of moderate-to-severe PMS				
1) at least one of #1, #2, #3, #4 is moderate to severe				
2) in addition at least four of #1-#14 area moderate to severe				
3) at least one of A, B, C, D, E is moderate to severe				

PMDD: premenstrual dysphoric disorder, PMS: premenstrual syndrome.

The University of New Orleans

Alabama Parenting Questionnaire (Parent Form)

Child Name: ………………………………………………………….. ID #...............................

Parent Completing Form (Circle one) Mother Father Others …………………………..

Instruction: The following are a number of statements about your family. Please rate each item as to how often it TYPICALLY occurs in your home. The possible answers are **Never (1), Almost Never (2). Sometimes (3.), Often (4), Always (5).** PLEASE ANSWER ALL THE ITEMS

1. You have a friendly talk with your child
2. You let your child know when h e /she is doing a good job with something
3. You threaten to punish your child and then do not actually punish him / her
4. You volunteer to help with special activities that your child is involved in (such as sports, boy/girl scouts, church youth group)
5. You reward or give something extra to your child for obeying you or behaving well
6. Your child fails to leave a note or to let you know where he / she is going
7. You play games or do often fun things with your child
8. Your child tells you out of being punished after he / she has done something wrong
9. You ask your child about his / her day in school
10. Your child stays out in the evening past the time he/she is supposed to be home
11. You help your child with his /her homework
12. You feel that getting your child to obey you is trouble that it's worth
13. You complaint your child when he/she does something well
14. You ask your child what his /her plans are for the coming day
15. Your drive your child to a special activity
16. You praise your child if he/she behaves well
17. Your child is cut with friends you don't know
18. You hug or kiss your child when he/she has done something well

19. Your child goes without a set time to be home
20. You talk to your child about his/her friends
21. Your child is out after dark without an adult
22. You let your child out of a punishment early (like lift restrictions earlier than you originally said)
23. Your child helps family activities
24. You get so busy that you forget where your child is and what he/she is doing
25. Your child is not punished when he has done something wrong
26. You attend PTA meetings, parents/teachers conferences or other meetings at your child's school
27. You tell your child that you like it when he/she helps out around the house
28. You don't check that your child comes home at this time she/he was supposed to
29. You don't tell your child where you are going
30. Your child comes home from school more than an hour past the time you expect him/her
31. The punishment you give your child depends on your mood
32. Your child is at home without adult supervision
33. You spank your child with your hand when he/she has done something wrong
34. You ignore your child when he/she is misbehaving
35. You slap your child when he /she has done something wrong
36. You take away privileges or money from your child as punishment
37. You send your child to his /her room as punishment
38. You hit your child when a belt, switch, or other objects when he/she has done something wrong
39. You tell or scream at your child when he/she has done something wrong
40. You calmly explain to your child why his/her behavior was wrong when he/she misbehaves
41. You use timeout (make him/her sit or stand in a corner) as a punishment
42. You give your child chores as a punishment

The University of New Orleans

Alabama Parenting Questionnaire (Child Form)

Child Name: ………………………………………………………….. ID #................................

Instruction: The following are a number of statements about your family. Please rate each item as to how often it TYPICALLY occurs in your home. The possible answers are **Never (1), Almost Never (2). Sometimes (3.), Often (4), Always (5).** PLEASE ANSWER ALL THE ITEMS

1. You have a friendly talk with your mom
   a. How about your dad
2. Your parents tell you about you are doing a good job
3. Your parents threaten to punish you and then you do not do it
4. Your mom helps some of your special activities (such as sports, boy/girl scouts, church group)
   a. How about your dad?
5. Your parents reward or give something extra to behaving well
6. Your fail to leave a note or to let you know where you are going
7. You play games or do often fun things with your mom
   a. How about your dad?
8. You talk to your parents out of punishing of you after you have done something wrong
9. Your mom asks you about your day in school.
   a. How about your dad?
10. You sat out in the evening past the time you are supposed to be at home
11. Your mom helps you with your homework
    a. How about your dad?
12. Your parents give up trying to get you obey them because it is too much trouble.
13. Your parents complaint complement you when you have done something well
14. Your mom asks you what your plans are for the coming day?
    a. How about your dad?
15. Your mom drives you to a special activity.

a. How about your dad?

16. Your parents praise you for behaving well.
17. Your parents do know the friends you are with.
18. Your parents hug or kiss you when you have done something well
19. You go out with a set time to be home
20. Your mom talks to you about friends

    a. How about your dad?

21. You go out after dad without an adult with you.
22. Your parents let you out of a punishment early (like lift restrains earlier than they originally said)
23. You help plan family activities
24. Your parents get so busy that they forget where you are and what you are doing
25. Your parents do not punish you when you have done something wrong
26. Your mom goes to a meeting at school like PTA meeting or parent/teacher conference

    a. How about your dad?

27. Your parents tell you that they like it when you help around the house.
28. You stay later than you are supposed to and your parents don't know it.
29. Your parents leave the house and don't tell you where they are going
30. You come home from school more than an hour past the time your parents expect you to be home.
31. The punishment your parents give depend upon their mood
32. You are at home without an adult being with you
33. Your parents spank you with their hand when you have done something wrong
34. Your parents ignore you when you are misbehaving
35. Your parents slap you when you have done something wrong
36. Your parents take away privilege or money from you as a punishment
37. Your parents send you to your room as a punishment

38. Your parents hit you with belt, switch, or other objects when you have done something wrong
39. Your parents yell or scream at you when you have done something wrong
40. Your parents calmly explain to you when your behavior is wrong
41. Your parents use timeout (make you sit or stand in a corner) as punishment.
42. Your parents give you extra chores as punishment.

ICU
(Parent Version-Preschool)

Name of Child: _______________ Date of Birth: _______________

Completed by: MotherFather Other: _______________

Date completed: _______________

Instructions: *Please complete the background information above. Then read each statement and decide how well it describes your child. Mark your answer by circling the appropriate number (0-3) for each statement. Do not leave any statement unrated.*

	Not at all true	Somewhat true	Very true	Definitely True
1. Expresses his/her feelings openly.	0	1	2	3
2. Does not seem to know “right” from “wrong”.	0	1	2	3
3. Seems motivated to do his/her best in structured activities	0	1	2	3
4. Does not care who he/she hurts to get what he/she wants.	0	1	2	3
5. Feels bad or guilty when he/she has done something wrong.	0	1	2	3
6. Does not show emotions.	0	1	2	3
7. Does not care about being on time.	0	1	2	3
8. Is concerned about the feelings of others.	0	1	2	3
9. Does not care if he/she is in trouble.	0	1	2	3
10. Does not let feelings control him/her.	0	1	2	3
11. Does not care about doing things well.	0	1	2	3
12. Seems very cold and uncaring.	0	1	2	3
13. Easily admits to being wrong.	0	1	2	3
14. It is easy to tell how he/she is feeling.	0	1	2	3
15. Always tries his/her best.	0	1	2	3
16. Apologizes (“says he/she is sorry”) to persons he/she has hurt.	0	1	2	3

17. Tries not to hurt others' feelings.	0	1	2	3
18. Shows no remorse when he/she has done something wrong.	0	1	2	3
19. Is very expressive and emotional.	0	1	2	3
20. Does not like to put the time into doing things well.	0	1	2	3
21. The feelings of others are unimportant to him/her.	0	1	2	3
22. Hides his/her feelings from others.	0	1	2	3
23. Works hard on everything.	0	1	2	3
24. Does things to make others feel good.	0	1	2	3

Unpublished rating scale by Paul J. Frick, Department of Psychology, University of New Orleans (pfrick@uno.edu)

ICU
(Parent Version)

Name of Child: ________________ Date of Birth: ________________

Completed by: Mother Father Other: ________________

Date completed: ________________

Instructions: *Please complete the background information above. Then read each statement and decide how well it describes your child. Mark your answer by circling the appropriate number (0-3) for each statement. Do not leave any statement unrated.*

	Not at all true	Somewhat true	Very true	Definitely True
1. Expresses his/her feelings openly.	0	1	2	3
2. Does not seem to know "right" from "wrong".	0	1	2	3
3. Is concerned about schoolwork.	0	1	2	3
4. Does not care who he/she hurts to get what he/she wants.	0	1	2	3
5. Feels bad or guilty when he/she has done something wrong.	0	1	2	3
6. Does not show emotions.	0	1	2	3
7. Does not care about being on time.	0	1	2	3
8. Is concerned about the feelings of others.	0	1	2	3
9. Does not care if he/she is in trouble.	0	1	2	3
10. Does not let feelings control him/her.	0	1	2	3
11. Does not care about doing things well.	0	1	2	3
12. Seems very cold and uncaring.	0	1	2	3
13. Easily admits to being wrong.	0	1	2	3
14. It is easy to tell how he/she is feeling.	0	1	2	3
15. Always tries his/her best.	0	1	2	3
16. Apologizes ("says he/she is sorry") to persons he/she has hurt.	0	1	2	3
17. Tries not to hurt others' feelings.	0	1	2	3

18. Shows no remorse when he/she has done something wrong.	0	1	2	3
19. Is very expressive and emotional.	0	1	2	3
20. Does not like to put the time into doing things well.	0	1	2	3
21. The feelings of others are unimportant to him/her.	0	1	2	3
22. Hides his/her feelings from others.	0	1	2	3
23. Works hard on everything.	0	1	2	3
24. Does things to make others feel good.	0	1	2	3

Unpublished rating scale by Paul J. Frick, Department of Psychology, University of New Orleans (pfrick@uno.edu)

ICU
(Youth Version)

Name: ____________________

Date Completed: ____________________

Instructions: *Please read each statement and decide how well it describes you. Mark your answer by circling the appropriate number (0-3) for each statement. Do not leave any statement unrated.*

	Not at all true	Somewhat true	Very true	Definitely True
1. I express my feelings openly.	0	1	2	3
2. What I think is "right" and "wrong" is different from what other people think.	0	1	2	3
3. I care about how well I do at school or work.	0	1	2	3
4. I do not care who I hurt to get what I want.	0	1	2	3
5. I feel bad or guilty when I do something wrong.	0	1	2	3
6. I do not show my emotions to others.	0	1	2	3
7. I do not care about being on time.	0	1	2	3
8. I am concerned about the feelings of others.	0	1	2	3
9. I do not care if I get into trouble.	0	1	2	3
10. I do not let my feelings control me.	0	1	2	3
11. I do not care about doing things well.	0	1	2	3
12. I seem very cold and uncaring to others.	0	1	2	3
13. I easily admit to being wrong.	0	1	2	3
14. It is easy for others to tell how I am feeling.	0	1	2	3
15. I always try my best.	0	1	2	3
16. I apologize ("say I am sorry") to persons I hurt.	0	1	2	3
17. I try not to hurt others' feelings.	0	1	2	3
18. I do not feel remorseful when I do something wrong.	0	1	2	3
19. I am very expressive and emotional.	0	1	2	3
20. I do not like to put the time into doing things well.	0	1	2	3

21. The feelings of others are unimportant to me.	0	1	2	3
22. I hide my feelings from others.	0	1	2	3
23. I work hard on everything I do.	0	1	2	3
24. I do things to make others feel good.	0	1	2	3

Unpublished rating scale by Paul J. Frick, Department of Psychology, University of New Orleans (pfrick@uno.edu) .

APPENDIX

The CABI questionnaire for parents is reported here in the form in which it can be administered. It is free of charge and can be photocopied. An Italian version will be provided by the author on request (cianchet@unica.it).

Those using it extensively are invited to make a donation to UNICEF.

C.A.B.I.

QUESTIONNAIRE FOR PARENTS

By Carlo Cianchetti M.D., University of Cagliari, Italy

Name of child or youth:____ Sex: M□ F□
Date of birth:_______/_______/_____ Age:__________ Class:_________ Date of compilation:_____/____/_____
Compiler: mother (name)___________________________________father (name)________________

Instructions: The following statements refer to problems which may be present in children/youth. Please answer as regards your child and what has taken place during the last six months. For each statement, ask yourself if the situation is **very true, somewhat or sometimes true,** or **not true.** Answer by marking an "X" in the appropriate square. Some questions may not apply to your son or daughter if he/she is very young, as the questionnaire also regards adolescents; however, please answer all the questions. If the meaning of one or more questions in unclear to you, or you are unable to answer, immediately note the number of the question/s at the bottom of the questionnaire and when you hand it in, ask for explanations.

		Very True	Somewhat or Sometimes True	Not True
1	Your son/daughter often complains about some physical discomfort (for example: a headache, stomach ache, etc.)	□	□	□
2	He is excessively worried about illnesses and/or that he will get ill	□	□	□
3	He finds it difficult to fall asleep or says he does not sleep well	□	□	□
4	His sleep is disturbed by nightmares or waking up during the night	□	□	□
5	He appears tense and/or anxious	□	□	□
6	He tends to worry about everything	□	□	□
7	He worries about school too much	□	□	□
8	It is hard for him to be separated or far from his parents	□	□	□
9	He is excessively shy	□	□	□
10	He is usually embarrassed around strangers or people he does not know very well	□	□	□
11	He is excessively afraid of something (e.g. the dark, being alone, insects, thieves) Specify what he is afraid of	□	□	□
12	He is excessively afraid of dirt, so he has to wash continually	□	□	□
13	There are repetitive actions or "rituals" that he frequently repeats and he says he cannot help doing them, If yes, describe which ones	□	□	□
14	He has an obsessive need for things to be in a precise order	□	□	□
15	He is obsessed by unpleasant thoughts and cannot free himself from them	□	□	□
16	He is very afraid of making mistakes	□	□	□
17	It is hard for him to make decisions, even about unimportant things	□	□	□
18	Has he ever been involved in or witnessed particularly stressful events, after which his behaviour changed in some way? If true, indicate what behavioural changes occurred after the event	□	□	□

Appendix contd…

		Very True	Somewhat or Sometimes True	Not True
19	He cries for no reason or about unimportant things	□	□	□
20	He often seems sad	□	□	□
21	He is often in a black mood ("depressed")	□	□	□
22	He says or shows that he is not happy	□	□	□
23	He shows no interest, not even in pleasant things	□	□	□
24	He feels inferior to others; he has low self-esteem	□	□	□
25	He is often tired or listless; everything exhausts him	□	□	□
26	He blames himself too much	□	□	□
27	He has sometimes said he does not want to live any longer	□	□	□
28	He has hurt himself or tried to hurt himself	□	□	□
29	He is very irritable	□	□	□
30	He often gets angry, even about unimportant things	□	□	□
31	He has frequent mood changes	□	□	□
32	He is quick-tempered and has fits of anger	□	□	□
33	He does not obey and it is difficult to make him obey	□	□	□
34	He does not follow the rules	□	□	□
35	He often tells lies or cheats	□	□	□
36	He is domineering and always wants to assert himself	□	□	□
37	He quarrels frequently	□	□	□
38	He bothers and intentionally annoys others	□	□	□
39	He often hits people	□	□	□
40	He destroys things	□	□	□
41	He is or has been cruel to animals or people	□	□	□
42	He has committed petty theft	□	□	□
43	He is impulsive and acts before thinking	□	□	□
44	He tends not to take turns when he is playing	□	□	□
45	He interrupts, disturbing games or others' conversations	□	□	□
46	He is always moving around and cannot stay still	□	□	□
47	He cannot sit down for a long time but has to get up	□	□	□
48	He runs and jumps everywhere in an exaggerated way	□	□	□
49	He has trouble concentrating while doing his homework	□	□	□
50	He has trouble paying attention to something for a long period	□	□	□
51	He gets tired very quickly even when he is playing	□	□	□
52	He feels persecuted	□	□	□
53	He is overly suspicious	□	□	□
54	Sometimes he has strange ideas	□	□	□
55	Sometimes he says he sees or hears things that are not there	□	□	□
56	He has difficulty in relating to and interacting with others	□	□	□
57	He cannot make real friends or does not seem interested in doing so	□	□	□

Appendix contd…

		Very True	Somewhat or Sometimes True	Not True
58	He does not play willingly with his peers	□	□	□
59	He does not seem to express emotions using appropriate facial expressions	□	□	□
60	His behaviour is "strange", unlike that of his peers	□	□	□
61	He asks inappropriate questions, like overly-personal questions to strangers at inopportune times	□	□	□
62	He sometimes wets the bed	□	□	□
63	He sometimes dirties his pants during the day	□	□	□
64	He stuffs himself with food	□	□	□
65	He keeps to a strict diet (not prescribed by a doctor or dietician)	□	□	□
66	He feels too fat or says that parts of his body are too fat	□	□	□
67	He has recently lost a lot of weight	□	□	□
68	He appears to be overly interested in sex	□	□	□
69	He shows he would like to be of the opposite sex	□	□	□
70	He smokes	□	□	□
71	He drinks alcohol	□	□	□
72	He uses drugs (smokes hashish or other dangerous substances)	□	□	□
73	He does not do well at school	□	□	□
74	He has recently done much worse at school	□	□	□
75	His classmates or other children make fun of him, threaten or mistreat him	□	□	□

List the numbers of the questions whose meaning was unclear:...................... ....

Does your child exhibit behaviour which seems to you different from that of his peers? Give details.

....

....

Does your child exhibit behaviour which worries you? Give details... ....

....

....

If there are episodes that worry you, it is better not to ignore them. Problems can usually be solved if they are faced adequately and in time. Problems that are ignored may later be difficult to solve.

ABBREVIATIONS

ADHD = Attention Deficit Hyperactivity Disorder

CABI = Child and Adolescent Behavior Inventory

CBCL = Child Behavior Check-List

CD = Conduct Disorder

CSI-4 = Child Symptom Inventory-4

DSM-IV-TR = Diagnostic Statistic Manual-IV-Text Revised

K-SADS-PL = Kiddie-Schedule for Affective Disorders and Schizophrenia-Present and Lifetime

OCD = Obsessive-Compulsive Disorder

ODD = Oppositional Defiant Disorder

PDD = Pervasive Developmental Disorder

PTSD = Post-Traumatic Stress Disorder

SAFA = Scale Autosomministrazione per Fanciulli e Adolescenti (self-administered psychiatric scale for children and adolescents)

SD = Standard Deviation

REFERENCES

[1] Achenbach TM. Manual for the Child Behavior Checklist/ 4-18 and 1991 Profile. Burlington, VT: University of Vermont, Department of Psychiatry 1991.

[2] Goodman R. The strengths and difficulties questionnaire: A research note. J Child Psychol Psychiatry 1997; 38: 581-6.

Nutritional Deficiency

Nutritional Deficiency	
Height	cm
Weight	kg
Clinical Signs of Nutritional Deficiency	
NAD	
Emaciation	
Marasmus	
Nightblindness	
Conjunctival xerosis	
Bitot spots	
Corneal xerosis	
Keratomalacia	
Corneal Scar	
Angular stomatitis	
Glossitis	
Bleeding gums	
Phrynoderma	
Bow legs	
Dental caries	
Dental Flourosis	
Oedema	
Kwashiorkor	
Goitre I (Palpable)	
Goitre II (visible)	
.(Other	

IYCF

IYCF*		
Item	Response	
Has your child ever been breastfed?	Yes	No
When did you start breastfeeding your child?	days/months	
Did you only breastfeed your child for the first 2 days after birth?	Yes	No
If the child was only breastfed for the first 6 months?	Yes	No
Did you introduce mixed milk feeding before 6 months?	Yes	No
Did you continue to breastfeed your child from 12-23 months?	Yes	No
Did you introduce solid, semisolid or soft foods at 6–8 months?	Yes	No
Did you introduce any complementary foods between 6-23 months?	Yes	No
Did you provide one non-milk meal for breastfed children during 6-23 months?	Yes	No
Did you provide one milk-based meal for non-breasftfed children during 6-23 months?	Yes	No
Did you provide the following foods to your child during 6-23 months?		
Egg and or flesh food	Yes	No
Sweet beverage	Yes	No
Unhealthy food	Yes	No
Zero vegetable or fruits	Yes	No
Did you bottle feed your child between 0-23 months?	Yes	No
Have you continued to breastfeed your child at 2 years?	Yes	No

ICMR Task force Study

Schedule for Infants (Respondant-mothers of <12 months children)

1. Schedule Number :3.2
2. State (________________________) :___
3. District (________________________) :___
4. Sub District/Division (_______________) :___
5. Village (____________________) :___ ___
6. AWC Code :__ __ __
7. Area (1.Rural 2. Tribal 3.Urban) :___
8. Date of Survey : _ _/_ _/_ _
9. Sl No of Household :___ ___
10. Name of the mother : ____________________

Particulars of Index Child

1 Name of the Index Child: ________________

2 Date of birth : __ __/__ __/__ __

3 Age (in completed months) :__ __

4 Gender (1. Male 2. Female) :___

5 Birth order :___

6 If birth order is >1, interval between the last two live births (months) : __ __

Current Child Feeding Practices

7 Type of feeding being given currently? :___
1. Only breast milk
2. Breast milk + water
3. Breast milk + complementary feeds
4. Bottle feeding 5. Normal adult food

8 Up to what age (months) the child was given only breast-milk (without water)? : __ __
(Enter 99 if still breastfeeding)
ADD - Did you breastfeed your child within the 1st hour of birth?
Was your child on breastfeed exclusively (nothing else was given to the child) for the first 2 days after birth?

9 When did you start giving complementary food (CF) to your child? (Months) : __ __
(Enter '99' if not started)

10 If the CF was initiated before 6 months of age (<180 days), why did you do so? :___
1. Insufficient breast milk.
2. Advise of elders in the family
3. Advise of AWW/ ANM
5. Advise of Doctor 6. On my own
7. Others (____________)

Type of complementary foods currently
11 given? (1. Yes 2. No 9. NA)

12 Cow /goat/ buffalo milk :___
13 Formula milk :___
14 ICDS Supplement (____________) :___
15 Commercial baby foods :___
16 Processed Foods/Biscuits :___
17 Homemade semi-solids :___
18 Homemade solids :___
Others :___

What are the foods generally included in complementary foods.
(1.. Yes 2. No 9. NA)

19 Cereals & millets :___
20 Pulses, nuts and seeds :___
21 Green leafy vegetables :___
22 Vitamin-A rich vegatables (carrot, spinach, sweet potato, mango, papaya, apricots) :___ :___ :___
23 Other Vegetables :___
24 Roots & tubers :___
25 Fruits :___
27 Milk & milk products (infant formula, :___
28 Yogurt, cheese) :___
29 Eggs
Meat/fish/chicken
Fats & Oils
Sugar & jaggery
Sweet beverages (soda, fruit flavored drinks, sports drinks, chocolate and other flavored milk, malt drinks, fruit juice, any home-made drink with added sugar honey, syrup, etc.)

Unhealthy food (Candies, chocolate, other sugar confections, including those made with real fruit or vegetables like candied fruit; Frozen treats like ice cream, gelato, sherbet, sorbet, popsicles or similar confections. Cakes, pastries, sweet biscuits and other baked or fried confections which have at least a

partial base of a refined grain, including those made with real fruit or vegetables or nuts, like apple cake or cherry pie. Chips, crisps, cheese puffs, French fries, fried dough, instant noodles and similar items which contain mainly fat and carbohydrate and have at least a partial base of a refined grain or tuber)

30 No. of complementary feeds/day :___
<2 per day
2-3 per day
3-4 per day
>4 per day

30.1 How many complementary milk feeds does the child take per day?
None
1 per day
>/=2 per day
Do you use a bottle (bottle with nipple) for feeding milk/ water / other drink to your child between 0-23 months?

31 What food was given to the child during the previous day apart from breast milk? :___
(________________________)

32 Generally, how do you feed complementary food to the child :___
1. With spoon 2. With hand
3. Self with spoon 4. Self by hand
5. Bottle feeding

Participation in ICDS Programme

33 Did your child participate in ICDS Supplementary Feeding Programme :___
1.Yes 2. No 9. Child < 6 months of age

34 If yes, regularity of attendance : __
1.≥ 20 days/month (Regular)
2. <20 days/month (Irregular) 9. NA

35 If not/irregularly participating, give reasons :___
1.AWC not accessible 2. No need
3. Not Offered 4. Supplement not good
5. Causing ill health 8. Others 9. NA

36 If THR is received (6-12 mth children), is the supplement shared among family members? :___
1. Yes 2. No 9. NA

37 How many times did the AWW weighed your child in the last 3 months :___
1. Once 2. Twice 3. Thrice
4. Not Weighed 8. Don't Know 9. NA

38 Do the AWW discuss about weight of your child with you :___
1.Yes 2. No 9. NA

Care of the Child

39 Generally who looks after the child when you go out for work? :___
1. Mother-in-law 2.. Father-in- law
3. Elder siblings 4. Other
5. Carry the child to work spot
6. Left at AWC/ Crèche 9. NA

40 Do you wash your hands with soap before feeding the child? :___
1. Yes 2. No

41 How do you wash your hands after defecation? :___
1.With soap 2. With soil/ash
3. Only with water

42 Hand washing practices of the Child before taking food :___
1. Wash with soap
2. Wash without soap
3. Do not wash at all
9. Child on EBF

Morbidity condition of the Child

During past one year, did your child suffer from any of the following morbidities? (1. Yes 2. No)

43 Fever for 10 days :___
44 Diarrhea /Dysentery (2/3 episodes) :___
45 Acute Respiratory Infection (ARI) for 10 days (Cough) :___
46 Measles :___
Tuberculosis (TB)

47 Whom do you consult in case your child falls sick? :___
1. None 2 AWW 3. ANM/LHV
4. MO, PHC 5. Pvt. Practitioner
6. POSM 7. Others (_________) 9.NA

48 In case of diarrhoea, did you give ORS? :___
(1 Yes 2. No 9. NA)

If Yes, what did you give?
(1. Yes 2. No 9.NA)

49 Homemade ORS (salt & Sugar) :___
50 ORS given by AWW/ANM :___
51 Commercial ORS :___
52 Coconut water :___
53 Rice Gruel :___
54 Others (------------------------) :___

55 In case of cough (ARI), did the ANM give Co-trimoxazole tablets the child :___
1. Yes 2. No 9. NA

.

Nutritional Status

	Height (cm)	**Weight (kg)**	**Clinical Deficiency Signs (Codes)**
Index Child			
Mother			

Codes for Nutritional Deficiency signs

1. NAD 2. Emaciation 3. Marasmus 4. Night Blindness 5.Conjunctival xerosis	6. Bitot spots 7. Corneal xerosis 8. Keratomalacia 9. Corneal Scar 10.Angular stomatitis	11. Glossitis 12.Bleading Gums 13. Phrynoderma 14. Bow legs	15. Dental caries 16. Dental Flourosis 17. Oedema 18. Kwashiorkor	19. Goitre I (palpable) 20. Goitre II (visible) 21. Others _________ 22.Others __________

Name of the Investigator: …………………………….. Signature: …………………………

Name of Supervisor: ………………………………….. Signature : …………………………

Annexure 4:
Part I-Questionnaire on 24-hour Dietary Recall and Food Frequency

Part A: 24-hour dietary recall of the child (6-59 months)

1. What time did the child wake up yesterday? ___________________ (*24-hour clock*)
2. What time did the child sleep yesterday? _____________________ (*24-hour clock*)
3. How many times was the child breast fed yesterday? ____________ (*nos.*)
4. How often the child eats/drinks in between meals? __________________ (*nos. per day*)
5. Duration between meals (hrs) ___________________________________

S. No.	Time (24 hr clock)	Food/drink description	Amount of consumed food in standardized bowl	Ingredient of the food						Consistency
1										
2										
3										
4										
5										
6										
7										

Note: For consistency, Solid = SO; Semi-solid = SS, Liquid = L

Part B: Food frequency questionnaire (FFQ) of the child

S. No.	Food Items	Daily	2-4 times per week	5-6 times per week	Once a day	2-3 times per day	4+ times a day	Once a week	Once a month	Never
A	**Cereals/toots and tuber**									
1	Rice									

2	Chapati									
3	Paratha									
4	Puri									
5	White Bread									
6	Rice flaxes (Poha)									
7	Upma									
8	Idli									
9	Vada									
10	Dosa									
11	Wheat porridge									
12	Semolina Porridge									
13	Ragi porridge									
14	Puffed rice									
15	Sattu									
16	Potato fry									
17	Smashed potato									
18	Sweet potato									
19	Colocasia (Kosu, Taro)									
B	**Pulses and Legumes**									
20	Arhar dal									
21	Chana dal									
22	Masoor dal									
23	Urad/Mati dal									
24	Moong dal									
25	Soyabean									
26	Rajma									
27	Chick pea (Kabuli chana)									
28	Sambhar									
29	Green peas									
C	**Nuts and Oil seeds**									
30	Ground nut									

31	Coconut									
32	Almond									
33	Cashewnut									
34	Walnut									
35	Gingelly seeds (white **till**)									
D	**Milk and Milk products**									
36	Cow's milk									
37	Buffalo milk									
38	Curd									
39	Paneer									
40	Ghee									
E	**Meat & poultry**									
41	Boiled Egg									
42	Fried Egg									
43	Fish									
44	Chicken									
45	Mutton									
F	**Vitamin A rich fruits and vegetables**									
47	Carrots									
48	Palak									
49	Fenugreek leaves									
50	Drumstick leaves									
51	Any other GLV									
52	Sweet potato									
53	Pumpkin									
54	Tomato									
55	Mango									
56	Musk melon									
57	Papaya									
G	**Others**									
58	Beaten rice (Chira)									
59	Biscuits (plain)									

60	Tea (black)									
61	Tea (black with sugar)									
62	Milk tea									
63	Milk tea (with sugar)									
64	Milk with sugar									
65	Lassi									
66	Health Drink									
67	Salty snacks (chips)									
68	Jaggery									
69	Banana									
70	Fresh fruit juice									
71	Other									
H	**Sweets and desserts**									
72	Besan barfi									
73	Fruit cake									
74	Rice puttu									
75	Suji Halwa									
76	Besan halwa									
77	Ragi Halwa									
78	Ice cream									
79	Other market sweet									
80	Other									

Kessler Psychological Distress Scale (K10)

Source: Kessler R. Professor of Health Care Policy, Harvard MedicalSchool, Boston, USA.

