Institute of Living/Hartford HealthCare Corporation

Diagnostic Interview for Anxiety, Mood, and OCD and Related Neuropsychiatric Disorders: Child and Adolescent Version (DIAMOND-KID)

Patient name: _____

Date of birth: _____ Age: _____

Date: _____ Start Time: _____ End Time: _____

Interviewer: _____

Interviewee(s): _____

Version 1.7

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INSTRUCTIONS

Scope of the Interview

The DIAMOND-KID is intended to be used with children and adolescents (age 6-18) with known or suspected Mood, Anxiety, or Obsessive-Compulsive and Related Disorders. The DIAMOND-KID includes diagnostic and other information for all of the diagnoses in those sections of DSM-5. In addition, the DIAMOND-KID contains diagnostic information for disorders that commonly co-occur with, or can be mistaken for, Mood, Anxiety, and Obsessive-Compulsive and Related Disorders. Therefore, the interview contains modules for selected other diagnostic categories. However, these modules do not address all DSM-5 diagnoses in those sections, and supplemental interviews or self-report measures should be considered if a more thorough investigation of those conditions is warranted.

Relatedly, the DIAMOND-KID does not include modules for many DSM-5 disorders that do not commonly co-occur with Mood, Anxiety, or Obsessive-Compulsive and Related Disorders, are not well suited to assessment by interview, or which require a more involved method of assessment. These include certain Neurodevelopmental Disorders, Dissociative Disorders, Elimination Disorders, Sleep-Wake Disorders, Gender Dysphoria, and Personality Disorders.

Sources of Information

Although the DIAMOND-KID is designed as a semi-structured interview to be used with the child or adolescent, at times it can be helpful or necessary to consider other sources of information. Certain diagnoses, for example, have detailed medical rule-outs that may require medical examination or consultation with appropriate medical professionals. Some patients, particularly those with low insight, may be unable or unwilling to acknowledge certain symptoms, or may be unable or unwilling to provide sufficient detail about the symptoms. In such cases, other sources of information such as collateral reports (individuals familiar with the patient), behavioral observations, police records, medical records, school records, or physical examination may be useful. The clinician must use his or her best judgment, based on all of the available information, about whether a given symptom is present, rather than simply relying on the patient's self-report. It is noted, however, that like most diagnostic interviews, the DIAMOND-KID will not reliably detect over- or under-reporting of symptoms and assumes a certain level of honesty from interviewees.

When assessing children and adolescents, the clinician must use his/her judgment about whether to obtain information from the child, from the parent/guardian, or from both sources. Some of the modules in the DIAMOND-KID, particularly the externalizing disorders, are specifically directed toward parents/guardians, as it is unlikely that the child will be able to provide accurate responses. The decision about whom to interview is based on several factors, including:

- *Age/developmental status.* Younger children, or those in earlier stages of development, may require parent's input. However, older children may prefer to be interviewed alone.
- *Cognitive functioning.* Children with intellectual or other cognitive impairments may have difficulty providing complete or accurate answers to the DIAMOND-KID questions, and questions might be better directed toward the parent/guardian.
- *Internalizing vs. externalizing symptoms.* All other things being equal, parents/guardians tend to be more accurate reporters about externalizing symptoms (e.g., conduct disorder), whereas children tend to be more accurate reporters about internalizing symptoms (e.g., anxiety, depression).
- *Selective mutism.* Children with selective mutism might refuse to speak to the assessor, in which case the parent/guardian would be the best source of information.
- *Sensitive topics.* Children may be reluctant to discuss certain sensitive topics, such as sex, substance use, suicidal ideation, or family distress, in the presence of a parent/guardian. If this is suspected, it is recommended that the child be given the opportunity to discuss these topics without the parent/guardian in the room.

Structure of the Interview

- *Modular Format.* The interview is divided into modules for each diagnosis. The modules do not have to be given in a fixed order; rather, it is usually preferable to start with the module that most closely targets the primary presenting complaint. When the assessment aims are circumscribed, the interviewer may opt to administer only selected modules, rather than the entire interview.