This is a 10-item questionnaire intended to yield a global measure of distress based on questions about anxiety and depressive symptoms that a person has experienced in the most recent 4 week period.

Why use the K10?
The use of a consumer self-report measure is a desirable method of assessment because it is a genuine attempt on the part of the clinician to collect information on the patient's current condition and to establish a productive dialogue. When completing the K10 the consumer should be provided with privacy. (Information sourced from the NSW Mental health Outcomes andAssessment Training (MH-OAT) facilitator's Manual, NSW HealthDepartment 2001)

How to administer the questionnaire?
As a general rule, patients who rate most commonly "Some of the time" or "All of the time" categories are in need of a more detailed assessment. Referral information should be provided to these individuals. Patients who rate most commonly "A little of the time" or "None of the time" may also benefit from early intervention and promotional information to assist raising awareness of the conditions of depression and anxiety as well as strategies to prevent future mental health issues. (Information sourced from the NSW Mental health Outcomes and Assessment Training (MH-OAT) facilitator's Manual, NSW Health Department 2001)

1. During the last 30 days, how often did you feel tired out for no good reason?	1. None of the time	2. A little of the time	3. Some of the time	4. Most of the time	5. All of the time
2. During the last 30 days, about how often did you feel nervous?	1. None of the time	2. A little of the time	3. Some of the time	4. Most of the time	5. All of the time
3. During the last 30 days, about how often did you feel so nervous that nothing could calm you down?	1. None of the time	2. A little of the time	3. Some of the time	4. Most of the time	5. All of the time
4. During the last 30 days, about how often did you feel hopeless?	1. None of the time	2. A little of the time	3. Some of the time	4. Most of the time	5. All of the time
5. During the last 30 days, about how often did you feel restless or fidgety?	1. None of the time	2. A little of the time	3. Some of the time	4. Most of the time	5. All of the time
6. During the last 30 days, about how often did you feel so restless you could not sit still?	1. None of the time	2. A little of the time	3. Some of the time	4. Most of the time	5. All of the time
7. During the last 30 days, about how often did you feel depressed?	1. None of the time	2. A little of the time	3. Some of the time	4. Most of the time	5. All of the time
8. During the last 30 days, about how often did you feel that everything was an effort?	1. None of the time	2. A little of the time	3. Some of the time	4. Most of the time	5. All of the time
9. During the last 30 days, about how often did you feel so sad that	1. None of the time	2. A little of the time	3. Some of the time	4. Most of the time	5. All of the time

nothing could cheer you up?					
10. During the last 30 days, about how often did you feel worthless?	1. None of the time	2. A little of the time	3. Some of the time	4. Most of the time	5. All of the time

DSM-PH9

Adolescent Form

Sl.No	Items	Response
1	Feeling down, depressed, irritable, or hopeless?	Not at all Several Days More than half the days Nearly everyday
2	Little interest or pleasure in doing things?	Not at all Several Days More than half the days Nearly everyday
3	Trouble falling asleep, staying asleep, or sleeping too much?	Not at all Several Days More than half the days Nearly everyday
4	Poor appetite, weight loss, or overeating?	Not at all Several Days More than half the days Nearly everyday
5	Feeling tired or having little energy?	Not at all Several Days More than half the days Nearly everyday
6	Feeling bad about yourself or feeling that you are a failure or that you have let yourself or your family down?	Not at all Several Days More than half the days Nearly everyday
7	Trouble concentrating on things like school work, reading or watching tv?	Not at all Several Days More than half the days Nearly everyday
8	Moving or speaking so slowly that other people could have noticed ? OR the opposite - being so fidgety or restless that you were moving around a lot more than usual ?	Not at all Several Days More than half the days Nearly everyday
9	Thoughts that you would be better off dead or of hurting yourself in some way?	Not at all Several Days More than half the days Nearly everyday

Adult Form

Sl.No	Items	Response
1	Feeling down, depressed, irritable, or hopeless?	Not at all Several Days More than half the days Nearly everyday
2	Little interest or pleasure in doing things?	Not at all Several Days More than half the days Nearly everyday
3	Trouble falling asleep, staying asleep, or sleeping too much?	Not at all Several Days More than half the days Nearly everyday
4	Poor appetite, weight loss, or overeating?	Not at all Several Days More than half the days Nearly everyday
5	Feeling tired or having little energy?	Not at all Several Days More than half the days Nearly everyday
6	Feeling bad about yourself or feeling that you are a failure or that you have let yourself or your family down?	Not at all Several Days More than half the days Nearly everyday
7	Trouble concentrating on things like school work, reading or watching tv?	Not at all Several Days More than half the days Nearly everyday
8	Moving or speaking so slowly that other people could have noticed ? OR the opposite - being so fidgety or restless that you were moving around a lot more than usual ?	Not at all Several Days More than half the days Nearly everyday
9	Thoughts that you would be better off dead or of hurting yourself in some way?	Not at all Several Days More than half the days Nearly everyday

FLII		
I am going to ask you some questions about how you have been feeling mentally and emotionally. Some questions relate to experiences you may have had at some point during your lifetime, while others are about your experiences during the past few months. Please answer each question as honestly and accurately as possible. Your responses will remain confidential and will only be used for the purposes of this research.		
	Questions	
A.	**MOOD EPISODES**	
	DEPRESSIVE EPISODE (DE)	
DE.1a	**Have you ever, for a period of at least 2 weeks, felt depressed, “down”, sad, or “empty” for most of the day, nearly every day?**	
DE.1b	**Have you ever, for a period of at least 2 weeks, been a lot less interested in, or experienced a lot less pleasure from doing things you normally enjoy?**	
	If DE.1a and DE.1b rated “NO” – Depressive episode screen negative SKIP TO MAN.1a - Manic episode screening	
DE.1c	DISPLAY IF DE.1a IS YES During the past month, have you, for a period of at least 2 weeks, felt depressed, “down”, sad, or “empty” for most of the day, nearly every day?	
DE.1d	DISPLAY IF DE.1b IS YES During the past month, have you, for a period of at least 2 weeks, been a lot less interested in, or experienced a lot less pleasure from doing things you normally enjoy?	
DE.1e	IF EITHER DE.1a or DE.1b or BOTH rated “YES” AND DE.1c and DE.1d BOTH rated “NO” Please tell me when you experienced the worst period of [LOW MOOD AND/OR LOSS OF INTEREST] that lasted for at least 2 weeks? Month____ Year _____	
	CURRENT DE: ASK “During the past month”; CHANGE GRAMMAR TO “Have you (had, felt, thought, etc,)” rather than “Did you”. LIFETIME DE: ASK “During that same period”; USE THE ANSWER FROM DE.1e AS PIPED TEXT IN THE QUESTIONS DE.2a – DE.3d DISPLAY LOGIC for DE.2a – DE.3d: When there is more than one question per item - each item requires at least one question to be answered YES in order to be rated as “YES” – hence the second question in an item need not be displayed if the first is answered YES / need only be displayed if the first question is answered NO.	
DE.2a	**During that same period, DE.1e, did you have more trouble concentrating and staying focused on things than usual?** **IF NO: During that same time period, DE.1e, did you struggle more than usual to make decisions?**	
DE.2b	**During that same period, DE.1c, did you feel less valuable as a person or even worthless?** **IF NO: During that same time period, DE.1c, did you feel overly guilty about things you did or neglected to do?**	
DE.2c	**During that same period, DE.1c, did you feel more hopeless about the future, like things would never get better or turn out well for you?**	
DE.2d	**During that same period, DE.1c, did you think often about death or suicide, or did you try to end your life?**	

DE.3a	**During that same period, DE.1c, did you have more trouble falling or staying asleep than usual, or did you wake up too early?** **IF NO: During that same period, DE.1c, were you sleeping a lot more than you usually do?**	
DE.3b	**During that same period, DE.1c, did your appetite increase or decrease compared to before you started experiencing symptoms?** **IF NO: During that same period, DE.1c, did you lose or gain a noticeable amount of weight without trying to?**	
DE.3c	**During that same period, DE.1c, did you have less energy than before the low mood and/or loss of interest started?** **IF NO: During that same period, were you much more tired than usual even when doing some small task?**	
DE.3d	**During that same period, DE.1c, did you feel more restless, or were you pacing around a lot more than is usual for you?** **IF NO: Or were you moving or speaking more slowly than is usual for you?** **IF YES TO EITHER OF THE ABOVE: Was your [RESTLESSNESS OR SLOWNESS] bad enough to be noticeable to others?** **(This last question has to be rated YES for the item rating to be "YES")**	
	SYMPTOM COUNT SCORING INSTRUCTION: FOR LIFETIME EPISODE - count each item from DE.1a-b and DE.2a - 3d rated as "yes" as 1 (maximum score = 10) FOR CURRENT EPISODE - count each item from DE.1c-d and DE.2a - 3d rated as "yes" as 1 (maximum score = 10) SCORE = 5 or more – DEPRESSION SYMPTOM COUNT AT OR ABOVE THRESHOLD - continue with DE.4 SCORE = 4 or less: IF ENQUIRING ABOUT CURRENT SYMPTOMS – LOOP BACK TO DE.1E IF ENQUIRING ABOUT LIFETIME SYMPTOMS – SKIP TO MAN.1A (MANIC EPISODE SCREENING QUESTION)	
DE.4	DISPLAY LOGIC: Only ask subsequent questions if initial questions are answered NO. (Only one question answered YES is enough for a "YES" rating) SKIP LOGIC: As soon as one question is answered YES – skip to DE.5 Did the changes in mood or interest, and the other experiences we've just talked about affect your ability to function in daily life, for example, your work or school, your social life or your relationships? IF NO: Or did you still continue to get things done, but with a lot of extra effort? YES TO EITHER OF THE TWO ABOVE QUESTIONS: FUNCTIONAL IMPAIRMENT PRESENT AND DEPRESSIVE EPISODE CDDR MET SKIP TO DE.5 IF NO – AND ENQUIRING ABOUT CURRENT SYMPTOMS – LOOP BACK TO DE.1e IF NO – AND ENQUIRING ABOUT LIFETIME SYMPTOMS – SKIP TO MAN.1a (Manic episode screening question)	
DE.5	**In the 6 months before you started having these changes in mood or loss of interest and the other experiences we just talked about, had someone very close to you died, like a spouse, parent or child?** **If NO: DEPRESSIVE EPISODE - SKIP to DE.6** **IF YES: BEREAVEMENT PRESENT** **IF YES, DISPLAY: Do you believe that the changes in mood or interest, and the other experiences we just talked about, were a part of your grief or reaction to that loss?** **If NO:** **DE.1c or d or both rated YES - DX CURRENT DEPRESSIVE EPISODE, NO BEREAVEMENT** **DE.1a or b or both rated YES – DX LIFETIME DEPRESSIVE EPISODE, NO**	

	BEREAVEMENT **IF NO DEPRESSIVE EPISODE, SKIP to MAN.1a (Manic episode screening question)** **IF YES: NORMAL GRIEF - SKIP to MAN.1a (Manic episode screening question)**	
DE.6	IF DX CURRENT DEPRESSIVE EPISODE or DX LIFETIME DEPRESSIVE EPISODE PRESENT Was there another time in your life when you had similar experiences such as [ENDORSED DEPRESSIVE SYMPTOMS] that lasted for 2 weeks or longer? IF NO: SINGLE DEPRESSIVE EPISODE = YES; SKIP to MAN.1a (Manic Episode screening question) IF YES: Was there a period of at least 3 months between these episodes when you did not have any symptoms or very minimal symptoms? IF NO: SINGLE DEPRESSIVE EPISODE = YES IF YES: RECURRENT DEPRESSIVE EPISODES = YES (FINAL MOOD DIAGNOSES DETERMINED IN MODULE D BELOW.)	
	MANIC EPISODE AND HYPOMANIC EPISODE (MAN)	
MAN.1a	**Have you ever, for a period of at least 3 days, felt much happier than is usual for you, or felt like you could do anything?** **IF YES: Did you feel like this for most of the day, nearly every day?** **BOTH QUESTIONS MUST BE ANSWERED YES FOR MAN.1a.TO BE SCORED AS YES**	
MAN.1b	DISPLAY IF MAN.1a = NO Have you ever, for a period of at least 3 days, felt much more irritable or short-tempered than is usual for you? IF YES: Did you feel like this for most of the day, nearly every day? BOTH QUESTIONS MUST BE ANSWERED YES FOR MAN.1b.TO BE SCORED AS YES	
	IF MAN.1a AND MAN.1b = NO: Manic and Hypomanic Episode screen negative SKIP TO MIX.1 - Mixed episode screening	
MAN.1c	DISPLAY IF MAN.1a = YES During the past month, have you, for a period of at least 3 days, felt much happier than is usual for you, or felt like you could do anything? IF YES: Did you feel like this for most of the day, nearly every day? BOTH QUESTIONS MUST BE ANSWERED YES FOR MAN.1c.TO BE SCORED AS YES	
MAN.1d	DISPLAY IF MAN.1b = YES During the past month, have you, for a period of at least 3 days, felt much more irritable or short-tempered than is usual for you? IF YES: Did you feel like this for most of the day, nearly every day? BOTH QUESTIONS MUST BE ANSWERED YES FOR MAN.1d.TO BE SCORED AS YES	
	IF MAN.1c AND/OR MAN.1d = YES, SKIP TO MAN.2a	
MAN.1e	DISPLAY IF MAN.1a AND/OR MAN.1b IS RATED YES; AND MAN.1c AND MAN.1d ARE RATED NO When did you experience your most extreme period of [ELEVATED MOOD AND/OR IRRITABILITY] that lasted for at least 3 days? _________________ (month, year) SKIP TO MAN.2b	
MAN.2a	DISPLAY IF MAN.1c OR MAN.1d IS RATED YES During this period within the past month, when you were experiencing [ELEVATED	

	MOOD AND/OR IRRITABILITY], were you also doing a lot more things than is usual for you, or did you have much more energy? IF NO: LOOP BACK TO MAN.1e IF YES: SKIP TO MAN.3a	
MAN.2b	DISPLAY IF MAN.1e IS PRESENTED Use the answer from MAN.1e as PIPED TEXT: During that same period, MAN.1e, when you were experiencing [ELEVATED MOOD AND/OR IRRITABILITY], were you also doing a lot more things than is usual for you, or did you have much more energy? IF NO: SKIP TO MIX.1 Mixed Episode screening IF YES – CONTINUE WITH MAN.3a	
	IF ASSESSING CURRENT: USE "During that same period, within the last month" AS PIPED TEXT IN QUESTIONS MAN.3a TO MAN.3g IF ASSESSING LIFETIME: USE THE ANSWER FROM MAN.1e AS PIPED TEXT IN QUESTIONS MAN.3a TO MAN.3g	
MAN.3a	**During that same period (within the past month OR MAN.1e), were you talking much more and faster than usual?**	
MAN.3b	**During that same period (within the past month OR MAN.1e), did you have many thoughts racing through your head, or did many different ideas come to your mind one after another, flowing quickly from one to the other?**	
MAN.3c	**During that same period (within the past month OR MAN.1e), did you sense that you could do almost anything, or that you were very special in some way?** **IF YES: Were you convinced that you had special powers or that you were extremely important?** **IF ANSWER TO FIRST QUESTION IS YES, MAN.3c = YES** **IF ANSWER TO SECOND QUESTION IS YES, IT IS SCORED AS A DELUSION AND PRECUDES THE POSSIBILITY OF A HYPOMANIC EPISODE.**	
MAN.3d	**During that same period (within the past month OR MAN.1e), did you need less sleep than usual or feel well-rested after only a few hours of sleep?**	
MAN.3e	**During that same period (within the past month OR MAN.1e), did you have more difficulty keeping your attention on a task because things around you were very distracting?**	
MAN.3f	DISPLAY SECOND QUESTION ONLY IF ANSWER TO FIRST QUESTION IS NO During that same period (within the past month OR MAN.1e), did you act on the spur of the moment, without thinking about the end results? For example, spending more money or choosing pleasurable activities instead of taking care of responsibilities, in ways that are not usual for you? IF NO: During that same period (within the past month OR MAN.1e), did you behave recklessly without regard for your safety—for example, driving recklessly, participating in dangerous sports, having impulsive unprotected sex, or taking other physical risks like climbing on things or crossing a busy highway—in ways that are not usual for you? IF ANSWER TO EITHER QUESTION IS YES, MAN.3f = YES	
MAN.3g	DISPLAY SUBSEQUENT QUESTION ONLY IF ANSWER TO PRECEDING QUESTON IS NO; SKIP TO SYMPTOM COUNT AT FIRST YES During that same period (within the past month OR MAN.1e), did you have an increased sex drive? IF NO, DISPLAY: During that same period (within the past month OR MAN.1e), were you more social and friendly than usual? IF NO, DISPLAY: During that same period (within the past month OR MAN.1e), were you much better at planning things and getting things done? IF ANSWER TO ANY OF THE 3 ABOVE QUESTIONS IS YES, MAN.3g = YES	
	SYMPTOM COUNT SCORING INSTRUCTIONS: COUNT EACH ITEM from MAN.3a to MAN.3g RATED AS "YES" as 1 (Maximum score = 7)	

	SCORE = 3 or more – MANIA OR HYPOMANIA SYMPTOM COUNT AT OR ABOVE THRESHOLD - continue with MAN.4 SCORE = 2 or less – IF ENQUIRING ABOUT CURRENT SYMPTOMS – LOOP BACK TO MAN.1e IF ENQUIRING ABOUT LIFETIME SYMPTOMS – SKIP TO MIX.1 (Mixed Episode screening question)	
MAN.4	**How long did the [MANIC AFFECT] and other experiences you have just told me about last?** **_____ 3 to 6 days _____ 1 week or more**	
MAN.5	**Were these symptoms so severe that you had to be admitted to hospital or some other supervised care setting?**	
MAN.6	**Did the mood changes and other experiences we've just talked about affect your ability to function in daily life, for example, your work or school, your social life, or your relationships?** **IF YES - FUNCTIONAL IMPAIRMENT PRESENT**	
	DIAGNOSE MANIC EPISODE IF MAN.6 = YES (functional impairment) AND MAN.4 = "1 week or more" OR DIAGNOSE MANIC EPISODE IF MAN.5 = YES (hospital or supervised care was required) AND/OR PSYCHOSIS WAS PRESENT DURING THE EPISODE (SEE MAN.3c). AND DIAGNOSE MANIC EPISODE CURRENT (if MAN.1c or MAN.1d is YES) OR DX MANIC EPISODE LIFETIME (if MAN.1a or MAN.1b is YES) THEN, SKIP TO MODULE B (OMIT MIXED EPISODE SCREENING AND ASSESSMENT) Dx HYPOMANIC EPISODE IF MAN.4 = 3 TO 6 DAYS AND MAN.5 = NO (hospital or supervised care NOT required) AND MAN.6 = NO (NO functional impairment) AND NO PSYCHOSIS PRESENT (SEE MAN.3c). OR DIAGNOSE HYPOMANIC EPISODE IF: MAN.5 = NO (no hospitalization) and MAN.3c = NO (no psychosis) AND: MAN.6 = YES (functional impairment) AND MAN.4 = "3 to 6 days" OR: MAN.6 = NO (NO functional impairment) AND MAN.4 = "1 week or more" DX HYPOMANIC EPISODE CURRENT IF MAN.1c OR MAN.1d = YES THEN, GO BACK TO MAN.1e. OR DX HYPOMANIC EPISODE LIFETIME IF (MAN.1a OR MAN.1b = YES THEN, GO TO MIX.1 (Mixed episode screening question)	
	MIXED EPISODE (MIX) (ASSESSED FOR CURRENT PRESENCE ONLY)	
MIX.1a	SQ : In the past month, have you experienced a period of changing moods such as switching between feeling very happy,"on top of the world", or like you could do anything alternating with feeling sad, down, unhappy, or just feeling miserable. changing from day-to-day or even within the same day?	

	IF NO: In the past month, have you experienced a period of having these different types of feelings a the same time, like feeling very happy but at the same time feeling hopeless or worthless, or feeling sad but also very talkative and energetic? IF YES TO EITHER: Did you feel like this most of the day, nearly every day for at least 2 weeks? (REQUIRED)	
	If MIX.1a rated "NO" - Mixed episode screen negative SKIP TO PSY.1a - Psychosis screening question	
MIX.1b	DISPLAY IF MIX.1a IS RATED YES Please tell me during which 2-week period these mood changes were at their worst over the past month: ______ the past 2 weeks _____ 2 – 3 weeks ago _____3 – 4 weeks ago	
MIX.2a	**Did you, during that 2-week period, feel depressed, "down", sad, or "empty" for most of the day, nearly every day?**	
MIX.2b	**During that 2-week period, were you a lot less interested in, or experienced a lot less pleasure from doing the things you normally enjoy?**	
MIX.2c	**During that same period, MIX.1b, did you have more trouble concentrating and staying focused on things than usual? IF NO: During that same time period, MIX.1b, did you struggle more than usual to make decisions?**	
MIX.2d	**During that same period, MIX.1b, did you feel less valuable as a person or even worthless? IF NO: During that same time period, MIX.1b, did you feel overly guilty about things you did or neglected to do?**	
MIX.2e	**During that same period, MIX.1b, did you feel more hopeless about the future, like things would never get better or turn out well for you?**	
MIX.2f	**During that same period, MIX.1b, did you think often about death or suicide, or did you try to end your life?**	
MIX.2g	**During that same period, MIX.1b, did you have more trouble falling or staying asleep than usual? IF NO: During that same period, MIX.1b, were you sleeping a lot more than you usually do?**	
MIX.2h	**During that same period, MIX.1b, did your appetite increase or decrease compared to before you started experiencing mood changes? IF NO: During that same period, MIX.1b, did you lose or gain a noticeable amount of weight without trying to?**	
MIX.2i	**During that same period, MIX.1b, did you have less energy than before the [LOW MOOD AND/OR LOSS OF INTEREST] started? IF NO: Were you much more tired than usual even when doing some small task?**	
MIX.2j	**During that same period, MIX.1b, did you feel more restless, or were you pacing around a lot more than is usual for you? IF NO: Or were you moving or speaking more slowly than is normal for you? DISPLAY THIS QUESTION IF YES TO EITHER: Was your [RESTLESSNESS OR SLOWNESS] bad enough to be noticeable to others? (This last question has to be rated YES for the item rating to be "YES")**	
	SCORING INSTRUCTIONS: ONLY CONTINUE WITH MIX.3 IF: At least 3 items of MIX.2a-j = YES MIXED DEPRESSIVE SYMPTOM SCORE = YES IF MIXED DEPRESSIVE SYMPTOM SCORE = NO, SKIP TO PSY.1	
MIX.3a	**During that 2-week period, MIX.1b, did you feel much happier than is usual for you or feel like you could do anything? IF NO: During that 2-week period, MIX.1b, did you feel much more irritable or short-tempered than is usual for you? IF YES TO EITHER: Did you feel like this for most of the day, nearly every day? (REQUIRED)**	

MIX.3b	**During that same period, MIX.1b, were you doing a lot more things than is usual for you, or did you have much more energy?**	
MIX.3c	**During that same period, MIX.1b, were you talking much more and faster than usual?**	
MIX.3d	**During that same period, MIX.1b, did you have many thoughts racing through your head, or did many different ideas come to your mind one after another, flowing quickly from one to the other?**	
MIX.3e	**During that same period, MIX.1b, did you sense that you could do almost anything or that you were very special in some way?**	
MIX.3f	**During that same period, MIX.1b, did you need less sleep than usual or feel well-rested after only a few hours of sleep?**	
MIX.3g	**During that same period, MIX.1b,did you have more difficulty keeping your attention on a task because things around you were distracting you?**	
MIX.3h	DISPLAY LOGIC – only display the second question if the first is answered NO (either question answered as YES is sufficient for a "YES" rating) During that same period, MIX.1b did you act on the spur of the moment, without thinking about the end results,—for example, spending more money, or choosing pleasurable activities instead of taking care of responsibilities—in ways that are not usual for you? IF NO: During that same period, MIX.1b did you behave recklessly without regard for your safety—for example, driving recklessly, participating in dangerous sports, having impulsive unprotected sex, or taking other physical risks like climbing on things or crossing a busy highway—in ways that are not usual for you?	
MIX.3i	FOR THE FOLLOWING 3 QUESTIONS, DISPLAY SUBSEQUENT QUESTION ONLY IF ANSWER TO PRECEDING QUESTON IS NO; SKIP TO MIX.4 AT FIRST YES During that same period, MIX.1b did you have an increased sex drive? IF NO: During that same period, MIX.1b were you more social and friendly than usual? IF NO: During that same period, MIX.1b were you much better at planning things and getting things done? IF ANSWER TO ANY OF THE 3 ABOVE QUESTIONS IS YES, MIX.3i = YES	
MIX.4	SCORING INSTRUCTIONS: ONLY CONTINUE WITH MIX.5 IF: At least 3 items of MIX.3a-i = YES MIXED MANIC SYMPTOM SCORE = YES IF MIXED MANIC SYMPTOM SCORE = NO, SKIP TO PSY.1	
MIX.5	DISPLAY IF MIX.4 is rated YES Did the changes in mood, thoughts, and/or behaviour we've just talked about affect your ability to function in daily life, for example, your work or school, your social life, or your relationships? YES: FUNCTIONAL IMPAIRMENT PRESENT AND MIXED EPISODE CDDR MET) AND DX MIXED EPISODE CURRENT IF NO – SKIP TO PSY.1a (PSYCHOSIS SCREENING QUESTION)	
B	**PSYCHOTIC SYMPTOMS (PSY) (All SQs)**	
PSY.1	DELUSIONS FOR ALL ITEMS IN THE DELUSIONS SECTION, THE LOGIC OF THE QUESTIONS IS AS FOLLOWS: Have you ever believed that [SPECIFIC DELUSION]?	

	IF YES: Were you convinced that this experience was real? IF NO, IT IS NOT A DELUSION (SKIP TO NEXT ITEM) IF YES: Did other people around you also believe this? ___ YES ____ NO ____ UNKNOWN (NO ONE AROUND OR DOESN'T KNOW.) IF YES, IT IS NOT A DELUSION (SKIP TO NEXT ITEM) IF NO: Would someone from your same religion or culture think this is a reasonable thing to believe? IF YES, IT IS NOT A DELUSION (SKIP TO NEXT ITEM) IF NO OR UNKNOWN: SCORE YES FOR LIFETIME [SPECIFIC DELUSION] THEN: Have you experienced this during the past month? IF YES: SCORE YES FOR CURRENT [SPECIFIC DELUSION] Have you ever believed that you were being watched or followed? IF NO: Have you ever believed that someone was planning to harm you? IF YES TO EITHER: Were you convinced that this experience was real? IF YES: Did other people around you also believe this? Or was there no one else around? IF NO OR UNKNOWN: Would someone from your same religion or culture think this is a reasonable thing to believe? IF NO OR UNKNOWN: LIFETIME PSY.1a = YES Have you believed this during the past month? IF YES: CURRENT PSY.1a = YES	
PSY.1a Persecutory	Have you ever believed that you were especially important or powerful, or that you had special powers? IF NO: How about being famous or related to very powerful people? IF YES TO EITHER: Were you convinced that this experience was real? IF YES: Did other people around you also believe this? Or was there no one else around? IF NO OR UNKNOWN : Would someone from your same religion or culture think this is a reasonable thing to believe? IF NO OR UNKNOWN: LIFETIME PSY.1b = YES Have you believed this during the past month? IF YES: CURRENT PSY.1b = YES	
PSY.1b Grandiose	Have you ever believed that you had an extraordinary connection with (God) or a spirit, or that you were chosen above other people to receive special messages or missions? IF NO: Have you ever believed that you were (God) or related to (God)? IF YES TO EITHER: Were you convinced that this experience was real? IF YES: Did other people around you also believe? Or was there no one else around? IF NO OR UNKNOWN: Would someone from your same religion or culture think this is a reasonable thing to believe? IF NO OR UNKNOWN: LIFETIME PSY.1c = YES Have you believed this during the past month?	

PSY.1c **Religious** **PSY. 1d** **Guilt** **PSY.1e** **Somatic**	IF YES: CURRENT PSY.1c = YES Have you ever believed that you had done something terribly wrong or committed a horrible crime for which you deserved punishment, or that you were responsible for a natural disaster such as a storm or earthquake? IF YES: Were you convinced that this experience was real? IF YES: Did other people around you also believe this? Or was there no one else around? IF NO OR UNKNOWN: Would someone from your same religion or culture think this is a reasonable thing to believe? IF NO OR UNKNOWN: LIFETIME PSY.1d = YES Have you believed this during the past month? IF YES: CURRENT PSY.1d = YES Have you ever believed that there was something wrong with your organs or other parts of your body? If YES: Was this limited to worries about the way your body looks? IF YES: SKIP TO PSY.1f – DELUSIONS OF JEALOUSY IF NO (I.E. NOT LIMITED TO BODY DYSMORPHIA): Were you convinced that this experience was real? IF YES: Did other people around you also believe this? Or was there no one else around? IF NO OR UNKNOWN: Would someone from your same religion or culture think this is a reasonable thing to believe? IF NO OR UNKNOWN: LIFETIME PSY.1e = YES Have you believed this during the past month? IF YES: CURRENT PSY.1e = YES Have you ever been convinced that your partner or spouse has been unfaithful, despite other people not believing it, or despite your partner never admitting it? IF YES: Were you convinced that this experience was real? IF YES: Did other people around you also believe this? Or was there no one else around? IF NO OR UNKNOWN: Would someone from your same religion or culture think this is a reasonable thing to believe? IF NO OR UNKNOWN: LIFETIME PSY.1f = YES Have you believed this during the past month? IF YES: CURRENT PSY.1f = YES Have you ever felt like something on TV, the movies, radio, social media, or the internet was meant specifically for you or was trying to send you a special message? IF NO: Have objects or people that you encounter in your daily life ever communicated particular special messages to you but not to most other people? IF YES: Were you convinced that this experience was real? IF YES: Did other people around you also believe this? Or was there no one else around? IF NO OR UNKNOWN: Would someone from your same religion or culture think this is a reasonable thing to believe? IF NO OR UNKNOWN: LIFETIME PSY.1g = YES Have you believed this during the past month? IF YES: CURRENT PSY.1I = YES	

PSY.1f **Jealousy** **PSY.1g** **Reference**		
PSY.2 **PSY.2a** **PSY.2b**	EXPERIENCES OF PASSIVITY, INFLUENCE AND CONTROL Have you ever felt like someone or something was controlling how you think, feel, or behave? IF YES: Has this happened during the past month? Have you ever had the experience that thoughts that were not your own were being put into your head? IF NO: Have you ever had the experience that your thoughts were being taken out of your head? IF NO: Or that your thoughts were being broadcast so that other people could know what you are thinking? (ONLY ONE YES ANSWER IS SUFFICIENT FOR A "YES" RATING) IF YES: Has this happened during the past month?	
PSY.3 **PSY. 3a** **Auditory** **PSY.3b** **Visual** **PSY.3c** **Tactile**	HALLUCINATIONS Have you heard voices talking to you or to each other when there was no one else around? IF YES: Did this last for longer than a few seconds? IF YES: Did this happen at least several times? IF YES: Has this happened during the past month? Have you ever seen things while you were awake that other people couldn't see, that were not caused by a substance or medication? IF YES: Did this last for longer than a few seconds? IF YES: Did this happen at least several times? IF YES: Has this happened during the past month? Have you ever felt unusual sensations on or under your skin that you could not explain, like feeling as if bugs were crawling on your skin?	

PSY. 3d **Somatic** **PSY.3e** **Gustatory** **PSY.3f** **Olfactory**	IF YES: At that time – were you taking a substance or withdrawing from a substance? (IF YES – SKIP to PSY.3d) IF NO: Did this last for longer than a few seconds? IF YES: Did this happen at least several times? IF YES: Has this happened during the past month? Have you ever experienced unusual and unexplained sensations inside your body, like electrical shocks, or feeling like there is something strange inside of your chest or abdomen? IF YES: Did this last for longer than a few seconds? IF YES: Did this happen at least several times? IF YES: Has this happened during the past month? Have you ever experienced a strange or bad taste that could not be explained by something you ate or drank, or caused by a substance or medication? IF YES: Did this last for longer than a few seconds? IF YES: Did this happen at least several times? IF YES: Has this happened during the past month? Have you ever smelled something strange or bad that other people couldn't smell? IF YES: Did this last for longer than a few seconds? IF YES: Did this happen at least several times? IF YES: Has this happened during the past month?	
C	**(PROBABLE) PRIMARY PSYCHOTIC DISORDER (PPD)**	**1.Lifetime**
PPD.1	IF: Psychotic symptoms current or lifetime AND No secondary cause at the time of symptoms (SEE p43-44) AND If mood symptoms present - Psychotic symptoms present majority of the time, mood symptoms do not occur outside of psychotic symptoms/episodes. IF MOOD EPISODE ALSO PRESENT: Was there a time when you had the things we just talked about, the [PSYCHOTIC SYMPTOMS], but you did not have the [MOOD SYMPTOMS]? (EXAMPLE of question with piped text / information supplied by interviewer: "Was there a time when you were hearing voices and thinking your life was in danger, but you did not have the irritability and sleeplessness? The aim is to separate a primary psychotic disorder from a mood disorder with psychotic features) NO: Likely Mood disorder YES: Likely Psychotic disorder	NO / YES
D	**MOOD DISORDERS** **IF Any Mood Episode rated as YES (current or past): (DE.5, MAN.6, or MIX.5)** **The first 4 are mutually exclusive disorders (e-version automatically scored)**	
SEDD.1	**Single Episode Depressive Disorder (6A70)** **Presence or history of a single Depressive Episode** **(No history of Manic, Mixed, or Hypomanic Episodes)** **IF A DEPRESSIVE EPISODE PRESENT – CURRENT OR LIFETIME** **AND NO MANIC / HYPOMANIC / MIXED EPISODES**	

	IF DE.6 RATED NO: DX SINGLE EPISODE DEPRESSIVE DISORDER (6A70) **IF DE.6 RATED YES: DX RECURRENT DEPRESSIVE DISORDER (6A71)**	
RDD.1	**Recurrent Depressive Disorder (6A71)** **At least two Depressive Episodes, which may include a current episode, separated by several months (3) without significant mood disturbance.** **(No history of Manic, Mixed, or Hypomanic Episodes)** **REFER TO DE.6 FOR THIS INFORMATION**	
BDI.1	**Bipolar Disorder type I (6A60)** **Presence or history of at least one Manic or Mixed Episode** **PRESENT IF ONE MANIC OR MIXED EPISODE CURRENT OR PAST**	
BDII.1	**Bipolar Disorder type II (6A61)** **A history of at least one Hypomanic Episode and at least one Depressive Episode** **(No history of Manic or Mixed Episodes.)** **PRESENT IF ONE DEPRESSIVE AND ONE HYPOMANIC EPISODE**	
MEPS.1	**Mood Episode with Psychotic Symptoms** **IF MOOD EPISODE PRESENT** **AND DELUSION OR HALLUCINATION PRESENT OVER THE LIEFTIME:** **Did you ever experience [DELUSION AND/OR HALLUCINATION] when you were not having [ABNORMAL MOOD – Low / elevated / irritable / loss of interest]?** **YES: MOOD DISORDER AND PROBABLE PRIMARY PSYCHOTIC DISORDER** **NO: MOOD EPISODE / DISORDER WITH PSYCHOTIC FEATURES**	
E	**ANXIETY AND FEAR-RELATED DISORDERS**	
	MB23.H PANIC ATTACK (PA)	
PA.1	SQ : Have you ever experienced an episode of intense fear or anxiety that started suddenly and got worse within minutes that was not a response to immediate danger? IF NO: SKIP to AGO.1 - screening question for Agoraphobia	
PA.2	DISPLAY IF PA.1 rated as YES. ONCE 3 SYMPTOMS ENDORSED = Dx LIFETIME PANIC ATTACK GO TO PD.1 screening for Panic disorder IF THE END IS REACHED AND < 3 SYMPTOMS ENDORSED – SKIP to AGO.1 screening question for Agoraphobia Along with the anxiety (“panic”), did you also experience: (CHECK ALL THAT APPLY) A racing / fast beating heart? Sweating? Trembling or feeling shaky? Feeling short of breath? Feeling like your throat was closing up or that you were choking? Having chest pain or pressure? Feeling nauseous, having stomach cramps? Feeling dizzy or lightheaded?	

	Chills or hot flushes? Tingling sensations or numbing in your hands or feet? Feeling like you were unreal and detached from your body, or that things around you were unreal? Fearing that you were losing control? Fearing that you were going crazy Fearing that you were going to die?	
	6B01 - PANIC DISORDER (PD)	
PD.1a	IF DX LIFETIME PANIC ATTACK IS PRESENT: Was there ever a time when you had two or more of these panic attacks during a single month? IF YES: Did some or all of these panic attacks happen unexpectedly ("out of the blue"), for no apparent reason? BOTH QUESTIONS NEED TO BE ANSWERED YES FOR THIS ITEM TO BE RATED "YES"	
	If PD.1a rated "NO" - Panic disorder screen negative SKIP TO AGO.1 – Agoraphobia screening	
PD.1b	DISPLAY IF PD.1a RATED AS YES SQ : In the past month, have you had more than one of these "panic attacks"? IF YES: Do some (or all) happen unexpectedly ("out of the blue"), for no apparent reason? BOTH QUESTIONS NEED TO BE ANSWERED AS YES FOR THIS ITEM TO BE RATED "YES"	
PD.1c	DISPLAY IF PD.1a is rated as YES and PD.1b is rated as NO Thinking about the panic attacks that you have experienced during your lifetime, when was the month that they occurred most frequently? Year _____Month____ Did you have at least 2 panic attacks during that month?	
PD.2	LIFETIME: Use the answer from PD.1c as PIPED TEXT in the questions PD.2-3 CURRENT: Change grammar – "Are you having / Do you …" AND "During the past month" DISPLAY IF PD.1a or PD.1b is rated as YES DISPLAY LOGIC: Only display subsequent questions if initial questions are answered NO. (Only one question answered YES is enough for a "YES" rating) One question answered YES is sufficient for a YES rating of this item During that month, did you worry that the panic attacks would happen again? IF NO: Did you worry that something was physically wrong with you? IF NO: Did you do things differently to try and prevent them from happening again? IF NO AND PD.1b was rated YES: LOOP BACK TO PD.1c OTHERWISE SKIP TO AGO.1a	
PD.3	DISPLAY IF PD.2 is rated YES DISPLAY LOGIC: Only display subsequent questions if initial questions are answered NO. (Only one question answered YES is enough for a "YES" rating) Did the panic attacks and your worry about having another panic attack affect your ability to function in daily life, for example, your work or school, your social life or your relationships? IF NO: Or did you still continue to get things done, but with a lot of extra effort?	

	YES TO EITHER OF THE TWO QUESTIONS: FUNCTIONAL IMPAIRMENT PRESENT (PANIC DISORDER CDDR MET) AND DX PANIC DISORDER CURRENT (if PD.1b is YES) Or DX PANIC DISORDER LIFETIME (if PD.1a is YES and PD.1b is NO) IF NO – AND ENQUIRING ABOUT CURRENT SYMPTOMS – LOOP BACK TO PD.1c IF NO – AND ENQUIRING ABOUT LIFETIME SYMPTOMS – SKIP TO AGO.1a (Agoraphobia screening question)	
	6B02 - AGORAPHOBIA (AGO)	
AGO.1a	SQ : Was there ever a time when, for three or more months, you were very anxious in public situations because you felt like you would be stuck without an easy way to leave or without access to help in case you needed it? Examples of these types of situations include: using public transport, being in crowds, being outside the home alone, being in the shops, going to the theatre, or standing in line. IF YES: Did you have this anxiety in more than one type of situation? BOTH QUESTIONS NEED TO BE ANSWERED YES FOR THIS ITEM TO BE RATED "YES"	
	If AGO.1a rated "NO" - Agoraphobia screen negative SKIP TO GAD.1a – Generalized Anxiety disorder screening	
AGO.1b	DISPLAY IF AGO.1a RATED AS YES SQ : Over the last three or more months, have you been very anxious in public situations because you felt like you would be stuck without an easy way to leave or without access to help in case you needed it? Examples of these types of situations include: using public transport, being in crowds, being outside the home alone, being in the shops, going to the theatre, or standing in line. IF YES: Did you have this anxiety in more than one type of situation? BOTH QUESTIONS NEED TO BE ANSWERED YES FOR THIS ITEM TO BE RATED "YES"	
AGO.1c	DISPLAY IF AGO.1a RATED AS YES and AGO.1b RATED AS NO When did you experience your worst period of anxiety about being in these types of situations that lasted for 3 months or more? Year _____ 3 Month period____	
AGO.2	DISPLAY IF AGO.1a or AGO.1b RATED AS YES LIFETIME: Use the answer from AGO.1c as PIPED TEXT in the questions AGO.2-3 CURRENT: Change grammar – "Are you having / Do you …" AND "During the last 3 months" During [the last / those] 3 months, were you afraid in these situations because you thought something bad might happen to you? For example, having a panic attack, fainting, falling, losing control of your bowels or bladder, or anything else disabling or embarrassing? IF NO AND AGO.1b was rated YES: LOOP BACK TO AGO.1c OTHERWISE SKIP TO GAD.1a	
AGO.3	DISPLAY IF AGO.2 RATED AS YES DISPLAY LOGIC: Only display subsequent questions if initial questions are	

	answered NO. (Only one question answered YES is enough for a “YES” rating) During [the last / those] 3 months, did you always avoid these places or situations? IF NO: Or when you had no choice but to be there, suffer through being in these places or situations with intense fear? IF NO: Or were you only able to tolerate these places or situations under certain circumstances, like being with a trusted person or taking medication to calm you down? IF NO AND AGO.1b was rated YES: LOOP BACK TO AGO.1c OTHERWISE SKIP TO GAD.1a	
AGO.4	DISPLAY IF AGO.3 is rated YES DISPLAY LOGIC: Only display subsequent questions if initial questions are answered NO. (Only one question answered YES is enough for a “YES” rating) Did the fear of being in these places or situations and your reactions to this fear affect your ability to function in daily life, for example, your work or school, your social life or your relationships? IF NO: Or did you still continue to get things done, but with a lot of extra effort? IF NO: Did your fear of being in these places or situations and your reactions to this fear bother you a lot? YES TO ANY OF THE 3 QUESTIONS: FUNCTIONAL IMPAIRMENT / DISTRESS PRESENT (AGORAPHOBIA CDDR MET) AND DX AGORAPHOBIA CURRENT (if AGO.1b is YES) Or DX AGORAPHOBIA LIFETIME (if AGO.1a is YES) IF NO – AND ENQUIRING ABOUT CURRENT SYMPTOMS – LOOP BACK TO AGO.1c IF NO – AND ENQUIRING ABOUT LIFETIME SYMPTOMS – SKIP TO GAD.1a (Generalised Anxiety Disorder screening question)	
	6B00 - GENERALIZED ANXIETY DISORDER (GAD)	
GAD.1a	SQ : Was there ever a time when, for a period of 3 months or more, you experienced anxiety or worry on most days? IF YES: At that time, were you very worried about many different aspects of your life, for example, relationships, work, health, money, etc.? IF NO: At that time, did you feel very anxious in general, without it being connected to a particular worry, or did you have a general feeling that something very bad was about to happen? (REQUIRED – 1st question = “YES” AND 2nd or 3rd question = “YES”)	
	If GAD.1a rated “NO” - Generalized Anxiety disorder screening is negative SKIP TO SAD.1 - Social Anxiety disorder screening question	
GAD.1b	DISPLAY IF GAD.1a is rated YES SQ : Over the last 3 months, have you experienced anxiety or worry on most days? IF YES: Have you been very worried about many different aspects of your life, for example, relationships, work, health, money, etc.? IF NO: Have you felt very anxious in general, without it being connected to a particular worry, or did you have a general feeling that something very bad was about to happen? (REQUIRED – 1st question = “YES” AND 2nd or 3rd question = “YES”)	
GAD.1c	DISPLAY IF GAD.1a IS RATED YES and GAD.1b IS RATED NO Please tell me during which 3-month period your feelings of anxiety or worry were at their worst: ______________, ___________ (3 Months, Year)	
GAD.2	DISPLAY IF GAD.1a or GAD.1b IS RATED YES	

	When you were anxious or worried, did you also have, on most days: (check all that apply, at least 2 required) (PROGRAM SKIP TO GAD.3 AS SOON AS 2 SYMPTOMS ENDORSED) Your muscles feeling tight or tense? Being unable to sit still or feeling physically restless? Feeling nauseous, or having abdominal cramps? A racing or pounding heart? Sweating a lot? Hands trembling or body shaking? Dry mouth? Feeling nervous or on edge? Struggling to concentrate? Feeling irritable? Having difficulty falling asleep or staying asleep? Not feeling rested when you wake up?	
GAD.3	DISPLAY IF GAD.1 - 2 ARE RATED YES Did the feelings of anxiety or worry we've just talked about affect your ability to function in daily life, for example, your work or school, your social life or your relationships? IF NO: Or did you still continue to get things done, but with a lot of extra effort? IF NO: Did feelings of anxiety or worry bother you a lot? YES TO ANY OF THE 3 QUESTIONS: FUNCTIONAL IMPAIRMENT / DISTRESS PRESENT and GENERALISED ANXIETY DISORDER CDDR MET) AND DX GENERALISED ANXIETY DISORDER CURRENT (if GAD.1b is YES) Or DX GENERALISED ANXIETY DISORDER LIFETIME (if GAD.1a is YES) IF NO – AND ENQUIRING ABOUT CURRENT SYMPTOMS – LOOP BACK TO GAD.1c IF NO – AND ENQUIRING ABOUT LIFETIME SYMPTOMS – SKIP TO SAD.1a (Social Anxiety Disorder screening question)	
	6B04 - SOCIAL ANXIETY DISORDER (SAD)	
SAD.1a	SQ: Have you ever, for a period of 3 months or more, consistently felt very anxious about interacting with other people in social situations? For example, at parties or other social functions, meeting people you don't know, or social contacts at work? IF NO: Have you felt consistently anxious for 3 months or more in situations where you need to perform or might be judged? For example, giving a speech, playing an instrument in public, eating in a restaurant, or using a public restroom? (EITHER QUESTION RATED YES IS SUFFICIENT FOR AN ITEM RATING OF YES)	
	If SAD.1a rated "NO" - screening for SAD is negative SKIP TO OCD.1a - OCD screening question	
SAD.1b	DISPLAY IF SAD.1a IS RATED "YES" SQ: Over the last 3 months, have you consistently felt very anxious about interacting with other people in social situations? For example, at parties or other social functions, meeting people you don't know, or social contacts at work? IF NO: Over the last 3 months, have you consistently felt anxious in situations where you need to perform or might be judged? For example, giving a speech, playing an instrument in public, eating in a restaurant, or using a public restroom? (EITHER QUESTION RATED YES IS SUFFICIENT FOR AN ITEM RATING OF YES)	
SAD.1c	DISPLAY IF SAD.1a IS RATED YES and SAD.1b IS RATED "NO" Please tell me during which 3-month period your anxiety about social situations or situations where you might be judged was at its worst.	

	______________, ___________ (3 Months, Year)	
SAD.2	DISPLAY IF SAD.1a or SAD.1b IS RATED YES LIFETIME: Use the answer from SAD.1c as PIPED TEXT in the questions SAD.2-3 CURRENT: Change grammar – “Are you having / Do you …” AND “During the last 3 months” When you were in these situations, were you concerned that others would form negative opinions of you? IF NO: Were you worried that you might say or do something embarrassing or offensive? (A YES ANSWER TO EITHER IS SUFFICIENT FOR A “YES” RATING) IF NO – AND ENQUIRING ABOUT CURRENT SYMPTOMS – LOOP BACK TO SAD.1c IF NO – AND ENQUIRING ABOUT LIFETIME SYMPTOMS – SKIP TO OCD.1a (OCD screening question)	
SAD.3	**Did you mostly avoid these kinds of social situations or situations where you might be judged?** **IF NO: When you could not avoid them, did you barely tolerate them and feel very anxious while they were going on?** **(A YES ANSWER TO EITHER IS SUFFICIENT FOR A “YES” RATING)** **IF NO – AND ENQUIRING ABOUT CURRENT SYMPTOMS – LOOP BACK TO SAD.1c** **IF NO – AND ENQUIRING ABOUT LIFETIME SYMPTOMS – SKIP TO OCD.1a (OCD screening question)**	
SAD.4	DISPLAY IF SAD.1 - 3 ARE RATED YES Did the anxiety about social situations or situations where you might be judged affect your ability to function in daily life, for example, your work or school, your social life or your relationships? IF NO: Or did you still continue to get things done, but with a lot of extra effort? IF NO: Did the anxiety about social situations or situations where you might be judged bother you a lot? YES TO ANY OF THE 3 QUESTIONS: FUNCTIONAL IMPAIRMENT / DISTRESS PRESENT and SOCIAL ANXIETY DISORDER CDDR MET) AND DX SOCIAL ANXIETY DISORDER CURRENT (if SAD.1b is YES) Or DX SOCIAL ANXIETY DISORDER LIFETIME (if SAD.1a is YES) IF NO – AND ENQUIRING ABOUT CURRENT SYMPTOMS – LOOP BACK TO SAD.1c IF NO – AND ENQUIRING ABOUT LIFETIME SYMPTOMS – SKIP TO OCD.1a (OCD screening question)	
F	**OBSESSIVE COMPULSIVE AND RELATED DISORDERS**	
	6B20 - OBSESSIVE COMPULSIVE DISORDER (OCD)	
OCD.1a	SQ : Was there ever a time when you had repetitive, unpleasant, and unwanted thoughts? For example, thoughts about germs, something bad happening, or having to organize things perfectly? IF NO: Did you have unwanted images appear in your mind over and over that caused you distress? For example, unwanted violent or sexual images? IF NO: Did you have repeated urges to do things over and over that didn’t really need to be done, even if you did not act on these urges? For example, the urge to ask about instructions multiple times, the urge to confess something, the urge to check a switch or a lock many times, the urge to arrange things until they are “just right,” or the urge to clean something more than once, even if you did not do it?	

	(SKIP TO OCD.1b at the first YES, only one YES answer is sufficient for a rating of "YES"	
OCD.1b	SQ : Was there ever a time when you felt driven to do something over and over, in a very specific way, and it was hard not to do this? For example, lining up objects in a specific way, washing your hands or objects many times, checking switches or locks multiple times, mentally reviewing everything you said or touched or have to do, counting objects or counting the number of times you're doing something. IF YES: Was this done in order to prevent something bad from happening or to make yourself feel better? BOTH THESE QUESTIONS NEED TO BE ANSWERED AS YES FOR OCD.1b TO BE RATED "YES"	
	If OCD.1a AND OCD.1b ARE RATED "NO" - SCREENING FOR OCD IS NEGATIVE SKIP TO HYP.1a - HYPCHONDRIASIS SCREENING QUESTION	
OCD.1c	DISPLAY IF OCD.1a IS RATED "YES" SQ : Over the past month, did you have repetitive, unpleasant, and unwanted thoughts? For example, thoughts about germs, or something bad happening, or having to organize things perfectly? IF NO: Did you have unwanted images appear in your mind over and over that caused you distress? For example, unwanted violent or sexual images? IF NO: Did you have repeated urges to do things over and over that didn't really need to be done, even if you did not act on these urges? For example, the urge to ask about instructions multiple times, the urge to confess something, the urge to check a switch or a lock many times, the urge to arrange things until they are "just right," or the urge to clean something more than once, even if you did not do it? (SKIP TO OCD.1d at the first YES, only one YES answer is sufficient for a rating of "YES")	
OCD.1d	DISPLAY IF OCD.1b IS RATED "YES" SQ : Over the past month, have you felt driven to do something over and over, in a very specific way, and it was hard not to do this? For example, lining up objects in a specific way, washing your hands or objects many times, checking switches or locks multiple times, mentally reviewing everything you said or touched or have to do, counting objects or counting the number of times you're doing something? IF YES: Was this done in order to prevent something bad from happening or to make yourself feel better? BOTH THESE QUESTIONS NEED TO BE ANSWERED AS YES FOR OCD.1d TO BE RATED "YES" IF YES, SKIP TO OCD.2	
OCD.1e	DISPLAY IF OCD.1a AND/OR OCD.1b ARE RATED YES AND OCD.1c AND OCD.1d ARE RATED "NO" Please tell me during what month these experiences were at their worst, that is, the experiences of unwanted thoughts, images, or urges, or feeling driven to do something over and over, in a very specific way. _______________, ___________ (Month, Year)	
OCD.2	IF OCD.1c OR OCD.1d ARE RATED YES, ASSESS FOR CURRENT IMPAIRMENT (PAST) MONTH: During the past month…	

	IF OCD.1e WAS PRESENTED, ASSESS FOR PAST IMPAIRMENT: During that month [MONTH, YEAR FROM OCD.1e] … Did you spend more than an hour a day having these thoughts, images or impulses and performing these repetitive actions? IF NO: Did having these thoughts, images or impulses and having to perform these repetitive actions affect your ability to function in daily life, for example, your work or school, your social life, or your relationships? IF NO: Or did you still continue to get things done, but with a lot of extra effort? IF NO: Did having these thoughts, images or impulses and having to perform these repetitive actions bother you a lot? ONE YES OF THE ABOVE FOUR QUESTIONS IS SUFFICIENT TO RATE THE FUNCTIONAL IMPAIRMENT / DISTRESS ITEM AS “YES”. IF YES: AND OCD.1c OR OCD.1d IS YES: DX CURRENT OCD AND OCD.1a OR OCD.1b IS YES AND OCD.1c AND OCD.1d IS NO: DX LIFETIME OCD IF NO AND ENQUIRING ABOUT CURRENT SYMPTOMS – LOOP BACK TO OCD.1e IF NO AND ENQUIRING ABOUT LIFETIME SYMPTOMS – PROCEED TO HYP.1a (HYPOCHONDRIASIS SCREENING QUESTION)	
	6B23 - HYPOCHONDRIASIS (HEALTH ANXIETY DISORDER) (HYP)	
HYP.1a	SQ : Was there ever a period when, for 3 months or longer, you were very worried that you had or would develop one or more serious, progressive, or life-threatening illnesses? IF YES: Was this because you had been diagnosed with or were getting tested for a serious disease, like cancer, HIV or multiple sclerosis, or a similar disease that would likely cause disability or early death? IF NO: HYP1a = YES; GO TO HYP.1b IF YES: Did you have this type of worry at other times, for 3 months or longer? IF YES: HYP1a = YES; GO TO HYP.1b IF NO OR IF WORRY SOLELY RELATED TO DIAGNOSED ILLNESS: HYP.1a = NO: SCREENING FOR HYPOCHONDRIASIS IS NEGATIVE SKIP TO PTSD.1 (PTSD TRAUMA SCREENING QUESTION)	
HYP.1b	DISPLAY IF HYP.1a = YES During the past 3 months, were very worried that you had or would develop one or more serious, progressive, or life-threatening illnesses? IF YES: Was this because you had been diagnosed with or were getting tested for a serious disease, like cancer, HIV or multiple sclerosis, or a similar disease that would likely cause disability or early death? IF YES: HYP1b = NO; GO TO HYP.1c IF NO: Did you talk to a doctor or other health professional about your concerns?	