- *Diagnostic Criteria.* The diagnostic criteria are numbered and in gray. For each criterion, circle "Yes" if, in the clinician's judgment, that criterion is met. Circle "No" if, in the clinician's judgment, that criterion is not met. If all criteria are rated "yes," the diagnosis should be considered present.
- *Interview Questions.* For each diagnostic criterion, one or more interview questions are provided. The interview does not have to be limited to these questions, and the clinician should use additional questions as needed in order to determine whether the criterion is met. Furthermore, not all questions must be asked. Essential questions are listed in **bold type** and marked with a diamond (💎), with additional follow-up questions, marked with an arrow (⇨), that can be asked if needed in order to obtain an accurate answer. The follow-up questions need not be asked if the information has already been obtained with the initial question(s) or in another section of the interview. Furthermore, the interviewer may ask additional questions not listed in the interview as needed in order to determine whether the diagnostic criterion is met.
- *Skip Rules.* For diagnostic criteria marked "No" (i.e., the criterion is not met), a skip rule is provided that allows subsequent questions to be skipped. Therefore, once it is clear that a diagnosis will not be assigned, no further questions about that diagnosis need to be asked. However, the interviewer may opt to ask about additional symptoms if desired, or go back to re-query certain sections if information given later in the interview raises questions about diagnoses that were covered earlier.
- *Screening Questions.* The DIAMOND-KID has an optional screening self-report and parent/guardian-report questionnaire that asks respondents yes/no questions about the primary symptoms of each condition. To reduce administration time, the interviewer may opt to have the patient and parent/guardian complete the measure prior to the interview. Typically, when the screening questionnaire is used, the interviewer need only administer those modules for which the patient or parent/guardian responded "Yes" (corresponding DIAMOND-KID page numbers are on the right side of the questionnaire). However, the interviewer may opt to ask about any diagnosis that is suspected, regardless of the patient or parent/guardian's response to the questionnaire. When the patient or parent/guardian has responded "Yes" to a screening question, the interviewer should change the wording of the initial question accordingly. For example, instead of the question "Have you ever had a panic attack, where you suddenly felt very afraid, or felt a lot of uncomfortable physical sensations?," the interviewer might ask, "You've said that you have had a panic attack, where you suddenly felt very afraid, or felt a lot of uncomfortable physical sensations. Can you tell me about the attack or attacks?"
- *Severity Scale.* For each diagnosis, the clinician should rate the severity of that disorder on a scale from 1 (normal) to 7 (extreme). This numeric rating, modified from the Clinician's Global Impression Scale,[1] should be based on the clinician's judgment, and not read to the patient as a numeric scale. For each diagnosis, consider the severity of (a) the patient's level of distress and (b) the level of impairment caused by the symptoms. Select the number that is associated with the **highest** anchor point. For example, if a patient's distress is rated "mild," but the impairment from the symptoms is rated "moderate," the overall rating for that diagnosis should be "moderate." The interviewer may opt to rate the severity of a specific cluster of symptoms if indicated for clinical or research purposes, even if formal diagnostic criteria for that disorder are not met.

  Severity ratings should be based on the patient's **current** level of distress and impairment (within the past month), not past levels of distress and impairment. For example, a patient with major depressive disorder that was severe during the most recent episode, but is currently normal with no distress or impairment, would receive a current rating of "normal."

[1] Guy, W. (1976). *Assessment manual for psychopharmacology*. Washington, DC: U.S. Government Printing Office.

	Distress	Impairment
1. Normal	• No distress at all or full remission	• No impairment at all or full remission
2. Borderline	• Between Normal and Mild, or subthreshold	• Between Normal and Mild, or subthreshold
3. Mild	• Fairly infrequent distress OR • Brief duration of distress OR • Distress is slight	• Impairment is slight in 1 domain of functioning (e.g., taking longer to complete school tasks, occasional social avoidance) OR • Still generally able to meet obligations
4. Moderate	• Between Mild and Marked	• Between Mild and Marked
5. Marked	• Very frequent distress OR • Very long-lasting distress OR • Distress is substantial	• Impairment is significant in many domains of functioning (e.g., school, social, family life) OR • Some failure to meet role obligations (e.g., poor school performance, missing days of school) OR • Symptoms pose a minor risk of harm to self or others
6. Severe	• Between Marked and Extreme	• Between Marked and Extreme
7. Extreme	• Distress occurs constantly without relief OR • Distress is extremely intense or unbearable	• Impairment is extreme in most or all domains of functioning (e.g., completely unable to perform in school or engage in social interactions) OR • Patient is considered incapacitated OR • Symptoms pose a severe risk of harm to self or others OR • Acutely psychotic OR • In need of hospitalization or residential care

Of note, the severity indicators should not be adjusted based on diagnosis (e.g., a "moderate" rating for specific phobia should reflect the same degree of distress and impairment as a "moderate" rating for schizophrenia). Rather, the severity code should be based, for all diagnoses, on the intensity and frequency of distress and on the degree of functional impairment associated with that disorder. It is likely that some diagnoses will, on average, be associated with higher severity ratings than others.

Autism Spectrum Disorder Screen

A screening tool for autism spectrum disorder (ASD) is on p. 143. A diagnosis of ASD likely requires specialized assessment that is beyond the scope of the DIAMOND-KID. When ASD is suspected, a referral for additional assessment is warranted.