	IF YES: Did the health professional confirm that something serious was wrong, or did they try to reassure you that you were healthy or only had a minor ailment? _____ Something serious was wrong ______ Said I was healthy or a minor ailment IF UNKNOWN OR UNDETERMINED (UNDIAGNOSED), CODE AS "Something serious was wrong". IF SOMETHING SERIOUS WAS WRONG: HYP1b = NO; GO TO HYP.1c IF HEALTHY OR MINOR AILMENT: Did you continue to worry even after the health professional said that nothing was seriously wrong with you? IF NO: HYP.1b = NO; GO TO HYP.1c IF YES: HYP.1b = YES; GO TO HYP.2 OR - IF DID NOT TALK TO A DOCTOR OR OTHER HEALTH PROFESSIONAL: Did you have physical symptoms that were getting worse and affecting your daily life? IF YES: HYP.1b = NO; GO TO HYP.1c IF NO: Did you continue to worry even though your health was not getting worse? IF YES: HYP.1b = YES; GO TO HYP.2 IF NO: HYP.1b = NO; GO TO HYP.1c	
HYP.1c	DISPLAY IF HYP.1a = YES AND HYP.1b = NO: When did you experience your worst period of 3 months or longer of being very worried that you had or would develop one or more serious, progressive, or life-threatening illnesses? Year _____ 3 Month period _____________	
HYP.1d	DISPLAY IF HYP.1c IS DISPLAYED During that 3-month period: Did you talk to a doctor or other health professional about your concerns? IF YES: Did the health professional confirm that something serious was wrong, or did they try to reassure you that you were healthy or only had a minor ailment? _____ Something serious was wrong ______ Said I was healthy or a minor ailment IF UNKNOWN OR UNDETERMINED (UNDIAGNOSED), CODE AS "Something serious was wrong". IF SOMETHING SERIOUS WAS WRONG: HYP1d = NO; SKIP TO PTSD.1 (PTSD TRAUMA SCREENING QUESTION) IF HEALTHY OR MINOR AILMENT: Did you continue to worry even after the health professional said that nothing was seriously wrong with you? IF NO: HYP.1d = NO; SKIP TO PTSD.1 (PTSD TRAUMA SCREENING QUESTION) IF YES: HYP.1d = YES; GO TO HYP.2 OR - IF DID NOT TALK TO A DOCTOR OR OTHER HEALTH PROFESSIONAL: Did you have physical symptoms that were getting worse and affecting your daily life?	

	IF YES: HYP.1d = NO; SKIP TO PTSD.1 (PTSD TRAUMA SCREENING QUESTION) IF NO: Did you continue to worry even though your health was not getting worse? IF YES: HYP.1d = YES; GO TO HYP.2 IF NO: SKIP TO PTSD.1 (PTSD TRAUMA SCREENING QUESTION)	
HYP.2	DISPLAY IF HYP.1b OR HYP.1d IS RATED YES IF HYP.1b = YES: During the past three months … IF HYP.1c WAS PRESENTED: During the time we just identified [MONTH, YEAR] … Did you repeatedly check your body for evidence that you have this illness? IF NO: Did you spend many hours seeking information about the illness? IF NO: Did you make many visits to doctors, nurses, or other healers to have your health checked out? IF NO: Did you avoid visits to health clinics (because you feared bad news) or avoid tests or hospitals, or even talking or thinking about this illness? ANY YES ANSWER YES IS SUFFICIENT FOR A "YES" RATING – GO TO HYP.3 IF NO – AND ENQUIRING ABOUT CURRENT SYMPTOMS – LOOP BACK TO HYP.1c IF NO – AND ENQUIRING ABOUT LIFETIME SYMPTOMS – SKIP TO PTSD.1 (PTSD TRAUMA SCREENING QUESTION)	
HYP.3	DISPLAY IF HYP.2 IS RATED YES DISPLAY LOGIC: ONLY DISPLAY SUBSEQUENT QUESTIONS IF INITIAL QUESTIONS ARE ANSWERED NO. (ONE QUESTION ANSWERED YES IS ENOUGH FOR A "YES" RATING) Did the worry about having a serious illness affect your ability to function in daily life, for example, your work or school, your social life or your relationships? IF NO: Or did you still continue to get things done, but with a lot of extra effort? IF NO: Did the worry about having a serious illness bother you a lot? YES TO ANY OF THE 3 QUESTIONS: FUNCTIONAL IMPAIRMENT / DISTRESS PRESENT AND HYPCHONDRIASIS CDDR ARE MET AND DX HYPCHONDRIASIS CURRENT (IF HYP.1A IS YES) OR DX HYPCHONDRIASIS LIFETIME (IF HYP.1B IS YES) IF NO – AND ENQUIRING ABOUT CURRENT SYMPTOMS – LOOP BACK TO HYP.1c IF NO – AND ENQUIRING ABOUT LIFETIME SYMPTOMS – SKIP TO PTSD.1 (PTSD TRAUMA SCREENING QUESTION)	
G	**6B40 - POST TRAUMATIC STRESS DISORDER (PTSD) AND COMPLEX PTSD**	
PTSD.1	**I am now going to ask you some questions about difficult experiences that people encounter over the course of their lives. I will ask whether you have ever experienced certain types of events that people often find threatening or horrifying. I am not going to ask you to tell me anything specific about what happened to you other than what type of event it was. Then, I will ask you about your reactions to those events.** **(ALL QUESTIONS ARE SQ)** **SQ : Have you ever been involved in war – either as a soldier or as a civilian in an area where armed conflict was ongoing?**	

PTSD.1a	Have you ever been the victim of physical violence, whether by a stranger or a family member or partner?	
PTSD.1b	Have you ever been forced to participate in sexual activity against your will, as a child or an adult, by someone known or unknown to you?	
PTSD.1c	Have you ever been in a serious accident, for example in a car, bus or train?	
	Have you ever been in a disaster such as a tsunami or flood, a major earthquake, a fire or a building collapse?	
PTSD.1d	Have you ever lost a loved person very suddenly and unexpectedly, or in a very horrific way?	
PTSD.1e	Have you ever witnessed extremely horrific events happening to other people, such as seeing a pedestrian getting hit by a car, someone jumping from a bridge, or someone being badly beaten?	
PTSD.1f	Have you experienced a medical event, like a heart attack or an injury that almost caused you to die?	
PTSD.1g	Have you ever been exposed to an event or a series of events (either short- or long-lasting) that wasn't covered by the types of events I just asked you about and that you experienced as extremely threatening or horrific?	
PTSD.1h	If NO TO ALL: Did you actually experience any of the things I just asked you about, but you didn't want to say what it was?	
PTSD.1i	IF NO: SCREEN FOR TRAUMA NEGATIVE; SKIP TO AN.1a – SCREENING FOR ANOREXIA NERVOSA IF YES: CONTINUE BELOW	
PTSD.1j	When did that occur or start? Trauma date/period: _____________________ (Year(s)) TICK HERE IF SINGLE EVENT BASED ON DESCRIPTION: _____ IF UNKNOWN, ASK: Was that a single event? IF NOT A SINGLE EVENT AND IF NOT CLEAR FROM ABOVE: How long did it last? _________ (Years) ________ (Months) IF MULTIPLE EVENTS REPORTED: Which of these events affected you the most in terms of your feelings and other reactions and how you were able to function in your everyday life over time? When did that occur or start? Trauma date/period: _____________________ (Year(s)) TICK HERE IF SINGLE EVENT BASED ON DESCRIPTION: _____ IF UNKNOWN, ASK:	

	Was that a single event? **IF NOT A SINGLE EVENT AND IF NOT CLEAR FROM ABOVE:** **How long did it last? _________ (Years) ________ (Months)**	
PTSD.2a	DISPLAY IF PTSD.1 RATED “YES” The next questions have to do with your reaction to that event. During a period of a month or more, did you ever have episodes when you suddenly felt as if the event was happening again in the here and now, like you were reliving it, for example, as a “flashback”? If NO: During a period of a month or more, did you have very vivid memories of what happened, so real that you had the same strong emotions or physical sensations again? IF NO: During a period of a month or more, did something that reminded you of the event make you feel overwhelmed with a rush of the same emotions or physical sensations you had when it happened? IF NO: During a period of a month or more, did upsetting images of the event intrude on your thoughts? IF NO: During a period of a month or more, did you have vivid and frightening dreams or nightmares related to the event? ONLY ONE QUESTION RATED “YES” IS SUFFICIENT FOR A “YES” RATING FOR THIS ITEM	
PTSD.2b	DISPLAY IF PTSD.2a RATED “YES” During the past month, have you had episodes when you suddenly felt as if the event was happening again in the here and now, like you were reliving it, for example, as a “flashback”? If NO: During the past month, have you had very vivid memories of the event, so real that you had the same strong emotions or physical sensations again? IF NO: During the past month, has something that reminded you of the event made you feel overwhelmed with a rush of the same emotions or physical sensations you had when it happened? IF NO: During the past month, have upsetting images of the event intruded on your thoughts? IF NO: During the past month, have you had vivid and frightening dreams or nightmares related to the event? SKIP TO PTSD.3 AS SOON AS ONE QUESTION ANSWERED YES	
	IF PTSD.2A AND PTSD 2B RATED “NO” - SCREENING FOR PTSD IS NEGATIVE SKIP TO AN.1A - ANOREXIA NERVOSA SCREENING QUESTION	
PTSD.2c	DISPLAY IF PTSD.2a RATED “YES” AND PTSD.2B RATED “NO” Please tell me during which month these reactions were at their worst: ______________, ___________ (Month, Year)	
PTSD.3	DISPLAY IF EITHER PTSD.2a or PTSD.2b rated “YES” During that time, (PTSD.2), did you try very hard to avoid anything that reminded you of what happened? For example, did you try to avoid thoughts or memories of what happened, or try to avoid reminders such as specific people, conversations, places or situations? If NO: Did you change anything in your social, work or everyday routine to stay	

	away from reminders of what happened? Were there things you didn't do, or places you didn't go to because it might cause you to think about what happened? A YES ANSWER TO EITHER IS SUFFICIENT FOR A "YES" RATING IF NO – AND ENQUIRING ABOUT CURRENT SYMPTOMS – LOOP BACK TO PTSD.2c IF NO – AND ENQUIRING ABOUT LIFETIME SYMPTOMS – SKIP TO AN.1a (ANOREXIA NERVOSA SCREENING QUESTION)	
PTSD.4	DISPLAY IF PTSD.3 is rated YES During that time (PTSD.2), were you constantly expecting danger, or were you more watchful of potential danger than before? Were you easily startled, for example, jumping at sudden noises? Were you constantly watching for signs of danger in regular situations, more so than before the event? (NOTE: IF NO MEMORY OF VIGILANCE LEVEL PRIOR TO TRAUMA BUT HYPERVIGILANCE IS PRESENT – SCORE AS "YES") IF NO – AND ENQUIRING ABOUT CURRENT SYMPTOMS – LOOP BACK TO PTSD.2c IF NO – AND ENQUIRING ABOUT LIFETIME SYMPTOMS – SKIP TO AN.1a (ANOREXIA NERVOSA SCREENING QUESTION)	
PTSD.5	DISPLAY IF PTSD.4 IS RATED YES DISPLAY LOGIC: ONLY DISPLAY SUBSEQUENT QUESTIONS IF INITIAL QUESTIONS ARE ANSWERED NO. (ONLY ONE QUESTION ANSWERED YES IS ENOUGH FOR A "YES" RATING) Did the experiences that you had after the event that we've just talked about affect your ability to function in daily life, for example, your work or school, your social life or your relationships? IF NO: Or did you still continue to get things done, but with a lot of extra effort? YES TO EITHER OF THE QUESTIONS: FUNCTIONAL IMPAIRMENT PRESENT and PTSD CDDR MET) AND DX PTSD CURRENT (if PTSD.2b is YES) Or DX PTSD LIFETIME (if PTSD.2a is YES) IF NO – AND ENQUIRING ABOUT CURRENT SYMPTOMS – LOOP BACK TO PTSD.2c IF NO – AND ENQUIRING ABOUT LIFETIME SYMPTOMS – SKIP TO AN.1a (ANOREXIA NERVOSA SCREENING QUESTION)	
	6B41 - COMPLEX POST TRAUMATIC STRESS DISORDER (C - PTSD) (CURRENT ONLY)	
PTSD.6	DISPLAY THE BELOW IF CURRENT PTSD IS PRESENT Since the event, have you been struggling with managing your emotions in the sense that you had strong, uncontrollable feelings, lots of emotional ups and downs, or felt numb or detached when you have been under stress, or only experienced negative feelings? IF NO: Have you been having emotional outbursts over small things, or have you acted recklessly because you are trying to get away from your feelings? A YES ANSWER TO EITHER IS SUFFICIENT FOR A "YES" RATING IF NO – SKIP TO AN.1a (ANOREXIA NERVOSA SCREENING QUESTION)	
PTSD.7	DISPLAY IF PTSD.6 is rated YES Since the event, have you believed that you are less worthy, like you aren't as good as others, or that you are a failure and have given up trying at life? IF NO: Since the event, have you had ongoing feelings of shame or guilt, related to	

	the event or more generally? A YES ANSWER TO EITHER IS SUFFICIENT FOR A “YES” RATING IF NO – SKIP TO AN.1a (ANOREXIA NERVOSA SCREENING QUESTION)	
PTSD.8	DISPLAY IF PTSD.7 is rated YES Since the event, have you had trouble sustaining relationships and feeling close to others? For example, do you struggle to maintain stable relationships with partners, family and friends, or do you avoid them altogether? IF NO: Do your relationships tend to have a lot of ups and downs, or typically last for a short time, or do you find it very difficult to be emotionally intimate with anyone? A YES ANSWER TO EITHER IS SUFFICIENT FOR A “YES” RATING IF NO – SKIP TO AN.1a (ANOREXIA NERVOSA SCREENING QUESTION)	
PTSD.9	DISPLAY IF PTSD.8 is rated YES DISPLAY LOGIC: Only display subsequent questions if initial questions are answered NO. (Only one question answered YES is enough for a “YES” rating) Since the event, do your difficulties with emotions and relationships and your negative view of yourself affect your ability to function in daily life, for example, your work or school, your social life or your relationships? IF NO: Or did you still continue to get things done, but with a lot of extra effort? YES TO EITHER OF THE QUESTIONS: FUNCTIONAL IMPAIRMENT PRESENT and COMPLEX PTSD CDDR MET) AND DX COMPLEX PTSD CURRENT IF NO – SKIP TO AN.1a (ANOREXIA NERVOSA SCREENING QUESTION)	
H	**EATING DISORDERS** **HIERARCHICAL DIAGNOSES => E.G., IF CURRENT ANOREXIA IS PRESENT, CURRENT BULIMIA CANNOT BE DIAGNOSED SIMULTANEOUSLY, BUT LIFETIME BULIMIA IS POSSIBLE DIAGNOSIS.**	
	6B80 - ANOREXIA NERVOSA (AN)	
AN.1a	SQ : Was there ever a time when you weighed much less than other people of your same sex and height? If NO – Did other people say they were concerned that your weight was too low? IF YES TO EITHER DETERMINE BMI – What was your approximate weight in kilograms and height in metres? (THRESHOLD: < 18.5 KG/M2 – PROGRAM WILL CALCULATE THIS)	
	IF AN.1A RATED “NO”: SCREENING FOR ANOREXIA NERVOSA IS NEGATIVE. SKIP TO BN.1A - BULIMIA NERVOSA SCREENING QUESTION	
AN.1b	SQ : Over the past month, have you weighed much less than other people of your same sex and height? If NO – Have other people said they were concerned that your weight is too low? IF YES TO EITHER - DETERMINE BMI – What is your current weight in kilograms and height in metres? (THRESHOLD: < 18.5 KG/M2 – PROGRAM CALCULATES THIS) IF YES – SKIP TO AN.2 IF NO – SKIP TO AN.1c	

AN.1c	DISPLAY IF AN.1a IS RATED "YES" and AN.1b rated "NO" Please tell me during which month you weighed the least for your height as an adolescent or adult: ________(month, year)	
AN.2	DISPLAY IF AN.1b IS RATED "YES" Have you been doing / Did you do things daily (or almost daily) to lose weight or keep your weight so low? USE "Do" OR "Did" DEPENDING ON WHETHER ASKING ABOUT CURRENT OR LIFETIME SYMPTOMS: IF NO: Do/Did you regularly try to restrict your calorie intake by fasting, skipping meals, or avoiding eating high-calorie foods? IF NO: Do/Did you regularly make yourself throw up or take laxatives to keep your weight this low? IF NO: Do/Did you regularly spend a lot of time exercising to lose weight or keep from gaining weight? IF NO: Do/Did you regularly take medication or substances to lose weight or prevent weight gain (for example, stimulants, appetite suppressants, laxatives)? (IF ANY OF THE ABOVE IS "YES", CODE "YES" TO AN.2) IF NO TO ALL – AND ENQUIRING ABOUT CURRENT SYMPTOMS – LOOP BACK TO AN.1c IF NO TO ALL – AND ENQUIRING ABOUT LIFETIME SYMPTOMS – SKIP TO BN.1a (Bulimia Nervosa screening question)	
AN.3	DISPLAY IF AN.2 IS RATED YES Are/Were you so preoccupied with your weight that you spent a lot of time and energy making sure it stayed low? Is/Was this one of the most important things in your life? IF NO: Is/Was your weight or shape extremely important in determining your view of yourself? IF NO: Do/Did it seem to you that you were a normal weight or overweight -- despite other people thinking that you were underweight? IF NO: Do/Did you repeatedly weigh yourself, check your shape in mirrors, measure yourself with a tape measures, or count calories of the foods that you ate? IF NO: Do/Did you avoid looking at yourself in the mirror, or avoid weighing yourself, or avoid wearing tight clothes? (IF ANY OF THE ABOVE IS "YES", CODE "YES" TO AN.3.) IF YES DX ANOREXIA NERVOSA CURRENT (if AN.1b is YES) Or DX ANOREXIA NERVOSA LIFETIME (if AN.1a is YES) IF NO – AND ENQUIRING ABOUT CURRENT SYMPTOMS – LOOP BACK TO AN.1c IF NO – AND ENQUIRING ABOUT LIFETIME SYMPTOMS – SKIP TO BN.1a (BULIMIA NERVOSA SCREENING QUESTION)	
	6B81 - BULIMIA NERVOSA (BN)	
BN.1a	SQ : Was there ever a time when, over a period of at least a month, you had recurrent eating binges, that is, short periods of time when you felt out of control about your eating, when you could not stop eating, or could not limit the amount or the type of food that you ate? IF YES - Did these eating binges occur at least once a week?	

	(A YES ANSWER TO BOTH IS NEEDED FOR A "YES" RATING)	
	If BN.1a rated "NO" - screening for Bulimia Nervosa AND BINGE EATING DISORDER is negative. – SKIP to SUBSTANCE USE SCREENING	
BN.1b	DISPLAY IF BN.1a RATED "YES" SQ : During the past month, have you had eating binges, that is, short periods of time when you felt out of control about your eating, when you could not stop eating, or could not limit the amount or the type of food that you ate? IF YES - Have these eating binges occurred at least once a week? (A YES ANSWER TO BOTH IS NEEDED FOR A "YES" RATING)	
BN.1c	DISPLAY IF BN.1a IS RATED "YES" and BN.1b rated "NO" Please tell me during which month you had the most frequent eating binges? ________(month, year) During that month, did the eating binges occur at least once a week?	
BN.2	DISPLAY IF BN.1a or BN.1b rated YES USE "Do" OR "Did" DEPENDING ON WHETHER ASKING ABOUT CURRENT OR LIFETIME SYMPTOMS: I am now going to ask you about things people do after eating binges to keep from gaining weight from the calories they had just consumed: Shortly after the eating binges, do/did you often…. (CHECK ALL THAT APPLY) □ …make yourself vomit? □ …use water pills (diuretics), laxatives, or enemas? □ …exercise very hard to burn calories gained from the eating binge? □ … do anything else to keep yourself from gaining weight from the calories had just consumed, for instance, take or omit a medication that influences your metabolism? IF ANY OF THE ABOVE IS "YES": Of the things you just told me that you often did shortly after the eating binges [COMPENSATORY BEHAVIOUR FROM ABOVE QUESTIONS], do/did you do [IT/ONE OF THEM] at least once a week? (REQUIRED) IF ANY QUESTION IS RATED "YES" CODE "YES" TO BN.2. IF NO – AND ENQUIRING ABOUT CURRENT SYMPTOMS – LOOP BACK TO BN.1c IF NO – AND ENQUIRING ABOUT LIFETIME SYMPTOMS – SKIP TO BED.1a (Binge Eating Disorder screening question)	
BN.3	DISPLAY IF BN.2 is rated YES USE "Do" OR "Did" DEPENDING ON WHETHER ASKING ABOUT CURRENT OR LIFETIME SYMPTOMS: Do/Did you worry or think constantly about your weight or your body shape? IF NO: Do/Did you repeatedly do things like constantly weighing yourself, checking your shape in mirrors or with tape measures, or counting calories of the foods that you eat? IF NO: Did you avoid looking at yourself in the mirror, or avoid weighing yourself, or avoid wearing tight clothes? (IF ANY OF THE ABOVE IS "YES", CODE "YES" TO BN.3.) IF NO – AND ENQUIRING ABOUT CURRENT SYMPTOMS – LOOP BACK TO BN.1c IF NO – AND ENQUIRING ABOUT LIFETIME SYMPTOMS – SKIP TO SUS.1 (Disorders Due to Substance Use screening question)	

BN.4	DISPLAY IF BN.3 IS RATED YES DISPLAY LOGIC: ONLY DISPLAY SUBSEQUENT QUESTIONS IF INITIAL QUESTIONS ARE ANSWERED NO. (ONLY ONE QUESTION ANSWERED YES IS ENOUGH FOR A "YES" RATING) USE "Do" OR "Did" DEPENDING ON WHETHER ASKING ABOUT CURRENT OR LIFETIME SYMPTOMS: Do/Did your eating binges, the ways you tried to counteract them, and your worries or feelings about your weight or shape affect your ability to function in daily life, for example, your work or school, your social life or your relationships? IF NO: Do/Did your eating binges, the ways you tried to counteract them, and your worries or feelings about your weight or shape bother you a lot? YES TO EITHER OF THE QUESTIONS: FUNCTIONAL IMPAIRMENT / DISTRESS PRESENT and BULIMIA NERVOSA CDDR MET) IF YES DX BULIMIA NERVOSA CURRENT (if BN.1b is YES) Or DX BULIMIA NERVOSA LIFETIME (if BN.1a is YES) IF NO – AND ENQUIRING ABOUT CURRENT SYMPTOMS – LOOP BACK TO BN.1c IF NO – AND ENQUIRING ABOUT LIFETIME SYMPTOMS – SKIP TO SUS.1 (Disorders Due to Substance Use screening question)	
	6B83 - BINGE-EATING DISORDER (BED)	
BED.1a	ONLY DISPLAY IF BN.1a WAS RATED "YES" AND BN.2 WAS RATED "NO" SQ : You said that in [TIME IN BN.1c] you had eating binges at least once a week – did this happen over a period of 3 months or longer?	
BED.1b	ONLY DISPLAY IF BN.1b was rated "YES" and BN.2 was rated "NO" SQ : You said that over the past month you had eating binges at least once a week – has this been going on for 3 months or longer?	
	IF BED.1a AND BED.1b BOTH RATED "NO" - SCREENING FOR BINGE EATING DISORDER IS NEGATIVE SKIP TO SUS.1a - SUBSTANCE USE DISORDERS SCREENING	
BED.1c	DISPLAY IF BED.1a IS RATED "YES" AND BED.1b RATED "NO" Please tell me during which 3-month period you had the most frequent eating binges? ________(3-month period, year)	
BED.2	DISPLAY IF BED.1a OR BED.1b IS RATED YES DISPLAY LOGIC: ONLY DISPLAY SUBSEQUENT QUESTIONS IF INITIAL QUESTIONS ARE ANSWERED NO. (ONLY ONE QUESTION ANSWERED YES IS ENOUGH FOR A "YES" RATING) USE "Do" OR "Did" DEPENDING ON WHETHER ASKING ABOUT CURRENT OR LIFETIME SYMPTOMS: Do/Did the eating binges and your feelings about them affect your ability to function in daily life, for example, your work or school, your social life or your relationships? IF NO: Do/Did your eating binges and your feelings about them bother you a lot? YES TO EITHER OF THE QUESTIONS: FUNCTIONAL IMPAIRMENT / DISTRESS PRESENT and BINGE EATING DISORDER CDDR MET) IF YES DX BINGE EATING DISORDER CURRENT (if BED.1b is YES) Or DX BINGE EATING DISORDER LIFETIME (if BED.1a is YES) IF NO – AND ENQUIRING ABOUT CURRENT SYMPTOMS – LOOP BACK TO BED.1c	

	IF NO – AND ENQUIRING ABOUT LIFETIME SYMPTOMS – SKIP TO SUBSTANCE USE DISORDERS MODULE	
I	**DISORDERS DUE TO SUBSTANCE USE (SUS)** **PART 1: SCREENING (SUS are all SQs)** **LOCAL PROJECT DIRECTOR SHOULD PROVIDE LOCAL EXAMPLES OF COLLOQUIAL DRUG NAMES AND TRADE NAMES OF MEDICATIONS IF NEEDED**	**Lifetime use**
SUS.1	(6C4A) TOBACCO / NICOTINE Have you ever smoked cigarettes? Have you used e-cigarettes or used vaping products containing nicotine? Have you used other tobacco or nicotine products, for example, chewing tobacco or nicotine gum or patches?	NO / YES
SUS.2	(6C40) ALCOHOL Have you ever had a drink of alcohol?	NO / YES
SUS.3	(6C41) CANNABIS Have you ever used marijuana – whether prescribed ("medicinal") or recreationally? IF NEEDED FOR CLARIFICATION: Also known as pot, grass, or weed. What about hashish or "hash"?	NO / YES
SUS.4	(6C42) SYNTHETIC CANNABIS Have you ever used synthetic cannabis, also known as K2 or Spice?	NO / YES
SUS.5	(6C43) OPIOIDS Have you ever used heroin, opium, methadone, or prescription painkillers? IF NEEDED FOR CLARIFICATION: Some examples are fentanyl, morphine, codeine, hydrocodone, oxycodone and oxymorphone. What substances? ______________________ IF A PRESCRIPTION MEDICATION: Was the [MEDICATION] specifically prescribed to you to help control pain, for example, after a surgery or injury? IF YES: Was your use of the medication limited to the 2-week period immediately after the injury or surgery? IF YES: SUS.5 = NO	NO / YES
SUS.6	(6C44) SEDATIVES/ANXIOLYTICS/HYPNOTICS Have you taken any pills to calm you down, help you relax, or help you sleep? IF NEEDED FOR CLARIFICATION: Some examples are diazepam, lorazepam, clonazepam, alprazolam and midazolam. DOES NOT INCLUDE ANTIHISTAMINES (E.G., BENADRYL) OR OPIOIDS (SEE ABOVE). What substances? ______________________ IF YES: Was [MEDICATION] specifically prescribed to you to help you calm down, relax, or sleep? IF YES: Was your use of the medication limited to the dosage and duration of prescription? That is you only took the amount that the health professional told you to take, and only for the length of time they told you to take it. IF YES: SUS.6 = NO	NO / YES
SUS.7	(6C45) COCAINE Have you ever used cocaine or "crack"?	NO / YES
SUS.8	(6C46) STIMULANTS (NOT INCLUDING CAFFEINE) Have you ever used any stimulants or "uppers" to give you more energy, keep you alert, lose weight, or help you focus? I am not talking about caffeine, as in coffee, tea, energy drinks, or caffeine pills. What is included here are amphetamines, "speed", or methamphetamine (also known as crystal meth), methcathinone, stimulant diet medications, or prescription drugs for Attention Deficit Hyperactivity Disorder like Methylphenidate (Ritalin), Adderall or Dexedrine. NOTE THAT OZEMPIC AND WEGOVY ARE NOT STIMULANT DIET PILLS. What substance(s)? ______________________ (ENTER EACH ON SEPARATE LINE)	NO / YES

	IF A PRESCRIPTION MEDICATION: Was [MEDICATION] specifically prescribed to you for attention deficit disorder, hyperactivity, narcolepsy, or another condition? IF YES: Was your use of the medication limited to the dosage and duration of prescription? That is you only took the amount that the health professional told you to take, and only for the length of time they told you to take it. IF YES: SUS.8 = NO.	
SUS.9	(6C47) SYNTHETIC CATHINONES Have you ever used synthetic cathinones, also known as bath salts?	NO / YES
SUS.10	(6C49) HALLUCINOGENS Have you ever used any drugs to “trip” or heighten your senses? IF NEEDED FOR CLARIFICATION: Some examples include: LSD (acid), peyote, mescaline, psilocybin (magic mushrooms), DMT, and Ayahuasca. What substance(s)? ______________________ (ENTER EACH ON SEPARATE LINE)	NO / YES
SUS.11	(6C4B) INHALANTS Have you ever used glue, paint, paint thinner, lighter fluid, gasoline, or other inhalants to get high? What about nitrites like amyl nitrite or butyl nitrite (also called poppers or snappers) or nitrous oxide (laughing gas)? What substance(s)? ______________________ (ENTER EACH ON SEPARATE LINE)	NO / YES
SUS.12	(6C4C) MDMA AND RELATED DRUGS Have you ever used ecstasy (MDMA, also called Molly), or MDA?	NO / YES
SUS.13	(6C4D) DISSOCIATIVE DRUGS Have you ever used PCP (also called angel dust) or ketamine (called K, Special K, or Vitamin K)? What substance(s)? ______________________ (ENTER EACH ON SEPARATE LINE)	NO / YES
SUS.14	(6C4E) OTHER PSYCHOACTIVE SUBSTANCES Have you ever used other drugs to get stoned, high, or as stimulants? This could include over-the-counter medicine for allergies, colds, cough, or sleep (containing, for example, ephedrine, pseudoephedrine), when not used as directed. What substance(s)? ______________________ (ENTER EACH ON SEPARATE LINE)	NO / YES

I	**DISORDERS DUE TO SUBSTANCE USE (SUD)** **PART 2: DIAGNOSES**	
	FOR TOBACCO/NICOTINE, BEFORE ASKING THE CORRESPONDING QUESTIONS, IF THE PERSON HAS ENDORSED MORE THAN ONE: You said that you have used different forms of tobacco or nicotine. For these questions, I am just going to refer to all of these together as “tobacco or nicotine”. So when I ask you a question about how you have used tobacco or nicotine, I am referring to any of them. GO TO SUD.2 FOR TOBACCO/NICOTINE FOR CANNABIS, BEFORE ASKING THE CORRESPONDING QUESTIONS, IF THE PERSON HAS ENDORSED BOTH MARIJUANA AND HASHISH: You said that you have used both marijuana and hashish. For these questions, I am just going to refer to all of these together as “cannabis”. So when I ask you a question about how you have used cannabis, I am referring to either marijuana and hashish. GO TO SUD.2 FOR CANNABIS FOR OPIODS, BEFORE ASKING THE CORRESPONDING QUESTIONS, IF THE PERSON HAS ENDORSED MORE THAN ONE: You said that you have used [SUBSTANCE] and [SUBSTANCE] and [SUBSTANCE] … For these questions, I am just going to refer to all of these	

	together as “opioids”. So when I ask you a question about how you have used opioids, I am referring to any of them. GO TO SUD.2 FOR OPIOIDS FOR SEDATIVES, BEFORE ASKING THE CORRESPONDING QUESTIONS, IF THE PERSON HAS ENDORSED MORE THAN ONE: You said that you have used [SUBSTANCE] and [SUBSTANCE] and [SUBSTANCE] … For these questions, I am just going to refer to all of these together as “sedatives”. So when I ask you a question about how you have used sedatives, I am referring to any of them. GO TO SUD.2 FOR SEDATIVES	
SUD.1	FOR ALL OTHER SUBSTANCES (I.E., STIMULANTS, HALLUCINOGENS, INHALANTS, DISSOCIATIVE DRUGS, OTHER), IF MULTIPLE SUBSTANCES ARE REPORTED IN A PARTICULAR CLASS: You said that you have used [SUBSTANCE] and [SUBSTANCE] and [SUBSTANCE] … Have you used [ANY/EITHER] of them within the past year? IF YES TO MULTIPLE: Which have you used most during the past year? IF NO TO USE DURING PAST YEAR: Would you say that [ANY/EITHER] of them has caused you problems in the past? ________________ IF ONE IS IDENTIFIED, GO TO SUD.2 FOR THAT SUBSTANCE IF YES TO MULTIPLE SUBSTANCES IN THE CLASS: Which of these substances have caused you the most problems in the past, or if you’re not sure, which one have you used the most of and most often in the past? ________________ IF NO TO PROBLEMS: Which one have you used the most of and most often in the past? If you’re not sure, please make your best estimate. ________________ THE SUBSTANCE IDENTIFIED IN THIS WAY WILL BE THE FOCUS OF THE INTERVIEW FOR THAT PARTICULAR CLASS OF SUSTANCES.	
SUSUD.2	FOR EACH SUBSTANCE IDENTIFIED IN SUS,AND CLARIFIED AS APPLICABLE PER SUD.1. A DEPENDENCE ASSESSMENT AND HARMFUL USE ASSESSMENT IS DONE. IF SUD.1 WAS NOT DISPLAYED: Have you used [SUBSTANCE] during the past year? OR, IF SUD.1 DISPLAYED AND PAST YEAR USE REPORTED: You said you have used [SUBSTANCE from SUD1] during the past year. IF YES: During the past year, have you used [SUBSTANCE] at least once a week? During the past year, have you had periods of [SUBSTANCE USE] alternating with periods where you did not [DRINK / USE] ? IF YES to EITHER – CONTINUE WITH SUD.3: IF NO OR IF SUD.1 DISPLAYED AND NO PAST YEAR USE REPORTED: Please tell me during which year you used the most [SUBSTANCE]… (year ___________) During that year, did you use [SUBSTANCE] at least once a week? During that year, did you have periods of [SUBSTANCE USE] alternating with periods where you did not [DRINK / USE]. ? IF YES to EITHER – CONTINUE WITH SUD.3: IF NO – SKIP TO HARMFUL USE ASSESSMENT	

	IF YES, PROCEED TO SUD.3, SUBSTANCE DEPENDENCE ASSESSMENT	
SUD.3	SUBSTANCE DEPENDENCE ASSESSMENT FIRST PASS THROUGH = CURRENT: During the past 12 months … IF NO CURRENT DEPENDENCE, SECOND PASS THROUGH = LIFETIME: During that time (IDENTIFIED IN SUD.2) … During that year, did you feel like you should stop, cut down, limit, or control your [DRINKING / DRUG USE] but have trouble doing that? For above question, either did not try to stop or cut down and did not have trouble both count as NO. IF NO: Did you find yourself [DRINKING/USING] much more [SUBSTANCE] than you had intended to? IF NO: Did you [DRINK/USE] for a much longer period of time than you were intending to? IF NO: Did you end up [DRINKING/USING] in situations in which you had decided that you wouldn't, like at work or at family occasions or in unsafe situations, where you might get hurt or taken advantage of? ANY YES ANSWER IS ENOUGH FOR A "YES" RATING	
SUD.4	Did you experience problems because of [DRINKING/USING DRUGS] in the following areas in your life? (YES/NO to each) School/work responsibilities Family responsibilities (childcare, chores, relationships) Maintaining friendships (aside from people who [DRINK/USE] with you) Engaging in hobbies, exercise, and other things you like to do (sober) Financial problems Risky behaviours like driving under the influence, stealing money to buy [ALCOHOL/DRUGS], public intoxication, fighting, etc. Your physical health (for example, being sick, blackouts, accidents) Your mental health (for example, feeling low or anxious, sleeping problems, paranoia, hearing voices, seeing things, feeling like your skin is infested) IF YES TO AT LEAST ONE: Were you unable to stop [DRINKING / USING], even though you were experiencing these problems? If NO: Did you find your thoughts and actions increasingly related to getting [ALCOHOL / DRUGS] , consuming [ALCOHOL / DRUGS], recovering from [DRINKING/USING], and dealing with the negative fallout? EITHER ANSWERED YES IS ENOUGH FOR A YES RATING	
SUD.5	DISPLAY IF EITHER OR BOTH OF SUD.3 AND SUD.4 ARE RATED YES Did you have noticeable symptoms when you cut down or stopped [DRINKING/USING] for a day or two? (Either by choice or when you did not have access to it). This might include symptoms such as racing heart, sweating, shaky hands, nausea, vomiting, difficulty sleeping, being easily distracted, being very anxious, difficulty sitting still, seeing or hearing things that other people could not see or hear, feeling bugs crawling on your skin, or having a convulsion or seizure. IF NO: Did you have any symptoms like this when you woke up in the morning? IF NO: Did you need to [HAVE A DRINK / USE] or take another drug or medication in order to prevent yourself from developing these kinds of symptoms? IF NO: Over time, did you have to [DRINK/USE] more and more [ALCOHOL/DRUG OF CHOICE] to get the same effect as when you first started [DRINKING/USING]?	

	IF NO: Did you find that the effects of [ALCOHOL/DRUG] lessened over time even though you were [DRINKING/USING] the same amount? YES TO ANY OF THE ABOVE ITEMS IS ENOUGH FOR A YES RATING ON TOLERANCE /WITHDRAWAL	
	DX CURRENT OR LIFETIME SUBSTANCE DEPENDENCE IF 2 OR 3 OUT OF 3 OF (SUD.3, SUD.4 SUD.5 ARE RATED "YES" FOR THE DURATION OF 12 MONTHS FOR ________________ (SPECIFY SUBSTANCE) THEN, GO TO NEXT SUBSTANCE SCREENED AS "YES" IF BELOW THRESHOLD (<2 OUT OF 3 PRESENT) FOR EITHER CURRENT OR LIFETIME, CONTINUE WITH HARMFUL USE ASSESSMENT	
SUD.6	DISPLAY IF SUBSTANCE DEPENDENCE = NO HARMFUL SUBSTANCE USE ASSESSMENT FIRST PASS THROUGH = CURRENT: During the past 12 months … IF NO CURRENT HARMFUL USE, SECOND PASS THROUGH = LIFETIME: During that time (IDENTIFIED IN SUD.2) … Have you been injured seriously enough that you needed medical attention because of something you did while you were under the influence of [ALCOHOL/ DRUG]? For example, have you been injured by getting into a car accident, falling down and hitting your head, or being involved in a physical fight that occurred while you were intoxicated? IF NO: Did the way in which you used [SUBSTANCE] cause any health problems? For example, vomiting blood, severe stomach pain, liver damage, pancreatitis or infections. IF NO: Was a physical health problem that you already had, like hypertension or diabetes, made worse by your use of [SUBSTANCE]? IF NO: Did the way in which you used [SUBSTANCE] cause any kind of emotional or behaviour problems that were bad enough to affect your ability to function in daily life, for example, your work or school, your social life, or your relationships? Examples of emotional or behaviour problems include feelings of depression or anxiety, paranoia, sleep disturbance, and self-injurious behaviour. ONE YES IS SUFFICIENT FOR A YES RATING ON SUD.6	
SUD.7	DISPLAY IF SUD.6 IS RATED "NO" FIRST PASS THROUGH = CURRENT: During the past 12 months … IF APPLICABLE,,SECOND PASS THROUGH (LIFETIME): During that time (IDENTIFIED IN SUD.2) … Were other people (family, friends, or strangers) seriously harmed in any way because of the way in which you used [SUBSTANCE]? Examples include physically assaulting someone while you were intoxicated; injuring someone while driving; someone else developing emotional problems because of your behaviour while you were intoxicated; children or other family members getting injured because you could not care for them adequately or developing health problems because your [DRINKING/USING] meant there was not enough money to buy food or medicine for them.	
	DX HARMFUL PATTERN OF SUBSTANCE USE if EITHER OR BOTH SUD.5 AND SUD.6 rated "YES" ________________ (SPECIFY SUBSTANCE),	

	__________________CURRENT OR LIFETIME IF NO AND ASSESSING CURRENT USE (LAST 12 MONTHS) – SKIP TO LIFETIME DEPENDENCE ASSESSMENT AT SUD.3 IF NO AND ASSESSING LIFETIME USE – SKIP TO NEXT SUBSTANCE	
	WHEN EACH SUBSTANCE HAS BEEN ASSESSED FOR CURRENT AND/OR LIFETIME DEPENDENCE AND/OR HARMFUL USE BASED ON ABOVE ALGORITHMS. GO TO GD.1a (Gambling Disorder screening question)	
J	**DISORDERS DUE TO ADDICTIVE BEHAVIOURS**	
	6C50 - GAMBLING DISORDER (GD)	
GD.1a	SQ: Has there ever been a period of a year or longer when you gambled regularly, either online or offline, such as betting on races or sports or e-sports, playing poker or other card or dice games involving betting, playing slot machines or other betting games at a bar or casino, or buying lottery tickets?	
	If GD.1a rated "NO" - screening for Gambling disorder is negative. SKIP TO GAME.1a – Gaming disorder screening question	
GD.1b	DISPLAY IF GD.1a IS RATED YES SQ: During the past 12 months, did you gamble regularly either online or offline, such as betting on races or sports or e-sports, playing poker or other card or dice games involving betting, playing slot machines or other betting games at a bar or casino, or buying lottery tickets?	
GD.1c	DISPLAY IF GD.1a IS RATED "YES" and GD.1b RATED NO What was the one-year period when you were gambling the most? ________(12 month period, year)	
GD.2	IF GD.1b IS YES: During the past year … IF GD.1a IS YES: During that time, GD.1c , Did you feel like you were losing control over your gambling, for example, did you try unsuccessfully to cut down or stop gambling, or did you spend more money and time than you planned to? IF NO – AND ENQUIRING ABOUT CURRENT SYMPTOMS – LOOP BACK TO GD.1c IF NO – AND ENQUIRING ABOUT LIFETIME SYMPTOMS – SKIP TO GAME 1a (Gaming Disorder screening question)	
GD.3	DISPLAY IF GD.2 IS RATED YES IF GD.1b IS YES: During the last year … IF GD.1a IS YES: During that time, GD.1c , … Did you spend less time on work or school, with family or friends, or on things you previously liked doing because of your gambling? IF NO: Did gambling cause you to neglect other important things in your life? (A YES ANSWER TO EITHER IS SUFFICIENT FOR A YES RATING) IF NO – AND ENQUIRING ABOUT CURRENT SYMPTOMS – LOOP BACK TO GD.1c IF NO – AND ENQUIRING ABOUT LIFETIME SYMPTOMS – SKIP TO GAME 1a (Gaming Disorder screening question)	
GD.4	DISPLAY IF GD.3 IS RATED YES IF GD.1b IS YES: During the last year … IF GD.1a IS YES: During that time, GD.1c , … Did you continue gambling, or even increase the time you spent gambling, even though it was causing problems in your life? For example, did you have problems such as conflict with loved ones, being unable to pay bills and getting into debt, or getting into trouble at work or school because of absences or missing deadlines? IF NO – AND ENQUIRING ABOUT CURRENT SYMPTOMS – LOOP BACK TO GD.1c	

	IF NO – AND ENQUIRING ABOUT LIFETIME SYMPTOMS – SKIP TO GAME 1a (Gaming Disorder screening question)	
GAME.3	DISPLAY IF GAME.2 IS RATED YES IF GAME.1b IS YES: During the last year … IF GAME.1a IS YES: During that time, GAME.1c , … Did you spend less time on work or school, with family or friends, or on things you previously liked doing because of your gaming? IF NO: Did gaming cause you to neglect other important things in your life? (A YES ANSWER TO EITHER IS SUFFICIENT FOR A YES RATING) IF NO – AND ENQUIRING ABOUT CURRENT SYMPTOMS – LOOP BACK TO GAME.1c IF NO – AND ENQUIRING ABOUT LIFETIME SYMPTOMS – SKIP TO ADHD.1a (ADHD screening question)	
GAME.4	DISPLAY IF GAME.3 IS RATED YES IF GAME.1b IS YES: During the last year … IF GAME.1a IS YES: During that time, GAME.1c , … Did you continue gaming, or even increase the time you spent gaming, even though it was causing problems in your life? For example, did you have problems such as conflict with loved ones, getting into trouble at work or school because of absences, missing deadlines, or lack of sleep, neglecting your hygiene, sleeping problems or developing physical problems, such as dehydration or blood clots, due to gaming for prolonged periods? IF NO – AND ENQUIRING ABOUT CURRENT SYMPTOMS – LOOP BACK TO GAME.1c IF NO – AND ENQUIRING ABOUT LIFETIME SYMPTOMS – SKIP TO ADHD.1a (ADHD screening question)	
GAME.5	DISPLAY IF GAME.4 is rated YES Did your gaming and its consequences affect your ability to function in daily life, for example, your work or school, your social life or your relationships? IF NO: Did your gaming and its consequences bother you a lot? YES TO EITHER OF THE QUESTIONS: FUNCTIONAL IMPAIRMENT / DISTRESS PRESENT and GAMING DISORDER CDDR MET) IF YES DX GAMING DISORDER CURRENT (if GAME.1b is YES) Or DX GAMING DISORDER LIFETIME (if GAME.1a is YES) IF NO – AND ENQUIRING ABOUT CURRENT SYMPTOMS – LOOP BACK TO GAME.1c IF NO – AND ENQUIRING ABOUT LIFETIME SYMPTOMS – SKIP TO SKIP TO ADHD.1a (ADHD screening question)	
K	**6A05 ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD) (Current only)**	
ADHD.1a	SQ 1 During the last 6 months, have you had difficulty focusing on everyday tasks, or were you easily distracted when trying to pay attention? AND SQ 2 During the last 6 months, have you felt uncomfortable or restless when sitting still? IF NO: During the last 6 months, have you had a pattern of acting without thinking, like frequently interrupting other people or making risky decisions?	
	IF ADHD.1a RATED “NO” - SCREENING FOR ADHD IS NEGATIVE – SKIP TO NEXT MODULE ANY OF THE THREE QUESTIONS ANSWERED YES IN ADHD.1a – CONTINUE BELOW	
	Over the last 6 months…	
ADHD.2a	**Did you often have a lot of problems with paying attention to things when you didn’t find them very interesting, even if they might have been important?**	

	IF YES: Was your difficulty with paying attention serious enough that it affected your performance at school or at work or your relationships with other people? (REQUIRED)	
ADHD.2b	**Did you often have problems with staying focused on things that were complex and difficult or that required long periods of attention?** **IF YES: Was your trouble staying focused serious enough that it affected your performance at school or at work or your relationships with other people? (REQUIRED)**	
ADHD.2c	**Did you regularly miss important details of tasks that you were doing, or make silly mistakes in your work?** **IF YES: Was your trouble with details serious enough that it affected your performance at school or at work or your relationships with other people? (REQUIRED)**	
ADHD.2d	**Did you often struggle to finish things you were supposed to do, like assignments at school or work or projects at home?** **IF YES: Was your trouble finishing tasks serious enough that it affected your performance at school or at work or your relationships with other people? (REQUIRED)**	
ADHD.2e	**Were you often easily distracted by things happening around you or by thoughts that came into your mind that were not related to the task?** **IF YES: Was your distractibility serious enough that it affected your performance at school or at work or your relationships with other people? (REQUIRED)**	
ADHD.2f	**Did you regularly miss important details of what people were saying to you, even if they are speaking to you directly?** **IF YES: Was your difficulty understanding the details of what people were saying to you serious enough that it affected your performance at school or at work or your relationships with other people? (REQUIRED)**	
ADHD.2g	**Did you regularly find yourself getting lost in daydreams rather than focusing on things that were happening at school or at work or in conversations?** **IF YES: Was your tendency to daydream serious enough that it affected your performance at school or at work or your relationships with other people? (REQUIRED)**	
ADHD.2h	**Do you often lose things like articles of clothing, your keys or your phone?** **IF YES: Was your tendency to lose things serious enough that it affected your performance at school or at work or your relationships with other people? (REQUIRED)**	
ADHD.2i	**Did you often forget about scheduled activities or assignments or tasks that were due?** **IF YES: Was the forgetfulness serious enough that it affected your performance at school or at work or your relationships with other people? (REQUIRED)**	
ADHD.2j	**Do you often struggle to make a plan and stick to it for managing assignments or tasks at school or work or projects at home?** **IF YES: Was your difficulty with planning and organizing serious enough that it affected your performance at school or at work or your relationships with other people? (REQUIRED)**	
ADHD.3	THRESHOLD SCORE FOR INATTENTION = 3 ITEMS WITH IMPACT ON SCHOOL OR WORK OR RELATIONSHIPS	
	Over the last 6 months…	
ADHD.4a	**Did you often find it difficult to sit still or to prevent yourself from fidgeting or moving when you were required to sit still?** **IF YES: Was your difficulty with being still serious enough that it affected your performance at school or at work or your relationships with other people? (REQUIRED)**	

ADHD.4b	**Did you often have a strong sense of restlessness or discomfort when you were expected to be still and quiet?** **IF YES: Was your feelings of restlessness and discomfort serious enough that they affected your performance at school or at work or your relationships with other people? (REQUIRED)**	
ADHD.4c	**Did you regularly have difficulty not talking or making noise when other people were doing the same activity in silence?** **IF YES: Was your difficulty with not talking or making noise serious enough that it affected your performance at school or at work or your relationships with other people? (REQUIRED)**	
ADHD.4d	**Did other people often tell you that you talked too much?** **IF YES: Did other people's view that you talked too much affect your performance at school or at work or your relationships with other people? (REQUIRED)**	
ADHD.4e	**In conversations, did you regularly find yourself interrupting or jumping in before other people had finished what they were saying?** **IF YES: Was your interrupting serious enough that it affected your performance at school or at work or your relationships with other people? (REQUIRED)**	
ADHD.4f	**Did you regularly have difficulty waiting your turn when playing games or other group activities?** **IF YES: Was your difficulty with waiting your turn serious enough that it affected your performance at school or at work or your relationships with other people? (REQUIRED)**	
ADHD.4g	**Did you regularly act impulsively or "on a whim" or "on the spur of the moment", without considering possible negative end results? For example, spending a substantial amount of money impulsively, choosing pleasurable activities in the moment rather than taking care of responsibilities, taking physical risks like climbing on things or crossing a busy highway, driving recklessly, or having impulsive unprotected sex.** **IF YES: Was your impulsivity and failure to consider longer-term consequences serious enough that it affected your performance at school or at work or your relationships with other people? (REQUIRED)**	
ADHD.5	THRESHOLD SCORE FOR HYPERACTIVITY/IMPULSIVITY = 3 ITEMS WITH IMPACT ON SCHOOL OR WORK OR RELATIONSHIPS	
ADHD.6	DISPLAY IF ADHD.3 OR ADHD.5 IS RATED YES Did your problems with focusing and sustaining your attention and controlling your activity and impulses that we have just discussed occur in more than one situation, that is, at school or work, at home, at community events or church, when you are socialising with friends or spending time with your family, or when you are practicing a hobby or playing a sport?	
ADHD.7	DISPLAY IF ADHD.6 IS RATED YES Did you have these same or similar difficulties to a degree that affected your performance at school or work or relationships with other people before the age of 12?	
	AT LEAST 3 ITEMS WITH IMPACT ON SCHOOL OR WORK OR RELATIONSHIPS RATED YES FROM EITHER ADHD.2 OR ADHD.4 FOR THE DOMAIN REACHING THRESHOLD **ADHD.6 AND ADHD.7 MUST BE RATED YES** **DX CURRENT ADHD**	
L	**POSSIBLE SECONDARY MENTAL OR BEHAVIOURAL SYNDROME (SD)**	**Dx 1**

	SKIP IF NO DISORDERS DIAGNOSED. FOR EACH DISORDER DIAGNOSE IN MODULES C, D, E AND F, ASK:	_____
SD.1	**Around the time when you started having [SYMPTOMS of DISORDER], did you have a medical condition that may have caused your [SYMPTOMS]?** **IF UNKNOWN, RECORD AS NO** **If YES, ASK BOTH OF THE FOLLOWING QUESTIONS:** **What medical condition did you have?** ____ **NOTE THAT MEDICAL CONDITION MAY BE UNKNOWN OR UNDIAGNOSED** **Did a medical practitioner tell you this medical condition could be causing your [SYMPTOMS]?** **IF NO: SD.1 = NO FOR THAT DX**	NO/ YES
M	**POSSIBLE SUBSTANCE-INDUCED MENTAL DISORDER**	**Dx 1**
	SKIP IF NO DISORDERS DIAGNOSED. FOR EACH DISORDER DIAGNOSE IN MODULES C, D, E AND F, ASK:	_____
SI.1	**Around the time when you started having [SYMPTOMS of DISORDER], did you start a new medication, increase or change the dose of a medication, or stop taking a medication?** **What medication (did you take or stop?** ____ **(MAY BE UNKOWN)** **Did a medical practitioner tell you that the change in medication could be causing your [SYMPTOMS]?** **IF NO: SI.1 = NO FOR THAT DX**	NO/ YES
SI.2	**Around the time when you started having [SYMPTOMS OF DISORDER], did you use drugs or alcohol for the first time, or increase your use of drugs or alcohol, or drastically cut down or stop using drugs or alcohol?** **If YES, ASK BOTH OF THE FOLLOWING QUESTIONS:** **What drug (including alcohol) did you take or stop?** ____ **Did a medical practitioner tell you this could be causing your [SYMPTOMS]?** **IF NO: SI.2 = NO FOR THAT DX**	NO/ YES
	CODE POSSIBLE SECONDARY SYNDROME FOR A PARTICULAR DIAGNOSIS IF QUESTION SD.1 = YES CODE POSSIBLE SUBSTANCE-INDUCED MENTAL DISORDER FOR A	

	PARTICULAR DIAGNOSIS IF QUESTION SI.1 AND/OR SI.2 = YES OTHERWISE CODE LIKELY PRIMARY MENTAL DISORDER	
N	**SUICIDAL IDEATION AND BEHAVIOUR SCREENING (SOS)**	**Current**
SOS.1	In the past month, have you thought about ending your life?	NO / YES
SOS.2	DISPLAY IF SOS.1 = YES In the past month, have you made any preparations in order to end your life, for example, deciding on a method or writing a will?	NO / YES
SOS.3	DISPLAY IF SOS.1 = YES In the past month, have you tried to end your life but were interrupted, or the attempt was unsuccessful?	NO / YES
SOS.4	**In the past month, have you hurt yourself deliberately, without wanting to end your life, for example, cutting or burning your skin?**	NO / YES
IF ANY QUESTION RATED “YES” – ASSESS / REFER FOR ASSESSMENT - DETERMINE SUICIDE RISK AND TAKE APPROPRIATE STEPS TO CONTAIN THE RISK BASED ON CLINICAL FINDINGS AND LOCAL SERVICES AND PROTOCOLS. IF ALL QUESTIONS RATED “NO” – END OF INTERVIEW		

FLII-11 – Epidemiology ENGLISH (V 1.0.0)

Target Users

Trained lay interviewers

Instructions for programmers and raters

- **Questions are provided in bold font** - they are to be asked verbatim
- Additional instructions to programmers / raters are in normal font
- Please retain the numbering system
- Each item requires a rating of "NO" or "YES", or a timeframe (Month, Year)
- Some items may comprise multiple questions – rating rules will be provided
- The full interview or individual modules may be used
- Note that this is not possible for Modules C and D – information from Modules A and B is needed to make ratings in C and D
- SKIP LOGIC, DISPLAY LOGIC, PIPED TEXT and SCORING INSTRUCTIONS are indicated in capital letters
- DEPRESSIVE EPISODE CDDR MET – diagnoses in capitals and underlined – to be set as embedded variables
- Page breaks are indicated by double lines ========= in the table
- (Depressive episodes) – headings are retained to be used as block names

NOTE: "Force response" for all questions unless otherwise stated

Please display this message at the beginning of the survey or individual survey module:

The next set of questions are designed to gather information about your mental health. Please answer each question as honestly and accurately as possible. Your responses will remain confidential and will only be used for the purposes of this research.

A	(Mood episodes)
	(Depressive episode)
	During the last month, have you felt depressed, "down", sad or irritated for most of the day, nearly every day? Did this last for a period of at least 2 weeks?
	During the last month, have you been a lot less interested in, or experienced a lot less pleasure from, doing the things you normally enjoy? Did this last for a period of at least 2 weeks?
	SKIP LOGIC: If either or both ADE.1a or ADE.1b is rated "YES" – SKIP to DE.2a

	DISPLAY IF ADE1a and b are BOTH NO: **During your <u>lifetime,</u> have you felt depressed, “down”, sad, or “irritated” for most of the day, nearly every day? Did this last for a period of <u>at least 2 weeks</u>?**
	During your <u>lifetime</u>, have you been a lot less interested in, or experienced a lot less pleasure from, doing the things you normally enjoy? Did this last for a period of <u>at least 2 weeks</u>?
	If ADE.1c and ADE.1d both rated “NO” – SKIP to MAN.1a (Manic episode screening question)
	DISPLAY IF EITHER ADE.1c or ADE.1d OR BOTH rated “YES” **During your lifetime, when did you experience your <u>worst</u> period of low mood or loss of interest that lasted at least 2 weeks?** Month____ Year _____ *Note: It is useful to enquire around significant life events or social occasions (e.g. festivals); e.g. "was it before or after, say, Holi or Ugadi?" Or “how old were you?”, or “what age were you?”, or “what grade were you at school?”.*
	Use the answer from ADE.1e as PIPED TEXT in the questions DE.2a – DE.3d DISPLAY LOGIC for DE.2a – DE.3d – when there is more than one question per item - each item requires at least one question to be answered YES in order to be rated as “YES” – hence the second question in an item need not be displayed if the first is answered YES / need only be displayed if the first question is answered NO.
	During that same period, DE.1c**, did you have more trouble concentrating and staying focused on things than usual? E.g. Needing more time to do homework.** IF NO: **During that same time period,** DE.1c**, was it difficult to make everyday decisions?**
	During that same period, DE.1c**, did you feel bad about yourself like you weren’t as good as other people or were even worthless?** IF NO: **During that same time period,** DE.1c**, Did you feel really guilty about things you did, or should have done?**
	During that same period, DE.1c**, did you feel more hopeless about the future, like things would never get better or turn out well for you?**
	During that same period, DE.1c**, did you often think about death or suicide, or did you try to end your life?**
	During that same period, DE.1c**, did you wake up too early or have more trouble falling or staying asleep than usual?** IF NO: **During that same period,** DE.1c**, were you sleeping a lot more than you usually do?**

	During that same period, DE.1c**, did your appetite increase compared to before you started experiencing low mood or loss of interest?** **During that same period,** DE.1c**, did your appetite decrease compared to before you started experiencing low mood or loss of interest?** IF NO: **During that same period,** DE.1c**, Did you lose or gain a noticeable amount of weight without trying to?**
	During that same period, DE.1c**, did you feel much more tired than before the low mood and loss of interest started?** IF NO: **Were you much more tired than usual even when doing some small task?**
	During that same period, DE.1c**, did you feel more restless, or were you pacing around a lot more than is usual for you?** IF NO: **Or were you moving or speaking more slowly than is normal for you?** DISPLAY THIS QUESTION IF YES TO EITHER: **Did other people notice your restlessness or slowness?** (This last question has to be rated YES for the item rating to be "YES")
	SYMPTOM COUNT SCORING INSTRUCTION: COUNT EACH ITEM from DE.1a to DE.3d RATED AS "YES" as 1 (Maximum score = 10) SCORE = 5 or more – DEPRESSION SYMPTOM COUNT AT OR ABOVE THRESHOLD - continue with DE.4 SCORE = 4 or less – IF BUSY WITH CURRENT SYMPTOMS – LOOP BACK TO DE.1c IF BUSY WITH LIFETIME SYMPTOMS – SKIP TO MAN.1a (Manic episode screening question)
	DISPLAY LOGIC: Only display subsequent questions if initial questions are answered NO. (Only one question answered YES is enough for a "YES" rating) SKIP LOGIC – as soon as one question is answered YES – skip to DE.5 **Did the symptoms we've just talked about make it hard for you to do things or cause any problems for you like with your family, friends, at school, in your social life, or getting things done you needed to do?** IF NO: **Or did you still continue to get things done, but with a lot of extra effort?** IF NO: **Did your symptoms bother you a lot?** YES TO ANY OF THE 3 QUESTIONS: FUNCTIONAL IMPAIRMENT / DISTRESS PRESENT AND DEPRESSIVE EPISODE CDDR MET AND DX DEPRESSIVE EPISODE CURRENT (if DE.1a or b is YES) Or DX DEPRESSIVE EPISODE LIFETIME (if DE.1c or d is YES)

	IF NO – AND BUSY WITH CURRENT SYMPTOMS – LOOP BACK TO DE.1c IF NO – AND BUSY WITH LIFETIME SYMPTOMS – SKIP TO MAN.1a (Manic episode screening question)
	In the <u>6 months before</u> the symptoms we just talked about began, had someone very close to you died, like a partner, parent or child? If NO: <u>DEPRESSIVE EPISODE</u> - SKIP to MAN.1 IF YES: <u>BEREAVEMENT PRESENT</u> IF YES, DISPLAY: **Do you believe that your symptoms happened because of that loss?** If NO: ADE.1a or b or both rated YES - DX <u>CURRENT DEPRESSIVE EPISODE</u> ADE.1c or d or both rated YES - <u>LIFETIME DEPRESSIVE EPISODE</u> SKIP to MAN.1 (Manic episode screening question) IF YES: <u>NORMAL GRIEF</u> - SKIP to MAN.1 (Manic episode screening question)

	(Manic episode)
	DISPLAY LOGIC – only display the second question if the first is answered NO (either question answered as YES is sufficient for a "YES" rating) **During the <u>last month</u>, have you, felt much happier than is usual for you, or felt like you could do anything that you wouldn't have thought possible previously? Did this last for a period of <u>at least 1 week</u> ?** IF YES: **Did you feel like this for most of the day, nearly every day?** (REQUIRED) IF YES - SKIP to MAN.2a IF NO: **During the <u>last month</u>, have you felt significantly more irritable or short-tempered than is usual for you? Did this last for a period of <u>at least 1 week</u>?** IF YES: **Did you feel like this for most of the day, nearly every day?** (REQUIRED) IF YES - SKIP to MAN.2a IF NO: SKIP TO MAN.1b

<table>
<tr><td></td><td>DISPLAY LOGIC – only display the second question if the first is answered NO (either question answered as YES is sufficient for a “YES” rating)

During your lifetime, have you ever felt much happier than is usual for you, or felt like you could do anything? Did this last for a period of <u>at least 1 week</u>?

IF YES: Did you feel like this for most of the day, nearly every day? (REQUIRED)

IF YES - SKIP to MAN.1c

IF NO: During your lifetime, have you ever felt much more irritable or short-tempered than is usual for you? Did this last for a period of <u>at least 1 week</u>?

IF YES: Did you feel like this for most of the day, nearly every day? (REQUIRED)

IF YES - SKIP to MAN.1c

IF NO: SKIP TO HME.1 Hypomanic episode screening</td></tr>
<tr><td></td><td>IF MAN.1a AND MAN.1b RATED “NO” - MANIC EPISODE SCREEN NEGATIVE

SKIP to HME.1 Hypomanic episode screening</td></tr>
<tr><td></td><td>DISPLAY IF MAN.1b is rated “YES”
When did you experience your <u>most prominent</u> period of elevated mood and/or irritability that lasted at least a week? ________________ (month, year)
Note: It is useful to enquire around significant life events or social occasions (e.g. festivals); e.g. "was it before or after, say, Holi or Ugadi?" Or “how old were you?”, or “what age were you?”, or “what grade were you at school?”.
SKIP TO MAN.2b</td></tr>
<tr><td></td><td>DISPLAY IF MAN.1a RATED YES
During this period in the last month, were you doing a lot more things than is usual for you or did you have much more energy?

IF NO – SKIP TO MAN.1b

IF YES – CONTINUE WITH MAN.3a</td></tr>
<tr><td></td><td>DISPLAY IF MAN.1b RATED YES
Use the answer from MAN.1c as PIPED TEXT in the questions MAN.2 – MAN.3g

During that same period, MAN.1c, were you doing a lot more things than is usual for you or did you have much more energy?

IF NO: SKIP TO HME.1 Hypomanic episode screening

IF YES – CONTINUE WITH MAN.3a</td></tr>
<tr><td></td><td>During that same period, MAN.1c, were you talking much more and faster than usual?</td></tr>
<tr><td></td><td>During that same period, MAN.1c, did you have many thoughts racing through your head and more ideas than usual?</td></tr>
<tr><td></td><td>During that same period, MAN.1c, did you sense more than usual that you could do things that other people would think impossible and you were never able to do before?</td></tr>
<tr><td></td><td>During that same period, MAN.1c, did you need less sleep than usual or feel well-rested after only a few hours of sleep?</td></tr>
</table>

	During that same period, MAN.1c,**did you have more difficulty keeping your attention on a task (e.g. classwork) because things around you were distracting you?**
	DISPLAY LOGIC – only display the second question if the first is answered NO (either question answered as YES is sufficient for a "YES" rating) **During that same period,** MAN.1c **did you act on the spur of the moment, without thinking about the end results? (for example, spending more money than is usual for you, choosing fun activities instead of taking care of your responsibilities)** IF NO: **During that same period,** MAN.1c **did you do things that later you wished you hadn't done and that are not usual for you? (for example reckless driving, participating in dangerous activities, posting explicit content, engaging in sexualised behaviour, taking drugs)**
	(Any of the 3 questions answered as YES is enough for a "YES" rating) SKIP TO SYMPTOM COUNT at the first YES **During that same period,** MAN.1c **did you have an increased sex drive or think a lot more about sex than usual?** IF NO, DISPLAY: **During that same period,** MAN.1c **were you more social and friendly than usual?** IF NO, DISPLAY: **During that same period,** MAN.1c **were you planning or doing a lot of things than you usually were?**
	SYMPTOM COUNT SCORING INSTRUCTION: COUNT EACH ITEM from MAN.3a to MAN.3g RATED AS "YES" as 1 (Maximum score = 7) SCORE = 3 or more – MANIA SYMPTOM COUNT AT OR ABOVE THRESHOLD - continue with MAN.4 SCORE = 2 or less – IF BUSY WITH CURRENT SYMPTOMS – LOOP BACK TO MAN.1b IF BUSY WITH LIFETIME SYMPTOMS – SKIP TO HME.1 (Hypomanic episode screening question)
	(Only one question answered YES is enough for a "YES" rating) **Did the symptoms we've just talked about affect your ability to function in daily life (for example your work or school, your social life, your relationships)?** IF NO, DISPLAY: **Did your symptoms bother you a lot?** IF YES - FUNCTIONAL IMPAIRMENT / DISTRESS PRESENT and MANIC EPISODE CDDR MET) AND DX MANIC EPISODE CURRENT (if MAN.1a is YES) Or DX MANIC EPISODE LIFETIME (if MAN.1b is YES) IF NO – AND BUSY WITH CURRENT SYMPTOMS – LOOP BACK TO MAN.1b IF NO – AND BUSY WITH LIFETIME SYMPTOMS – SKIP TO HME.1 (Hypomanic episode screening question)

	(Hypomanic episode)
	DO NOT DISPLAY IF CURRENT MANIC EPISODE PRESENT **During the last month, have you, for a period of at least several (3) days felt** **much happier than is usual for you, or felt like you could do anything that previously you couldn't?** IF YES: **Did you feel like this for most of the day, nearly every day?** (REQUIRED) IF YES - SKIP to HME.2a IF NO: **During the last month, have you, for a period of at least several (3) days felt much more irritable or short-tempered than is usual for you?** IF YES: **Did you feel like this for most of the day, nearly every day?** (REQUIRED) IF YES - SKIP to HME.2a IF NO: SKIP TO HME.1b
	DO NOT DISPLAY IF LIFETIME MANIC EPISODE PRESENT **During your lifetime, have you, for a period of at least several (3) days felt** **much happier than is usual for you, or felt like you could do anything?** IF YES: **Did you feel like this for most of the day, nearly every day?** (REQUIRED) IF YES - SKIP to HME.1c IF NO: **During your lifetime, have you, for a period of at least several (3) days felt much more irritable or short-tempered than is usual for you?** IF YES: **Did you feel like this for most of the day, nearly every day?** (REQUIRED) IF YES - SKIP to HME.1c IF NO: SKIP TO HME.1 Hypomanic episode screening
	IF HME.1a AND HME.1b RATED "NO" - HYPOMANIC EPISODE SCREEN NEGATIVE SKIP to MIX.1a Mixed episode screening
	DISPLAY IF HME.1b is rated "YES" **When did you experience your most prominent period of elevated mood or irritability that lasted at least a several days?** _________________ (month, year) SKIP TO HME.2b
	DISPLAY IF HME.1a RATED YES **During this period in the last month, were you doing a lot more things than is usual for you or did you have much more energy?** IF NO – SKIP TO HME.1b IF YES – CONTINUE WITH HME.3a
	DISPLAY IF HME.1b RATED YES Use the answer from HME.1c as PIPED TEXT in the questions **During that same period,** HME.1c, **were you doing a lot more things than is usual for you or did you have much more energy?**

	IF NO: SKIP TO MIX.1a – Mixed episode screening IF YES – CONTINUE WITH HME.3a
	During that same period, HME.1c, **were you talking much more and faster than usual?**
	During that same period, HME.1c, **did you have many thoughts racing through your head, and more ideas than usual?**
	During that same period, HME.1c, **did you sense more than usual that you could do things that other people would think impossible and you were never able to do before?**
	During that same period, HME.1c, **did you need less sleep than usual or feel well-rested after only a few hours of sleep?**
	During that same period, HME.1c,**did you have more difficulty keeping your attention on a task (e.g. classwork) because things around you were distracting you?**
	DISPLAY LOGIC – only display the second question if the first is answered NO (either question answered as YES is sufficient for a “YES” rating) **During that same period,** HME.1c **did you act on the spur of the moment, without thinking about the end results? (for example, spending more money than is usual for you, choosing fun activities instead of taking care of your responsibilities)** IF NO: **During that same period,** HME.1c **did you behave recklessly without regard for your safety in ways that are not usual for you? (for example reckless driving, participate in dangerous activities, promiscuity)**
	(Any of the 3 questions answered as YES is enough for a “YES” rating) SKIP TO SYMPTOM COUNT at the first YES **During that same period,** HME.1c **did you have an increased sex drive?** IF NO, DISPLAY: **During that same period,** HME.1c **were you more social and friendly than usual?** IF NO, DISPLAY: **During that same period,** HME.1c **were you much better at planning or doing?**
	SYMPTOM COUNT SCORING INSTRUCTION: COUNT EACH ITEM from HME.3a to HME.3g RATED AS “YES” as 1 (Maximum score = 7) SCORE = 3 or more – HYPOMANIA SYMPTOM COUNT AT OR ABOVE THRESHOLD AND HYPOMANIA CDDR MET AND DX HYPOMANIC EPISODE CURRENT (if HME.1a is YES) Or DX HYPOMANIC EPISODE LIFETIME (if HME.1b is YES) SCORE = 2 or less – IF BUSY WITH CURRENT SYMPTOMS – LOOP BACK TO HME.1b

	IF BUSY WITH LIFETIME SYMPTOMS – SKIP TO MIX.1a (Mixed episode screening question) (NOTE: No distress / functional impairment required as in Manic episode) NOTE: Any psychotic symptoms present at the time of the episode preclude a diagnosis of Hypomania - a diagnosis of Mania may be more appropriate

	MIXED EPISODE
	(MIXED EPISODE IS ASSESSED FOR CURRENT PRESENCE ONLY) SQ : **In the last month have you experienced changing moods such as feeling very happy and very sad, either all at the same time or switching from one mood to another? Did this last for a period of <u>at least 2 weeks</u>?** IF NO: **Or another example of "changing moods" could be in the last month - feeling very happy but at the same time feeling hopeless or worthless, or feeling sad but also very talkative and energetic? Did this last for a period of <u>at least 2 weeks</u>?** IF YES TO EITHER**: Was this happening most of the day, nearly every day during that time?** IF NO – SKIP TO PSY.1a (Psychosis screening question)
	DISPLAY IF MIX.1a IS RATED YES **Please tell me about the 2-week period when these symptoms were at their worst over the last month _________________(**Specify dates) *Note: It is useful to enquire around significant life events or social occasions (e.g. festivals); e.g. "was it before or after, say, Holi or Ugadi?" Or "how old were you?", or "what age were you?", or "what grade were you at school?".*
	Did you, during that 2 week period, feel depressed, "down", sad, or "irritable" for most of the day, nearly every day?
	During that 2 week period, were you a lot less interested in, or experienced a lot less pleasure from, doing the things you normally enjoy?
	During that same period, MIX.1b**, did you have more trouble concentrating and staying focused on things than usual? E.g. Needing more time to do homework.** IF NO: **During that same time period,** MIX.1b**, was it difficult for you to make everyday decisions?**
	During that same period, MIX.1b**, did you feel bad about yourself like you weren't as good as other people or were even worthless?** IF NO: **During that same time period,** MIX.1b**, Did you feel really guilty about things you did or should have done?**
	During that same period, MIX.1b**, did you feel more hopeless about the future, like things would never get better or turn out well for you?**
	During that same period, MIX.1b**, did you think often about death or suicide, or did you try to end your life?**

	During that same period, MIX.1b**, did you have wake up too early or have more trouble falling or staying asleep than usual?** IF NO: **During that same period,** MIX.1b**, were you sleeping a lot more than you usually do?**
	During that same period, MIX.1b**, did your appetite increase compared to before you started experiencing mood problems?** **During that same period,** MIX.1b**, did your appetite decrease compared to before you started experiencing mood problems?** IF NO: **During that same period,** MIX.1b**, Did you lose or gain a noticeable amount of weight without trying to?**
	During that same period, MIX.1b, **did you feel much more tired than before the mood problems started?** IF NO: **Were you much more tired than usual even when doing some small task?**
	During that same period, MIX.1b**, did you feel more restless, or were you pacing around a lot more than is usual for you?** IF NO: **Or were you moving or speaking more slowly than is normal for you?** DISPLAY THIS QUESTION IF YES TO EITHER: Did other people notice **your restlessness or slowness?** (This last question has to be rated YES for the item rating to be "YES")
	SCORING INSTRUCTIONS - ONLY CONTINUE WITH MIX.3 IF • MIX.2a rated "YES" and at least 2 items of MIX.2b-j rated YES • MIX.2a rated "NO" and at least 3 items of MIX.2b-j rated YES
	During that 2 week period, MIX.1b**, did you feel much happier than is usual for you, or felt like you could do anything that you wouldn't have thought possible previously?** IF YES: **Did you feel like this for most of the day, nearly every day?**
	During that same period, MIX.1b, **were you doing a lot more things than is usual for you or did you have much more energy?**
	During that same period, MIX.1b, **were you talking much more and faster than usual?**
	During that same period, MIX.1b, **did you have many thoughts racing through your head and more ideas than usual?**
	During that same period, MIX.1b, **did you sense more than usual that you could do things that other people would think impossible and you were never able to do before?**
	During that same period, MIX.1b, **did you need less sleep than usual or feel well-rested after only a few hours of sleep?**

	During that same period, MIX.1b,**did you have more difficulty keeping your attention on a task (e.g. classwork) because things around you were distracting you?**
	DISPLAY LOGIC – only display the second question if the first is answered NO (either question answered as YES is sufficient for a "YES" rating) **During that same period,** MIX.1b **did you act on the spur of the moment, without thinking about the end results?** EXAMPLES: **spending more money than is usual for you, choosing fun activities instead of taking care of your responsibilities)** IF NO: **During that same period,** MIX.1b **did you do things that later you wished you hadn't done and that are not usual for you?** EXAMPLES: **reckless driving, participating in dangerous activities, posting explicit content, engaging in sexualised behaviour, taking drugs)**
	(Any of the 3 questions answered as YES is enough for a "YES" rating) SKIP TO MIX.4 at the first YES **During that same period,** MIX.1b **did you have an increased sex drive or think a lot more about sex than usual?** IF NO, DISPLAY: **During that same period,** MIX.1b **were you more social and friendly than usual?** IF NO, DISPLAY: **During that same period,** MIX.1b **were you planning or doing a lot of things that you usually were?**
	SCORING INSTRUCTIONS – IF MIX.2a and MIX.3a RATED "NO" – MIXED EPISODE ABSENT – CONTINUE WITH PSY.1a (Psychosis screening question) ONLY CONTINUE WITH MIX.5 - IF MIX.2a rated "YES" OR "NO" and MIX.3.a rated YES and at least 2 items of MIX.3b - i rated "YES" IF MIX.2a rated "YES" and MIX.3.a rated "NO" and at least 3 items of MIX.3b - i rated "YES"
	DISPLAY IF MIX.4 is rated YES DISPLAY LOGIC: Only display subsequent questions if initial questions are answered NO. (Only one question answered YES is enough for a "YES" rating) **Did the symptoms we've just talked about affect your ability to function in daily life (for example your work or school, your social life, your relationships)?** IF NO: **Or did you still continue to get things done, but with a lot of extra effort?** IF NO**: Did your symptoms bother you a lot?** YES TO ANY OF THE 3 QUESTIONS: FUNCTIONAL IMPAIRMENT / DISTRESS PRESENT AND MIXDED EPISODE CDDR MET) AND DX MIXED EPISODE CURRENT IF NO – SKIP TO PSY.1a (Psychosis screening question)

B	PSYCHOTIC SYMPTOMS	1.Lifetime	2.Current
	PSYCHOSIS SQ:		
	1. DELUSIONS **Have you ever believed that you were being watched or followed?** IF NO: **Have you ever believed that someone was planning to harm you?** IF YES TO EITHER: **Were you convinced that this experience was real?** AND: **Did anyone else in your family, school or community believe this?** IF YES: **Did you believe this for this last month?** **Have you ever believed that you were especially important or powerful, or that you had special powers?** IF NO: **How about being famous or related to very powerful people?** IF YES TO EITHER: **Were you convinced that this experience was real?** AND: **Did anyone else in your family, school or community believe this? Are you the only one who believes this or do others in your cultural or social group also believe or experience this?** IF YES: **Did you believe this for this last month?** **Have you ever believed that you had an extraordinary connection with (God), or that (God) chose you above other people to receive special messages or missions?** IF NO: **Have you ever believed that you were (God) or related to (God)?** IF YES TO EITHER: **Were you convinced that this experience was real?** AND: **Did anyone else in your family, school or community believe this?** IF YES: **Did you believe this for this last month?** **Have you ever believed you were very guilty of something – that you have done something wrong, or neglected to do something, or believed you deserve punishment for your actions – despite other people disagreeing with you about this?** IF YES TO EITHER: **Were you convinced that this experience was real?** AND: **Did anyone else in your family, school or community believe this?** IF YES: **Did you believe this for this last month?**	NO / YES NO / YES NO / YES NO / YES NO / YES	TICK IF PRESENT:

	Have you ever believed that there was something wrong with your organs or other parts of your body?- IF YES: **Were you convinced that this experience was real?** AND: **Did anyone else in your family, school or community believe this?** IF YES: **Did you believe this for this last month?** **Have you ever felt like something on TV, the movies, radio, social media or the internet was trying to send you a special message?** IF NO: **Do objects or people that you encounter in your daily life communicate particular special messages to you but not to most other people?** IF YES TO EITHER: **Were you convinced that this experience was real?** AND: **Did anyone else in your family, school or community believe this?** IF YES: **Did you believe this for this last month?**	NO / YES	
	2. EXPERIENCES OF PASSIVITY, INFLUENCE AND CONTROL **Have you ever felt like someone or something was controlling how you think, feel, or behave?** IF YES: **Was this happening in the last month?** **Have you ever had the experience that thoughts that were not your own were being put into your head?** IF NO: **Have you ever had the experience that your thoughts were being taken out of your head?** If NO: **Or that your thoughts were being broadcast so that other people could know what you are thinking?** (ONLY ONE YES ANSWER IS SUFFICIENT FOR A "YES" RATING) IF YES: **Was this happening in the last month?**	NO / YES NO / YES	
	3. HALLUCINATIONS **Have you heard voices talking to you or to each other when there was no-one else around or sounds when there was no explanation for the sound?** IF YES: **Was this happening in the last month?** **Have you ever seen things other people couldn't see while completely awake?** IF YES: **Was this happening in the last month?** **Have you ever felt unusual sensations on or under your skin that you could not explain, like feeling as if bugs were crawling on your skin?** IF YES: **Was this happening in the last month?**	NO / YES NO / YES NO / YES NO / YES	

	Have you ever experienced unusual and unexplained sensations inside your body, like electrical shocks or the feeling that there is something strange inside of your chest or stomach? IF YES: **Was this happening in the last month?** **Have you ever experienced a strange or bad taste that could not be explained by something you had eaten?** IF YES: **Was this happening in the last month?** **Have you ever smelled something strange or bad that other people couldn't smell?** IF YES: **Was this happening in the last month?**	NO / YES NO / YES	
	4. DISORGANIZED THINKING NOTE TO THE RATER: Rate as <u>present currently</u> if speech is difficult to follow due to jumping from one topic to seemingly unrelated topics, or because words or sentences are jumbled**.**		

C	(PROBABLE) PRIMARY PSYCHOTIC DISORDER (6A2)	1.Lifetime	2.Current
	IF: 1. Psychotic symptoms current or lifetime AND 2. No secondary cause at the time of symptoms (SEE p22) AND 3. If mood symptoms present - Psychotic symptoms present majority of the time, mood symptoms do not occur outside of psychotic symptoms/episodes. IF MOOD EPISODE ALSO PRESENT: ASK: **Was there a time when you had the things we just talked about, the** [PSYCHOTIC SYMPTOMS] **but you did not have the** [MOOD SYMPTOMS]? NO: Likely Mood disorder YES: Likely Psychotic disorder	NO YES	NO YES
Use the **SCII-11** Modules A - D to diagnose different Primary Psychotic Disorders: (6A20) Schizophrenia. (6A21) Schizoaffective disorder. (6A23) Acute and transient Psychotic Disorder (ATPD). (6A24) Delusional disorder. (6A2Y) Other Specified Psychotic Disorder.			

D	**MOOD DISORDERS** IF Any Mood Episode rated as YES (current or past): (DE.5, MAN.5, HME.1 or MIX.2)	The first 4 are mutually exclusive disorders:
	Single Episode Depressive Episode (6A70) esence or history of a single Depressive Episode lo history of Manic, Mixed, or Hypomanic Episodes) A DEPRESSIVE EPISODE PRESENT – CURRENT OR LIFETIME ND NO MANIC / HYPOMANIC / MIXED EPISODES SK: **Was there another time in your life when you had similar symptoms to** [ENDORSED DEPRESSIVE SYMPTOMS] **for 2 weeks or longer?** IF YES: <u>DX SINGLE EPISODE DEPRESSIVE EPISODE</u> (6A70)	NO YES

	IF NO: DX RECURRENT DEPRESSIVE DISORDER (6A71)	
	Recurrent Depressive Disorder (6A71) least two Depressive Episodes, which may include a current episode, separated by several months (3) without significant mood disturbance. lo history of Manic, Mixed, or Hypomanic Episodes)	NO YES
	Bipolar Disorder type I (6A60) esence or history of at least one Manic or Mixed Episode PRESENT IF ONE MANIC OR MIXED EPISODE CURRENT OR PAST	NO YES
	Bipolar Disorder type II (6A61) ry of at least one Hypomanic Episode *and* at least one Depressive isode o history of Manic or Mixed Episodes.) ENT IF ONE DEPRESSIVE AND ONE HYPOMANIC EPISODE	NO YES
	Mood episode with Psychotic Features: ("with Psychotic Symptoms" Qualifier in ICD-11) 1. Mood symptoms predominate, 2. Mood symptoms present for majority of time 3. Psychotic symptoms are limited to (usually mood congruent) delusions and/or hallucinations, and do not occur outside of the mood episode (This does not include all nuances of all possible presentations, consult **SCII-11** for more valid diagnoses in the case of co-occurring mood and psychotic symptoms) IF MOOD EPISODE PRESENT AND DELUSION OR HALLUCINATION PRESENT OVER THE LIEFTIME ASK: **Did you ever experience [**DELUSION AND/OR HALLUCINATION**] when you were not having [**ABNORMAL MOOD – Low / elevated / irritable / loss of interest**]?**	NO YES

E	(Anxiety disorders)
	(Mb23.h Panic attack)
	SQ **: Have you ever had a time when all of a sudden you had an intense fear or anxiety and it got worse within minutes?** IF YES**: Was this despite there not being any immediate danger to you? For example, there was nothing around to scare you, or you weren't in any danger.** IF EITHER ANSWERED NO: SKIP to EAG.1 screening question for Agoraphobia

	DISPLAY IF EPA.1 rated as YES. ONCE 3 SYMPTOMS ENDORSED = Dx LIFETIME PANIC ATTACK GO TO EPD.1 screening for Panic disorder IF THE END IS REACHED AND < 3 SYMPTOMS ENDORSED – SKIP to EAG.1 screening question for Agoraphobia **Did you also experience, along with the sudden onset of anxiety ("panic"):** *(check all that apply, several symptoms – i.e. at least 3 - required)*✔ **A racing / fast beating heart?** IF YES/NO: **Sweating?** IF YES/NO: **Trembling or feeling shaky?** IF YES/NO: **Feeling short of breath?** IF YES/NO: **Feeling like your throat is closing up or that you are choking?** IF YES/NO: **Having chest pain or pressure?** IF YES/NO: **Feeling nauseous, having stomach cramps?** Etc. **Feeling dizzy or lightheaded?** **Chills or hot flushes?** **Tingling sensations or numbing in your hands or feet?** **How about feeling like you were unreal and detached from your body, or that things around you were unreal?** **Fearing that you were losing control?** **Fearing that you were going crazy** **Fearing that you were going to die?**

	(6b01 - Panic disorder)
	DISPLAY IF DX LIFETIME PANIC ATTACK IS PRESENT SQ **: In the last month, have you had more than one of these "panic attacks"?** IF YES**: Do some (or all) happen unexpectedly ("out of the blue") for no apparent reason?** BOTH QUESTIONS NEED TO BE ANSWERED AS YES FOR THIS ITEM TO BE RATED "YES"
	DISPLAY IF EPD.1a RATED AS NO **Was there ever a month long period when you had two or more panic attacks?** IF YES**: Did some (or all) happen unexpectedly ("out of the blue") for no apparent reason?** BOTH QUESTIONS NEED TO BE ANSWERED YES FOR THIS ITEM TO BE RATED "YES"
	IF EPD.1a AND EPD.1b RATED NO PANIC DISORDER SCREEN NEGATIVE
	DISPLAY IF EPD.1b is rated as YES **When did you experience your worst period of having panic attacks?**

	Year _____Month____ *Note: It is useful to enquire around significant life events or social occasions (e.g. festivals); e.g. "was it before or after, say, Holi or Ugadi?" Or "how old were you?", or "what age were you?", or "what grade were you at school?".*
	DISPLAY IF EPD.1a or EPD.1b is rated as YES DISPLAY LOGIC: Only display subsequent questions if initial questions are answered NO. (Only one question answered YES is enough for a "YES" rating) SKIP LOGIC – as soon as one question is answered YES **During the month, did you worry that the panic attacks would happen again?** IF NO: **Did you worry that something was physically wrong with you?** If NO: **Are there things you didn't do or did differently to avoid having a panic attack? E.g. have your parent/caregiver with you** IF NO AND EPD.1a was rated YES: LOOP BACK TO EPD.1b OTHERWISE SKIP TO EAG.1a
	DISPLAY IF EPD.2 is rated YES DISPLAY LOGIC: Only display subsequent questions if initial questions are answered NO. (Only one question answered YES is enough for a "YES" rating) **Did the symptoms we've just talked about affect your ability to function in daily life (for example your work or school, your social life, your relationships)?** IF NO: **Or did you still continue to get things done, but with a lot of extra effort?** IF NO**: Did your symptoms bother you a lot?** YES TO ANY OF THE 3 QUESTIONS: FUNCTIONAL IMPAIRMENT / DISTRESS PRESENT (PANIC DISORDER CDDR MET) AND DX PANIC DISORDER CURRENT (if EPD.1a is YES) Or DX PANIC DISORDER LIFETIME (if EPD.1b is YES) IF NO – AND BUSY WITH CURRENT SYMPTOMS – LOOP BACK TO EPD.1b IF NO – AND BUSY WITH LIFETIME SYMPTOMS – SKIP TO EAG.1a (Agoraphobia screening question)

	6B02 - AGORAPHOBIA
	SQ **: In the last three or more months, have you been very afraid or anxious in situations when you were somewhere that was not easy to get out of or you couldn't get help if you needed it?** IF YES: **Did you have this anxiety in more than one type of situation – for example, using public transport, being in crowds, being outside the home alone, being in the shops, going to the theatre, sitting in class, or standing in line)** BOTH QUESTIONS NEED TO BE ANSWERED YES FOR THIS ITEM TO BE RATED "YES"

	DISPLAY IF EAG.1a RATED AS NO SQ **: Was there ever a time when, for <u>three or more months</u> you were very afraid or anxious in situations when you were somewhere that was not easy to get out of or you couldn't get help if you needed it?** IF YES: **Did you have this anxiety in more than one type of situation – for example, using public transport, being in crowds, being outside the home alone, being in the shops, going to the theatre, sitting in class, or standing in line)** BOTH QUESTIONS NEED TO BE ANSWERED YES FOR THIS ITEM TO BE RATED "YES"
	IF EAG.1a AND EAG.1b RATED NO - AGORAPHOBIA SCREEN NEGATIVE Skip TO GAD.1a – Generalised anxiety disorder screening
	DISPLAY IF EAG.1b RATED AS YES **When did you experience your <u>worst</u> period of anxiety?** Year _____ 3 Month period____ *Note: It is useful to enquire around significant life events or social occasions (e.g. festivals); e.g. "was it before or after, say, Holi or Ugadi?" Or "how old were you?", or "what age were you?", or "what grade were you at school?".*
	DISPLAY IF EAG.1a or EAG.1b RATED AS YES **Were you afraid in these situations, because you thought something bad might happen to you?** **(e.g., having a panic attack, fainting, falling, losing control of your bowels or bladder or anything else disabling or embarrassing?)** IF NO: SKIP TO EGA.1
	DISPLAY IF EAG.2 RATED AS YES DISPLAY LOGIC: Only display subsequent questions if initial questions are answered NO. (Only one question answered YES is enough for a "YES" rating) SKIP LOGIC – as soon as one question is answered YES **Did you always try to avoid these places or situations?** IF NO: **Or when you had no choice but to be there, suffer through them with intense fear?** IF NO: **Or were you only able to tolerate them under certain circumstances, like being with a trusted person such as your parent(s) or friend(s) or taking medication to calm you down?**
	DISPLAY IF EAG.3 is rated YES DISPLAY LOGIC: Only display subsequent questions if initial questions are answered NO. (Only one question answered YES is enough for a "YES" rating) **Did the symptoms we've just talked about affect your ability to function in daily life (for example your work or school, your social life, your relationships)?** IF NO: **Or did you still continue to get things done, but with a lot of extra effort?** IF NO**: Did your symptoms bother you a lot?** YES TO ANY OF THE 3 QUESTIONS: <u>FUNCTIONAL IMPAIRMENT / DISTRESS PRESENT (AGORAPHOBIA CDDR MET)</u>

AND DX AGORAPHOBIA CURRENT (if EAG.1a is YES)
Or DX AGORAPHOBIA LIFETIME (if EAG.1b is YES)

IF NO – AND BUSY WITH CURRENT SYMPTOMS – LOOP BACK TO EAG.1b

IF NO – AND BUSY WITH LIFETIME SYMPTOMS – SKIP TO GAD.1a (Generalised Anxiety Disorder screening question)

	6b00 - Generalized Anxiety Disorder
	SQ **: In the last 3 months have you felt anxiety or worry a lot (that is, felt it for more days than you did not feel it)?** IF YES: **Have you been very worried about many different aspects of your life (e.g., how well you did in your studies, how you got along with people, your health, getting in to trouble or following rules)?** IF NO: **Have you felt very anxious in general, or worried for no particular reason, or just worried that something bad might happen or you might get into trouble?** IF EITHER THE SECOND OR THIRD QUESTION IS ANSWERED YES – SKIP TO GAD.2
	SQ **: Was there ever a time when, for a period of 3 months or more, you experienced anxiety or worry on most days?** IF YES: **Have you been very worried about many different aspects of your life (e.g., relationships, work, health, money etc)?** IF NO: **Have you felt very anxious in general, or worried for no particular reason, or just worried that something bad might happen?** IF EITHER THE SECOND OR THIRD QUESTION IS ANSWERED YES – SKIP TO GAD.1c
	If GAD.1a and GAD.1b BOTH rated "NO" - screening for Generalised Anxiety disorder is negative – SKIP to SAD.1 (Social Anxiety disorder screening question)
	DISPLAY IF GAD.1b IS RATED YES **Please tell me when feeling anxious or worried like this was as its worst.** ______________, ___________ (3 Months, Year) *Note: It is useful to enquire around significant life events or social occasions (e.g. festivals); e.g. "was it before or after, say, Holi or Ugadi?" Or "how old were you?", or "what age were you?", or "what grade were you at school?".*
	When you were anxious or worried, did you also have, on more days than not: (*check all that apply, at least 2 required)*✔ **Your muscles feeling tight or tense?** IF YES / NO: **Being unable to sit still or feeling physically restless?** IF YES / NO: **Feeling like you wanted to throw up, or having stomach cramps?**

	ETC: **A racing or pounding heart?** **Sweating a lot?** **Hands trembling or body shaking?** **Dry mouth?** **Feeling nervous or on edge?** **Struggling to focus or pay attention?** **Feeling irritable?** **Having difficulty falling asleep or staying asleep?** **Feeling tired in the morning when you wake up?**
	DISPLAY IF GAD.1 - 2 ARE RATED YES **Did the symptoms we've just talked about affect your ability to function in daily life (for example your work or school, your social life, your relationships)?** IF NO: **Or did you still continue to get things done, but with a lot of extra effort?** IF NO**: Did your symptoms bother you a lot?** YES TO ANY OF THE 3 QUESTIONS: FUNCTIONAL IMPAIRMENT / DISTRESS PRESENT and GENERAL ANXIETY DISORDER CDDR MET) AND DX GENERAL ANXIETY DISORDER CURRENT (if GAD.1a is YES) Or DX GENERAL ANXIETY DISORDER LIFETIME (if GAD.1b is YES) IF NO – AND BUSY WITH CURRENT SYMPTOMS – LOOP BACK TO GAD.1b IF NO – AND BUSY WITH LIFETIME SYMPTOMS – SKIP TO SAD.1a (Social Anxiety Disorder screening question)

	6b04 - Social anxiety disorder
	SQ**: In the last 3 months, have you consistently felt very anxious about interacting with other people in social situations?** **(**EXAMPLES: **at functions, meeting strangers, social contact at work, with teachers or peers at school, eating in front of other people)** IF NO: **Have you felt almost always anxious for the last 3 months in situations where you need to perform or might be judged?** **(**EXAMPLES: **giving a speech in front of class, playing an instrument, using a public restroom)?** IF YES - SKIP TO SAD.2
	DISPLAY IF SAD.1a IS RATED "NO" SQ**: Have you ever, for a period of 3 months or more, consistently felt very anxious about interacting with other people in social situations?** **(**EXAMPLES**: at functions, meeting strangers, social contact at work, with teachers or peers at school, eating in front of other people)** IF NO: **Have you felt consistently anxious for 3 months or more, in situations where you need to perform or might be judged?** **(**EXAMPLES: **giving a speech, playing an instrument, using a public restroom)**
	If SAD.1a and SAD.1b BOTH rated "NO" - screening for SAD is negative – SKIP to OCD.1a (OCD screening question)
	DISPLAY IF SAD.1b IS RATED YES **Please tell me when these problems were at their worst**

	_______________, ____________ (3 Months, Year) *Note: It is useful to enquire around significant life events or social occasions (e.g. festivals); e.g. "was it before or after, say, Holi or Ugadi?" Or "how old were you?", or "what age were you?", or "what grade were you at school?".*
	When you were in these situations, were you concerned that others will form negative opinions of you? IF NO: **Were you worried that you might say or do something embarrassing or offensive?** A YES ANSWER TO EITHER IS SUFFICIENT FOR A "YES" RATING IF NO – AND BUSY WITH CURRENT SYMPTOMS – LOOP BACK TO SAD.1b IF NO – AND BUSY WITH LIFETIME SYMPTOMS – SKIP TO OCD.1a (OCD screening question)
	Did you mostly avoid these situations where you would have to interact with people? IF NO**: When you could not avoid them, did you barely tolerate them and feel very nervous nearly the whole time when you were there?** A YES ANSWER TO EITHER IS SUFFICIENT FOR A "YES" RATING IF NO – AND BUSY WITH CURRENT SYMPTOMS – LOOP BACK TO SAD.1b IF NO – AND BUSY WITH LIFETIME SYMPTOMS – SKIP TO OCD.1a (OCD screening question)
	DISPLAY IF SAD.1 - 3 ARE RATED YES **Did the symptoms we've just talked about affect your ability to function in daily life (for example your work or school, your social life, your relationships)?** IF NO: **Or did you still continue to get things done, but with a lot of extra effort?** IF NO**: Did your symptoms bother you a lot?** YES TO ANY OF THE 3 QUESTIONS: FUNCTIONAL IMPAIRMENT / DISTRESS PRESENT and SOCIAL ANXIETY DISORDER CDDR MET) AND DX SOCIAL ANXIETY DISORDER CURRENT (if SAD.1a is YES) Or DX SOCIAL ANXIETY DISORDER LIFETIME (if SAD.1b is YES) IF NO – AND BUSY WITH CURRENT SYMPTOMS – LOOP BACK TO SAD.1b IF NO – AND BUSY WITH LIFETIME SYMPTOMS – SKIP TO OCD.1a (OCD screening question)

F	6b20 - Obsessive compulsive disorder (OCD)
	SQ **: In the last month, did you have repetitive, unwanted, unpleasant thoughts?** IF NO**: Did you have unwanted images appear in your mind over and over that caused you distress?** IF NO**: Did you have repeated urges to do things that you found not useful or unpleasant?**

	(EXAMPLES IF UNCLEAR: **For example thoughts / images / impulses about germs or something bad happening or organising things perfectly etc)** SKIP TO OCD.2a at the first YES, only one YES answer is sufficient for a rating of "YES"
	SQ **: In the last month, have you felt like you had to do something over and over in a very specific way? And that it was hard not to do.** IF YES: **Was this in order to prevent something bad from happening or to make yourself feel better?** (EXAMPLES IF UNCLEAR: **For example, washing more than necessary, checking locks or switches over and over, counting things, repeating things in your mind, arranging things until they are just right etc)** BOTH QUESTIONS NEED TO BE ANSWERED AS YES FOR THIS ITEM TO BE RATED "YES"
	DISPLAY IF BOTH OCD.1a AND OCD.2a ARE RATED "NO" SQ **: Was there ever a time when you had repetitive, unwanted, unpleasant thoughts?** IF NO**: Did you have unwanted images appear in your mind over and over that caused you distress?** IF NO**: Did you have repeated urges to do things that you found not useful or unpleasant?** (SKIP TO OCD.2b at the first YES, only one YES answer is sufficient for a rating of "YES")
	SQ **: Was there ever a time when you felt like you had to do something over and over in a very specific way? And that it was hard not to do.** IF YES: **Was this in order to prevent something bad from happening or to make yourself feel better?** BOTH QUESTIONS NEED TO BE ANSWERED AS YES FOR THIS ITEM TO BE RATED "YES"
	If OCD.1a and OCD.2 a and OCD.1b and OCD.2b all rated "NO" - screening for OCD is negative – SKIP to HAD.1 (Health Anxiety disorder screening question)
	DISPLAY IF EITHER OR BOTH OCD.1b AND OCD.2b ARE RATED YES **Please tell me when these problems were at their worst** _______________, ___________ (Month, Year) *Note: It is useful to enquire around significant life events or social occasions (e.g. festivals); e.g. "was it before or after, say, Holi or Ugadi?" Or "how old were you?", or "what age were you?", or "what grade were you at school?".*
	DISPLAY IF ANY OF OCD.1a or b or OCD.2 a or b ARE RATED YES **Do these symptoms take up more than an hour a day?**

	IF NO: **Did the symptoms we've just talked about affect your ability to function in daily life (for example your work or school, your social life, your relationships)?** IF NO**: Did your symptoms bother you a lot?** ONE YES IS SUFFICIENT TO RATE THE FUNCTIONAL IMPAIRMENT / DISTRESS ITEM AS PRESENT and OCD CDDR MET IF OCD.1a or b OR BOTH ARE RATED YES – DX CURRENT OCD IF OCD.2 a or b OR BOTH ARE RATED YES – DX LIFETIME OCD IF NO – AND BUSY WITH CURRENT SYMPTOMS – LOOP BACK TO OCD.1b IF NO – AND BUSY WITH LIFETIME SYMPTOMS – SKIP TO HAD.1a (Health Anxiety Disorder screening question)

G	6B23 - Hypochondriasis (Health anxiety disorder)
	SQ **: In the last 3 months, did you spend a lot of time worrying about having one or more serious physical or mental illnesses?** ~~IF YES: **Did you have this fear or worry for most of the time?**~~ IF YES: **Did you continue to worry even though medical professionals reassured you that nothing was seriously wrong with you?** OR - IF DID NOT SEEK MEDICAL ATTENTION: **Did you continue to worry even though your health was not deteriorating?**
	SQ **: Was there ever a period where, for 3 months or longer, you were spending a lot of time worrying about having one or more serious physical or mental illnesses?** IF YES: **Did you continue to worry even though medical professionals reassured you that nothing was seriously wrong with you?** OR - IF DID NOT SEEK MEDICAL ATTENTION: **Did you continue to worry even though your health was not deteriorating?**
	If HAD.1a and HAD.1b both rated "NO" - screening for Health Anxiety disorder is negative. – SKIP to PTSD.1a (PTSD screening question)
	DISPLAY IF HAD.1b IS RATED YES **Please tell me about the time when these problems were at their worst:** _______________, ____________ (Month, Year) *Note: It is useful to enquire around significant life events or social occasions (e.g. festivals); e.g. "was it before or after, say, Holi or Ugadi?" Or "how old were you?", or "what age were you?", or "what grade were you at school?".*
	DISPLAY IF HAD.1a OR HAD.1b IS RATED YES **Did you repeatedly check your body for evidence that you have this illness?** IF NO: **Did you spend many hours seeking information about the illness?** IF NO: **Did you make many visits to doctors or nurses or other healers to have your health checked out?** IF ANY ANSWERED YES – SKIP TO HAD.3

	IF NO: **Did you avoid visits to health clinics (because you feared bad news) or avoid tests, or avoid hospitals or even talking or thinking about them?** A YES ANSWER TO EITHER IS SUFFICIENT FOR A "YES" RATING
	DISPLAY IF HAD.2 is rated YES DISPLAY LOGIC: Only display subsequent questions if initial questions are answered NO. (Only one question answered YES is enough for a "YES" rating) **Did the symptoms we've just talked about affect your ability to function in daily life (for example your work or school, your social life, your relationships)?** IF NO: **Or did you still continue to get things done, but with a lot of extra effort?** IF NO**: Did your symptoms bother you a lot?** YES TO ANY OF THE 3 QUESTIONS: FUNCTIONAL IMPAIRMENT / DISTRESS PRESENT and HEALTH ANXIETY DISORDER CDDR MET) AND DX HEALTH ANXIETY DISORDER CURRENT (if HAD.1a is YES) Or DX HEALTH ANXIETY DISORDER LIFETIME (if HAD.1b is YES) IF NO – AND BUSY WITH CURRENT SYMPTOMS – LOOP BACK TO HAD.1b IF NO – AND BUSY WITH LIFETIME SYMPTOMS – SKIP TO PTSD.1a (PTSD screening question)

G	(6b40) Post Traumatic Stress Disorder (PTSD)
	SQ **: Have you ever experienced or witnessed an event / events that you found extremely threatening or horrifying, i.e. traumatic events?** If NO: **Have you ever been in one or more of the following situations?** O **A situation where you feared for your life, e.g. thought you were going to die** O **An event where you were seriously injured** O **An event when you thought that you would get seriously injured** O **Being forced to participate in sexual acts against your will** O **Witnessing something bad like that happen to someone else,** O **Hearing about something bad like that happening to a loved one** IF NO TO BOTH – Screen for TRAUMA negative - SKIP TO AN.1 – Screening for Anorexia Nervosa IF YES – SPECIFY TRAUMA TYPE AND DATE IF MULTIPLE EVENTS REPORTED: **Which of these events caused you the most distress or affected your life in a negative way the most?** Trauma type: ____ Trauma date/period: ______________________
	In the last month, have you suddenly felt as if it was happening again in the here and now, like you were reliving the event or events (as a "flashback")?

	If NO: **Have you had very vivid memories of what happened, so real that you had the same strong emotions and sensations again?** IF NO: **Did something that reminded you of the event make you feel overwhelmed with the same emotions you had when it happened?** IF NO: **Did upsetting images of the trauma (event??) intrude on your thoughts?** IF NO: **Did you have unpleasant dreams / nightmares of the event that disrupted your sleep?** SKIP TO PTSD.3 AS SOON AS ONE QUESTION ANSWERED YES
	DISPLAY IF PTSD.2a RATED “NO” **Following the trauma (event??), did you ever have times when you, suddenly felt as if it was happening again in the here and now, like you were reliving the event or events (as a “flashback”)? And did these times happen for at least a month?** If NO: **Have you had very vivid memories of what happened, so real that you had the same strong emotions and sensations again?** IF NO: **Did something that reminded you of the trauma (event??), make you feel overwhelmed with a rush of the same emotions you had when it happened?** IF NO: **Did upsetting images of the trauma (event??), intrude on your thoughts? Or did you think about it when you were doing other things?** IF NO: **Did you have unpleasant dreams / nightmares of the event that disrupted your sleep?** SKIP TO PTSD.3 AS SOON AS ONE QUESTION ANSWERED YES
	If PTSD.2a and PTSD.2b both rated “NO” - screening for PTSD is negative. – SKIP to PTSD.1a (PTSD screening question)
	DISPLAY IF PTSD.2b rated “YES” **Please tell me about the time when these problems were at their worst:** ______________, ___________ (Month, Year) *Note: It is useful to enquire around significant life events or social occasions (e.g. festivals); e.g. "was it before or after, say, Holi or Ugadi?" Or “how old were you?”, or “what age were you?”, or “what grade were you at school?”.*
	DISPLAY IF EITHER PTSD.2a or PTSD.2b rated “YES” **During that time (**PTSD.2**), did you try very hard to avoid anything that reminded you of what happened?** **(**EXAMPLES: **thoughts or memories of what happened, reminders such as specific people, conversations, places or situations)** If NO: **Did you change anything in your social, work or everyday routine to get away from reminders of what happened? Or were there things you didn’t do or places you didn’t go because you might think about what happened?** A YES ANSWER TO EITHER IS SUFFICIENT FOR A “YES” RATING
	DISPLAY IF PTSD.3 is rated YES **During that time (**PTSD.2**), were you constantly expecting danger, or were you more watchful of potential danger than before?**

	(FOR EXAMPLE**, were you easily startled, or much more cautious in regular situations, more so than is usual for you? E.g. jumped at sudden noises.**
	DISPLAY IF PTSD.4 is rated YES DISPLAY LOGIC: Only display subsequent questions if initial questions are answered NO. (Only one question answered YES is enough for a "YES" rating) **Did the symptoms we've just talked about affect your ability to function in daily life (for example your work or school, your social life, your relationships)?** IF NO: **Or did you still continue to get things done, but with a lot of extra effort?** IF NO**: Did your symptoms bother you a lot?** YES TO ANY OF THE 3 QUESTIONS: FUNCTIONAL IMPAIRMENT / DISTRESS PRESENT and PTSD CDDR MET) AND DX PTSD CURRENT (if PTSD.2a is YES) Or DX PTSD LIFETIME (if PTSD.2b is YES) IF NO – AND BUSY WITH CURRENT SYMPTOMS – LOOP BACK TO PTSD.2b IF NO – AND BUSY WITH LIFETIME SYMPTOMS – SKIP TO AN.1a (Anorexia Nervosa screening question)
	(6B41) COMPLEX POST TRAUMATIC STRESS DISORDER (C - PTSD)
	(COMPLEX-PTSD IS ASSESSED FOR CURRENT PRESENCE ONLY) PTSD.1 - IF the current symptoms relate to a TRAUMA AS DESCRIBED BELOW: "Exposure to an event or series of events of an extremely threatening or horrific nature, most commonly prolonged or repetitive events from which escape is difficult or impossible. Such events include, but are not limited to, torture, concentration camps, slavery, genocide campaigns and other forms of organized violence, prolonged domestic violence, and repeated childhood sexual or physical abuse." IF UNKNOWN**: Was this trauma something that happened repeatedly?** **If NO: Was it something that lasted a long time?** **If YES to either: Was it difficult to escape from?**
	PTSD.5 – DISPLAY THE BELOW IF CURRENT PTSD IS PRESENT **Since the trauma, have you been struggling with your feelings in the sense that you are having strong uncontrollable feelings, or feeling numb or detached when you are under stress, or with only having negative feelings?** IF NO: **Have you been having emotional outbursts over small things or have you acted recklessly because you are trying to get away from your feelings?** A YES ANSWER TO EITHER IS SUFFICIENT FOR A "YES" RATING IF NO – SKIP TO AN.1a (Anorexia Nervosa screening question)
	DISPLAY IF PTSD.6 is rated YES **Since the trauma, have you had ongoing feelings of being less worthy than others, or felt you weren't as good as others, or that you are a failure?** IF NO: **Since the trauma, do you have a lot of guilt and shame related to the trauma?**

	A YES ANSWER TO EITHER IS SUFFICIENT FOR A "YES" RATING IF NO – SKIP TO AN.1a (Anorexia Nervosa screening question)
	DISPLAY IF PTSD.7 is rated YES **Since the trauma, have you had problems with how you get along with others people or in your relationships with other people, e.g. family or friends, or do you avoid them altogether?** **(**EXAMPLES: **do you have relationships with lots of ups and downs, do your relationships typically last for a short time only, or do you find it very difficult to be emotionally intimate with anyone?)** IF NO – SKIP TO AN.1a (Anorexia Nervosa screening question)
	DISPLAY IF PTSD.8 is rated YES DISPLAY LOGIC: Only display subsequent questions if initial questions are answered NO. (Only one question answered YES is enough for a "YES" rating) **Did the symptoms we've just talked about affect your ability to function in daily life (for example your work or school, your social life, your relationships)?** IF NO: **Or did you still continue to get things done, but with a lot of extra effort?** IF NO**: Did your symptoms bother you a lot?** YES TO ANY OF THE 3 QUESTIONS: FUNCTIONAL IMPAIRMENT / DISTRESS PRESENT and COMPLEX PTSD CDDR MET) AND DX COMPLEX PTSD CURRENT IF NO – SKIP TO AN.1a (Anorexia Nervosa screening question)

H	Eating disorders
	6B80 - ANOREXIA NERVOSA
	SQ : **In the last month, have you weighed much less than what other people of your height weighed?** If NO **– Have other people told you that your weight is too low?** DETERMINE BMI **– What is your current weight in kilograms and height in metres?** (THRESHOLD: < 18.5 kg/m2 – Qualtrics can calculate this) IF YES – SKIP TO AN.2 IF NO – SKIP TO AN.1b
	SQ : **Was there ever a time when you weighed much less than what other people of your height weighed?** If NO **– Did other people tell you that your weight was too low?** DETERMINE BMI **– What was your approximate weight in kilograms and height in metres?**

	(THRESHOLD: < 18.5 kg/m2 – Qualtrics can calculate this)
	If AN.1a and AN.1b both rated “NO” - screening for Anorexia Nervosa is negative. – SKIP to BN.1a (Bulimia Nervosa screening question)
	DISPLAY IF AN.1b IS RATED “YES” **Please tell me about the time when you weighed the least?** ________(month, year) *Note: It is useful to enquire around significant life events or social occasions (e.g. festivals); e.g. "was it before or after, say, Holi or Ugadi?" Or “how old were you?”, or “what age were you?”, or “what grade were you at school?”.*
	DISPLAY IF AN.1b or AN.1b IS RATED “YES” **[Have you been doing / Did you do things] daily (or almost daily) to lose weight or keep your weight so low?** IF NO**: Did you regularly try to restrict your calorie intake by fasting, skipping meals or avoiding eating high-calorie foods** IF NO: **Did you regularly make yourself throw up or take laxatives to keep your weight this low?** IF NO: **Did you regularly spend a lot of time exercising in order to lose weight, maintain this weight or keep from gaining weight?** IF NO: **Did you regularly take medication that causes weight loss or prevents weight gain (e.g., appetite suppressants)?** ~~IF NO: **Did you regularly do anything else repeatedly to keep your weight this low?**~~ (IF ANY OF THE ABOVE IS “YES”, CODE “YES” TO AN.2) IF NO TO ALL – AND BUSY WITH CURRENT SYMPTOMS – LOOP BACK TO AN.1b IF NO TO ALL – AND BUSY WITH LIFETIME SYMPTOMS – SKIP TO BN.1a (Bulimia Nervosa screening question)
	DISPLAY IF AN.2 IS RATED YES **Were you so preoccupied with your weight that you spent a lot of time and energy making sure it stayed this low? Is your weight among the most important things in your life?** IF NO: **Was your weight extremely important in determining your view of yourself?** IF NO: **Did it seem to you that you were a normal weight or overweight - despite other people’s thinking you were underweight?** IF NO: **Did you repeatedly weigh yourself, check your shape in mirrors, measure yourself with a tape measures or count calories of the foods that you ate?** IF NO: **Did you avoid looking at yourself in the mirror, or avoid weighing yourself, or avoid wearing tight clothes?** (IF ANY OF THE ABOVE IS “YES”, CODE “YES” TO AN.3.)

IF YES DX ANOREXIA NERVOSA CURRENT (if AN.1a is YES)
Or DX ANOREXIA NERVOSA LIFETIME (if AN.1b is YES)

IF NO – AND BUSY WITH CURRENT SYMPTOMS – LOOP BACK TO AN.1b

IF NO – AND BUSY WITH LIFETIME SYMPTOMS – SKIP TO BN.1a (Bulimia Nervosa screening question)

6B81 - BULIMIA NERVOSA

DISPLAY IF AN.1a RATED "NO"

SQ **: In the last month, have you had eating binges, that is, short periods of time when you felt out of control about your eating, when you could not stop eating, or could not limit the amount or the type of food that you ate?**
IF YES **- Have these eating binges occurred at least once a week?**

(A YES ANSWER TO BOTH IS NEEDED FOR A "YES" RATING)

~~**(BMI > 18,5 kg/m2)**~~

SQ **: Was there ever a time when, for at least a month you had eating binges, that is, short periods of time when you felt out of control about your eating, when you could not stop eating, or could not limit the amount or the type of food that you ate?**
IF YES **- Did these eating binges occur at least once a week?**

(A YES ANSWER TO BOTH IS NEEDED FOR A "YES" RATING

If BN.1a and BN.1b both rated "NO" - screening for Bulimia Nervosa AND BINGE EATING DISORDER is negative.
– SKIP to SUBSTANCE ABUSE MODULE

DISPLAY IF BN.1b IS RATED "YES"

Please tell me about the time when you had the most frequent eating binges?
________(month, year)

Note: It is useful to enquire around significant life events or social occasions (e.g. festivals); e.g. "was it before or after, say, Holi or Ugadi?" Or "how old were you?", or "what age were you?", or "what grade were you at school?".

DISPLAY IF BN.1a or BN.1b rated YES

Shortly after most (or all) of these eating binges, did you do anything to keep yourself from gaining weight?

IF NO**: Shortly after most (or all) of these eating binges, did you make yourself throw up?**
IF NO: **Shortly after most (or all) of these eating binges did you use water pills (diuretics), laxatives or enemas?**

	IF NO: **Shortly after most (or all) of these eating binges did you spend a lot of time exercising or exercise hard to burn calories gained from the eating binge?** (IF ANY OF THE ABOVE IS "YES", CODE "YES" TO BN.2.) IF NO – AND BUSY WITH CURRENT SYMPTOMS – LOOP BACK TO BN.1b IF NO – AND BUSY WITH LIFETIME SYMPTOMS – SKIP TO BED.1a (Binge Eating Disorder screening question)
	DISPLAY IF BN.2 is rated YES **Did you nearly constantly think about your weight or your body shape?** IF NO: **Did you repeatedly do things like constantly weighing yourself, checking your shape in mirrors or with tape measures or counting calories of the foods that you eat?** IF NO: **Did you avoiding looking at yourself in the mirror, or avoid weighing yourself, or avoid wearing tight clothes?** (IF ANY OF THE ABOVE IS "YES", CODE "YES" TO BN.3.) IF NO – AND BUSY WITH CURRENT SYMPTOMS – LOOP BACK TO BN.1b IF NO – AND BUSY WITH LIFETIME SYMPTOMS – SKIP TO BED.1a (Binge Eating Disorder screening question)
	DISPLAY IF BN.3 is rated YES DISPLAY LOGIC: Only display subsequent questions if initial questions are answered NO. (Only one question answered YES is enough for a "YES" rating) **Did the symptoms we've just talked about affect your ability to function in daily life (for example your work or school, your social life, your relationships)?** IF NO: **Or did you still continue to get things done, but with a lot of extra effort?** IF NO**: Did your symptoms bother you a lot?** YES TO ANY OF THE 3 QUESTIONS: FUNCTIONAL IMPAIRMENT / DISTRESS PRESENT and BULIMIA NERVOSA CDDR MET) IF YES DX BULIMIA NERVOSA CURRENT (if BN.1a is YES) Or DX BULIMIA NERVOSA LIFETIME (if BN.1b is YES) IF NO – AND BUSY WITH CURRENT SYMPTOMS – LOOP BACK TO BN.1b IF NO – AND BUSY WITH LIFETIME SYMPTOMS – SKIP TO BED.1a (Binge Eating Disorder screening question)

	6B83 - Binge-eating disorder
	ONLY DISPLAY IF BN.1a was rated "YES" and BN.2 was rated "NO" SQ : **You said that over the last month you had eating binges at least once a week – has this been happening for 3 months or longer?**

	ONLY DISPLAY IF BN.1b was rated “YES” and BN.2 was rated “NO” SQ **: You said that in** [TIME IN BN.1c**] you had eating binges at least once a week – was this happening for a period of 3 months or longer?**
	If BED.1a and BED.1b both rated “NO” - screening for Binge eating disorder is negative. – SKIP to SUBSTANCE ABUSE MODULE
	DISPLAY IF BN.1b IS RATED “YES” **Please tell me about the time when you had the most frequent eating binges?** ________(3 month period, year) *Note: It is useful to enquire around significant life events or social occasions (e.g. festivals); e.g. "was it before or after, say, Holi or Ugadi?" Or “how old were you?”, or “what age were you?”, or “what grade were you at school?”.*
	DISPLAY IF BED.1a or BED.1b is rated YES DISPLAY LOGIC: Only display subsequent questions if initial questions are answered NO. (Only one question answered YES is enough for a “YES” rating) **Did the symptoms we’ve just talked about affect your ability to function in daily life (for example your work or school, your social life, your relationships)?** IF NO: **Or did you still continue to get things done, but with a lot of extra effort?** IF NO**: Did your symptoms bother you a lot?** YES TO ANY OF THE 3 QUESTIONS: FUNCTIONAL IMPAIRMENT / DISTRESS PRESENT and BINGE EATING DISORDER CDDR MET) IF YES DX BINGE EATING DISORDER CURRENT (if BED.1a is YES) Or DX BINGE EATING DISORDER LIFETIME (if BED.1b is YES) IF NO – AND BUSY WITH CURRENT SYMPTOMS – LOOP BACK TO BED.1b IF NO – AND BUSY WITH LIFETIME SYMPTOMS – SKIP TO SUBSTANCE ABUSE MODULE

	SUBSTANCE USE DISORDERS SCREENING (SUS are all SQs)	**Lifetime use**
	ALCOHOL: **Have you ever had a drink of alcohol ?** CANNABIS: **Have you ever used marijuana? (also known as “pot,” “grass,” “weed”), hashish (“hash”), THC, K2, or “spice”?** ~~(Full list: Spice, K2, Spice Gold, Spice Silver, Spice Diamond, Genie, Yucatan Fire, Bliss, Black Mamba, Bombay Blue, Fake Weed, Zohai, Red Magic.~~ SPECIFY DRUG (S): _________________ OPIATES**: Have you ever used heroin or methadone? Or Fentanyl? How about prescription pain killers (more than prescribed)?** EXAMPLES: **Drugs like morphine, codeine, Percocet, Percodan, Oxycontin, Tylox, or oxycodone, Vicodin, Lortab, Lorcet or hydrocodone, suboxone or buprenorphine?)** SPECIFY DRUG(S): _________________	NO YES NO YES NO YES NO YES

	SEDATIVES/ANXIOLYTICS/HYPNOTICS: **Have you taken any pills to calm you down (more than prescribed), help you relax, or help you sleep?** EXAMPLES: **Drugs like Valium, Xanax, Ativan, Klonopin, Ambien, Sonata, or Lunesta?)** SPECIFY DRUG(S): _________________ STIMULANTS: **Have you ever used cocaine or "crack"? How about any stimulants or "uppers" to give you more energy, keep you alert, lose weight, or help you focus that weren't prescribed for you by a doctor?** EXAMPLES: **Drugs like speed, methamphetamine, crystal meth, "crank," Ritalin or methylphenidate, Dexedrine, Adderall or amphetamine or prescription diet pills?** SPECIFY DRUG(S): _________________ HALLUCINOGENICS: **Have you ever used any drugs to "trip" or heighten your senses?** EXAMPLES: **Drugs like LSD, "acid," peyote, mescaline, psilocybin, DMT or other hallucinogens?** SPECIFY DRUG(S): _________________ INHALANTS: **Have you ever used glue, paint, correction fluid, gasoline, or other inhalants to get high?** SPECIFY DRUG(S): _________________ MDMA and related**: Have you ever used Ecstasy?** (MDMA, "molly") PHENCYCLIDINE and related: **Have you ever used PCP ("angel dust," "peace pill") or ketamine ("Special K," "Vitamin K")?** SPECIFY DRUG(S): _________________ OTHER: **What about other drugs, like anabolic steroids, nitrous oxide (laughing gas, "whippets"), nitrites (amyl nitrite, butyl nitrite, "poppers," "snappers"), diet pills (phentermine), or over-the-counter medicine for allergies, colds, cough, or sleep?** SPECIFY DRUG(S): _________________	NO YES NO YES NO YES NO YES NO YES NO YES

I	SUBSTANCE USE DISORDERS
	FOR EACH SUBSTANCE RATED "YES" IN SUS ask SUD.2, AND CONTINUE BELOW FIRST PASS THROUGH = CURRENT: **During the last 12 months …** SECOND PASS THROUGH = LIFETIME: **Please tell me about the period of 12 months when you used the most** [SUBSTANCE]…**(**date __________) **During that time,** SUD.1, **…**
	Was it hard to stop, cut down, limit, or control your [DRINKING / DRUG USE] **even though you wanted to?** IF NO: **Were you** [DRINKING/USING] **much more** [ALCOHOL OF CHOICE / DRUG] **than you had intended to?** IF NO: **Were you** [DRINKING/USING] **for a much longer period of time than you were intending to?**

	IF NO: **Were you** [DRINKING/USING] **in situations in which you had decided not to** [DRINK/USE]**, like at work or in unsafe situations, where you could possibly get hurt or taken advantage of?** ANY YES ANSWER IS ENOUGH FOR A YES RATING
	Did you experience problems because of [DRINKING/USING DRUGS] **in the following areas in your life?** (select all that apply) • **Performing well in school or school/work responsibilities** • **Family responsibilities (childcare, chores, relationships)** • **Maintaining friendships (aside from people who** [DRINK/USE] **with you)** • **Engaging in hobbies, exercise and other things you like to do (sober)** • **Financial problems** • **Risky behaviour like driving under the influence, stealing money to buy** [ALCOHOL/DRUGS], **public intoxication, fighting, etc.** • **Your physical health (e.g., being sick, blackouts, accidents)** • **Your mental health (e.g., feeling low or anxious, sleeping problems, paranoia, hearing voices, seeing things, feeling like your skin is infested)** IF YES TO AT LEAST ONE: **Were you unable to stop** [DRINKING / USING], **even though you were experiencing these problems?** If NO: **Did you find your thoughts and actions increasingly related to getting** ALCOHOL / DRUGS**] , consuming it/them, recovering from** [DRINKING/USING] **and dealing with the negative fallout?** EITHER ANSWERED YES IS ENOUGH FOR A YES RATING
	Did you feel physically bad or feel sick when you cut down or stopped [DRINKING/USING] **for a day or two? (Either by choice or when you could not get hold of it).** IF NO: **Did you have these symptoms when waking up in the morning?** **(**EXAMPLES**: Symptoms such as racing heart, sweating, shaky hands, nausea, vomiting, difficulty sleeping, being easily distracted, very anxious, difficulty sitting still, seeing or hearing things that other people could not see, or hear, feeling bugs crawling on your skin, or having a convulsion or seizure?)** IF NO: **Did you need to** [HAVE A DRINK / USE] **or take another drug or medication in order to prevent yourself from having these symptoms?** IF NO: **Did you, over time, have to [**DRINK/USE**] more and more** [ALCOHOL/DRUG OF CHOICE] **to get the same effect as when you first started [**DRINKING/USING**]? (or did you find that the effects of [**ALCOHOL/DRUG**] lessened over time even though you were [**DRINKING/USING**] the same amount?)**
	DX SUBSTANCE DEPENDENCE if 2 out of 3 (SUD.2-4) rated "YES" for the duration of 12 months for ________________ (SPECIFY SUBSTANCE), _________________CURRENT OR LIFETIME AND ASSESS NEXT SUBSTANCE SCREENED AS "YES" IF BELOW THRESHOLD; (<2 OUT OF 3 PRESENT) – CONTINUE WITH HARMFUL PATTERN OF USE ASSESSMENT

	ONLY DISPLAY IF <u>SUBSTANCE DEPENDENCE</u> ABSENT **HARMFUL PATTERN OF SUBSTANCE USE** FIRST PASS THROUGH = CURRENT: **During the last 12 months …** SECOND PASS THROUGH = LIFETIME: **Please tell me about the period of 12 months when you used the most** [SUBSTANCE]…**(**date __________) **During that time,** SUD.5, **…**
	Did you get <u>injured</u> - serious enough that you needed medical attention - because of something you did while you were under the influence of [ALCOHOL/ DRUG] **like getting in to a car accident, falling down and hitting your head, or getting injured in a physical fight that occurred while you were intoxicated?** IF NO**: Did your <u>physical health</u> suffer because of** [DRINKING/DRUG USE] **– e.g., vomiting blood, severe stomach pain, liver damage, or pancreatitis, or make a physical health problem that you already have, like hypertension or diabetes, worse? Did the way in which you take [**SUBSTANCE] **cause health problems?** IF NO: **Has your** [DRINKING/DRUG USE] **caused <u>emotional symptoms</u> such as depression or anxiety or sleep disturbances (or self-harm behaviour) that was bad enough to interfere with your ability to work, go to school, function socially or take care of things at home?** ONE YES IS SUFFICIENT FOR A YES RATING IF YES – DX <u>HARMFUL PATTERN OF USE (SPECIFY SUBSTANCE AND TIMEFRAME)</u>
	DISPLAY IF SUD.6 RATED “NO” **Were other people (family, friends or strangers) seriously harmed in any way because of your [**DRINKING/DRUG USE**]?** If NO: **Did you physically assault someone while intoxicated/drunk?** IF NO**: Did you injure someone while driving intoxicated/drunk?** IF NO: **Did someone else develop mental health problems (e.g., depression or PTSD) because of your behaviour while** [DRINKING/USING]? IF NO**: Did a person get injured because you could not provide adequate care because of** [DRINKING/USING**]?** IF NO: **Did someone develop physical health problems because** [DRINKING/USING] **meant there was not enough money for food or medicine?** IF YES – DX <u>HARMFUL PATTERN OF USE (</u>SPECIFY SUBSTANCE AND TIMEFRAME)
	DX HARMFUL PATTERN OF <u>SUBSTANCE USE</u> if 1 out of 2 (SUD.6-7) rated “YES” ________________ (SPECIFY SUBSTANCE), _________________CURRENT OR LIFETIME **During the last year / during that time,** SUD.5, **…** **Were you if [**DRINKING/USING**] daily or almost daily**? (CONTINUOUS PATTERN – 1 month)

	Were you [DRINKING/USING] **only on weekends, or special occasions, or when** [substance] **was available**? **Were you having** [SUBSTANCE] **binges followed by periods of not [**DRINKING / USING]? (EPISODIC PATTERN – 12 months) IF NO AND ASSESSING CURRENT USE (LAST 12 MONTHS) – SKIP TO LIFETIME ASSESSMENT IF NO AND ASSESSING LIFETIME USE – SKIP TO NEXT SUBSTANCE ONCE EACH SUBSTANCE HAS BEEN ASSESSED FOR CURRENT AND LIFETIME DEPENDENCE or HARMFUL PATTERN OF USE – SKIP TO NEXT MODULE

	6A05 Attention Deficit Hyperactivity Disorder
	SQ 1 **Have you had difficulty focusing on everyday tasks or were you easily distracted when trying to pay attention for the last 6 months?** AND/ OR SQ 2 **For at least six months have you almost always had difficulty sitting still for long periods of time?** IF NO: **Have you had trouble being impulsive, like frequently interrupting other people or making risky decisions?**
	DISPLAY IF ADHD.1a is RATED "NO" SQ 1 **Have you ever had difficulty focusing on everyday tasks or were you easily distracted when trying to pay attention for a period of 6 months or more?** AND SQ 2 **Have you ever felt uncomfortable or restless when sitting still for a period of 6 months or more?** F NO: **Have you ever had trouble being impulsive, like frequently interrupting other people or making risky decisions for 6 months or longer?**
	If ADHD.1a and ADHD.1b both rated "NO" - screening for ADHD is negative. – SKIP to next module
	DISPLAY IF ADHD.1b IS RATED "YES" **Please tell me about the time when you had the most difficulties?** ________(6 month period, year)
	DISPLAY ADHD.2a – j IF SQ 1 (INATTENTION) IS ANSWERED YES If ADHD.1a is YES: **Over the last 6 months…** IF ADHD 1b is YES: **During that 6 month period,** ADHD.1c …
	Did you often have problems with paying attention to things that are not that interesting?
	Did you often have problems with paying attention to things that are complex and difficult or that require long periods of attention?

	Did you regularly miss important details of tasks, or made silly mistakes in your work?
	Did you often struggle to finish things you were supposed to do, like your work or projects at home?
	Were you easily distracted by things happening around you or by thoughts in your mind not related to the task?
	Do you often miss what is being said even if you are spoken to directly?
	Did you get lost in daydreams or is your focus on things other than what is happening in the class or in conversations?
	Do you often lose things like clothing, your keys or your phone?
	Did you often forget about scheduled activities or tasks that were due?
	Do you struggle to plan and manage your (school) work or tasks at home?
	INATTENTIVE SYMPTOM COUNT – THRESHOLD = 3 (Maximum = 10) IF = 3 OR MORE - DISPLAY ADHD.3 BELOW IF < 2 – AND BUSY WITH CURRENT SYMPTOMS – SKIP TO ADHD.4 IF SQ.2 IS YES, OTHERWISE LOOP BACK TO ADHD.1b IF < 2 – AND BUSY WITH LIFETIME SYMPTOMS, SKIP TO ADHD.4 IF SQ.2 IS YES, OTHERWISE SKIP TO NEXT MODULE
	Have the [INATTENTIVE SYMPTOMS] **caused problems for you at school in terms of getting your work done, or at home or with friends?** IF NO – AND BUSY WITH CURRENT SYMPTOMS – LOOP BACK TO ADHD.1b IF NO – AND BUSY WITH LIFETIME SYMPTOMS – SKIP TO NEXT MODULE
	DISPLAY ADHD.4a-f IF SQ 2 (HYPERACTIVITY / IMPULSIVITY) IS ANSWERED "YES" If ADHD.1a is YES: **Over the last 6 months…** IF ADHD 1b is YES: **During that 6 month period**, ADHD.1c **…**
	Did you find it difficult to sit still or not fidget when you were required to sit still?
	Did you often feel restless or feel uncomfortable when you were required to be still and quiet?
	Did you struggle to remain quiet in when others were doing the same activity in silence or were you told that you talk too much?
	Did you have problems waiting for your turn to speak in conversations, or when having to wait your turn in a game? Did you often interrupt others' conversations or activities?

	Did you often act upon a whim, without considering possible negative end results? EXAMPLES**: Jumping from somewhere high, going into a dangerous situation, driving recklessly**
	HYPERACTIVE / IMPULSIVE SYMPTOM COUNT – THRESHOLD = 3 (Maximum = 6) IF = 3 OR MORE DISPLAY ADHD.5 BELOW IF < 2 – AND BUSY WITH CURRENT SYMPTOMS – LOOP BACK TO ADHD.1b IF < 2 – AND BUSY WITH LIFETIME SYMPTOMS – SKIP TO NEXT MODULE
	Have the [HYPERACTIVITY SYMPTOMS] **caused problems for you at school in terms of getting your work done, or at home or with friends, especially when you were required to control your behaviour?** IF NO – AND BUSY WITH CURRENT SYMPTOMS – LOOP BACK TO ADHD.1b IF NO – AND BUSY WITH LIFETIME SYMPTOMS – SKIP TO NEXT MODULE
	DISPLAY IF ADHD.3 OR ADHD.5 IS RATED YES **Did you have these difficulties to a degree that affected your life before the age of 12?**
	DISPLAY IF ADHD.6 IS RATED YES **Do these symptoms that we have just discussed appear in more than one situation, that is at school or work, at home, when you are socialising with friends or family and when you are practicing a sport or hobby?**
	AT LEAST 3 SYMPTOMS RATED YES FROM EITHER ADHD.2 OR ADHD.4 FOR THE DOMAIN REACHING THRESHOLD – ADHD.3 OR ADHD.5 NEEDS TO BE RATED YES (FUNCTIONAL IMPAIRMENT) ADHD.6 AND ADHD.6 must be rated YES DX CURRENT ADHD IF ADHD.1a IS RATED YES DX LIFETIME ADHD IF ADHD.1b IS RATED YES

	GAMING DISORDER
	SQ: **During the last 12 months did you regularly play video games either online or on electronic devices or on game consoles (PS / X-box) which lead to negative consequences? E.g. getting in the way of school work, fighting with parents, losing friends, interfering with sleep.**
	SQ: **Was there ever a time when you, for a year or longer you played video games either online or on electronic devices or on game consoles (PS / X-box)?**
	If GAME.1a and GAME.1b both rated “NO” - screening for Gaming disorder is negative. – SKIP to NEXT MODULE
	DISPLAY IF GAME.1b IS RATED “YES” **Please tell me about the time when you were gaming the most?**

________(12 month period, year)
IF GAME.1a IS YES: **During the last year …** IF GAME.1b IS YES: **During that time,** GAME.1c **,** **Did you feel like you were losing control over your gaming, for example did you try unsuccessfully to cut down or stop gaming, or did you spend much more time gaming than you planned to?** IF NO – AND BUSY WITH CURRENT SYMPTOMS – LOOP BACK TO GAME.1b IF NO – AND BUSY WITH LIFETIME SYMPTOMS – SKIP TO NEXT MODULE
DISPLAY IF GAME.2 IS RATED YES IF GAME.1a IS YES: **During the last year …** IF GAME.1b IS YES: **During that time,** GAME.1c **, …** **Did you spend less time on work or school, with family or friends, or on things you normally liked doing because of your gaming?** IF NO: **Did gaming cause you to neglect other important things in your life?** A YES ANSWER TO EITHER IS SUFFICIENT FOR A YES RATING IF NO – AND BUSY WITH CURRENT SYMPTOMS – LOOP BACK TO GAME.1b IF NO – AND BUSY WITH LIFETIME SYMPTOMS – SKIP TO NEXT MODULE
DISPLAY IF GAME.3 IS RATED YES IF GAME.1a IS YES: **During the last year …** IF GAME.1b IS YES: **During that time,** GAME.1c **, …** **Did you continue gaming, or spend more time gaming, even though it was causing problems in your life?** EXAMPLES: **Problems such as conflict with loved ones, getting into trouble at work or school because of absences or missing deadlines, neglecting your hygiene or getting physical problems due to gaming for prolonged periods?** IF NO – AND BUSY WITH CURRENT SYMPTOMS – LOOP BACK TO GAME.1b IF NO – AND BUSY WITH LIFETIME SYMPTOMS – SKIP TO NEXT MODULE
DISPLAY IF GAME.4 is rated YES **Did the symptoms we've just talked about affect your ability to function in daily life (for example your work or school, your social life, your relationships)?** IF NO**: Did your symptoms bother you a lot?** YES TO EITHER OF THE QUESTIONS: FUNCTIONAL IMPAIRMENT / DISTRESS PRESENT and GAMING DISORDER CDDR MET) IF YES DX GAMING DISORDER CURRENT (if GAME.1a is YES) Or DX GAMING DISORDER LIFETIME (if GAME.1b is YES) IF NO – AND BUSY WITH CURRENT SYMPTOMS – LOOP BACK TO GAME.1b IF NO – AND BUSY WITH LIFETIME SYMPTOMS – SKIP TO NEXT MODULE

J	SECONDARY [PSYCHIATRIC] DISORDER	Dx 1	Dx 2	Dx 3
	SKIP if no disorders diagnosed. For each disorder diagnosed, ask:	_____	_____	_____
	Around the time when you started having [SYMPTOMS of DISORDER] **did you…** **…suffer from a medical condition that may have caused your** [DISORDER]**?** If YES**: What symptoms or illness did you have? What was the opinion of the treating physician?** ___ (See Manual for list of medical conditions known to mimic psychiatric disorders) Only rate as YES = Secondary disorder IF • Medical condition is known to cause the relevant symptoms • Condition preceded symptoms and symptoms resolve once condition adequately treated If uncertain regarding history or pathophysiology code "?" – Uncertain	NO YES ?	NO YES ?	NO YES ?
	[SUBSTANCE] INDUCED [PSYCHIATRIC] DISORDER			
	Around the time when you started having [SYMPTOMS of DISORDER] **did you…** **… start a new treatment, increase a dose or stop a treatment including medication*, radiation or chemotherapy?** If YES: **What was the treatment?** ___	Y / N	Y / N	Y / N
	… use drugs or alcohol for the first time, or increased the use of drugs or alcohol, or drastically cut down or stopped using drugs or alcohol? If YES: **What drug (including alcohol) did you take or stop?** ___ 1.	Y / N	Y / N	Y / N
	Code "NO" = Primary Psychiatric disorder • If both questions coded "N" Code "YES" = Substance induced disorder • If Any question rated "Y" AND Factors suggestive of secondary disorder are present: • likely causal link (pathophysiological explanation, sufficient dose/duration to explain symptoms)	NO YES	NO YES	NO YES

	• no symptoms present outside of substance use (no symptoms present before substance started / symptoms subside after substance stopped) • Prior episodes of disorder were all substance related If uncertain regarding history or pathophysiology code "?" – Uncertain	?	?	?

K	SUICIDALITY SCREENING	**1. Current**
	In the last month, have you thought that it would be better if you were dead? If YES: **have you thought that you wanted to end your life?**	• NO • YES
	In the past month – have you wanted to hurt yourself?	• NO • YES
	In the last month, have you hurt yourself intentionally?	• NO • YES

- If any question rated "YES" – Assess / refer for assessment - determine suicide risk and take appropriate steps to contain the risk based on clinical findings and local services and protocols.
- If all questions rated "NO" – end of interview