Pediatric Acute Onset Neuropsychiatric Syndrome (PANS) Screen

A screening tool for PANS, which incorporates Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcus (PANDAS), is on p. 145. This tool should be given in all cases of clinically significant obsessions, compulsions, tics, or restricted food intake, regardless of whether diagnostic criteria for a disorder have been met. A diagnosis of PANS likely requires specialized assessment that is beyond the scope of the DIAMOND-KID. When PANS is suspected, a referral for additional assessment is warranted.

Suicide Screen

A screening tool for suicidal ideation and behavior is on p. 147. This tool should be used whenever suicide risk is reported or suspected, or when the clinician wishes to understand suicide risk factors.

Optional Information

For the Mood, Anxiety, and Obsessive-Compulsive and Related Disorders, a separate sheet with optional information is included. This sheet includes:

- *Possible Rule-Outs.* Common differential diagnoses are listed, along with guidelines for distinguishing between the disorders. This list is not intended to be exhaustive.
- *Associated Features.* Associated features are not intended to be diagnostic, although their presence can support the diagnosis.
- *Specifiers.* Certain diagnoses can be made with specifiers; the clinician may check those that apply.

Citing the DIAMOND-KID

In published works, please use the following citation:

Tolin, D. F., Sain, K. S., Davis, E., Gilliam, C., Hannan, S. E., Springer, K. S., Stubbing, J., George, J. R., Jean, A., Goldblum, R., Katz, B. W., Everhardt, K., Darrow, S., Ohr, E. E., Young, M. E., & Serchuk, M. D. (2023). The DIAMOND-KID: Psychometric properties of a structured diagnostic interview for DSM-5 anxiety, mood, and obsessive-compulsive and related disorders in children and adolescents. *Assessment*, 10731911221143994.

Training

For an online training program in structured diagnostic interviewing and the use of the DIAMOND-KID, and to find the latest version of the DIAMOND-KID, please visit:

www.diamondinterview.org

Questions

Please direct questions or comments to Dr. David Tolin at david.tolin@hhchealth.org.

INITIAL INTERVIEW QUESTIONS

Please tell me about the kind of problem or problems you're having that you're here to talk about.

_____

_____

How is your physical health? Do you have any health problems?

_____

_____

What medications do you currently take?

_____

_____

Have you had mental health treatment before? If so, please tell me about your past treatment. When did you do this treatment? Has anything prevented you from getting the help you need? For example, money, work or family commitments, stigma or discrimination, immigration status, or lack of services that understand your language or background?

_____

_____

Have you ever been hospitalized for mental health problem before? If so, please tell me about it. Where and when were you hospitalized?

_____

_____

Does anyone in your family have a history of mental health problems? What kind of problems?

_____

_____

Have you been having any thoughts about hurting or killing yourself?[2]

_____

_____

How is your sleeping? Is it hard for you to fall asleep? Do you wake up a lot during the night?

_____

_____

[2] Complete the suicide screen on p. 146.

How is school going? What kind of grades do you get? Do you ever get in trouble at school? Are you in any special programs at school or receive any special accommodations or special education?

_____

_____

How are things going at home? How well do you get along with your parents and siblings? Do you have a lot of arguments? Do you ever get in trouble at home?

_____

_____

How are things going with friends? Do you have many friends? How often do you do things with friends outside of school? When you get together with friends, is it in person or over the Internet?

_____

_____

Are there aspects of your background or identity that impact [problem described], or that are relevant for me to know? By background or identity, I mean, for example, the communities you belong to, the languages you speak, where you or your family are from, your race or ethnic background, your gender identity or sexual orientation, or your faith or religion.

_____

_____

[For parent/guardian]: How was your child's early development? Were there any delays or concerns? What was his or her general temperament like (cheerful, fussy, shy, etc.)?

_____

_____

Note: The clinician should begin the interview with the section that pertains to the most likely primary diagnosis.

ANXIETY DISORDERS

SELECTIVE MUTISM

Best source: Parent, though child should be included to the extent possible. Consider behavioral observations in addition to self-report.

- **Are there situations in which your child refuses to speak?** _____
  - ⇨ For example, does he/she refuse to speak in school, in activities, or around certain people? _____
  - ⇨ When does this happen? What kinds of places? What kinds of activities? Which people? _____
  - ⇨ Does your child do things like pointing or shaking his/her head instead of speaking? _____
  - ⇨ Are there things your child does to avoid speaking, such as hiding behind people, running away from situations, or avoiding certain activities? _____
  - ⇨ Does this happen a lot? _____
  - ⇨ Are there times when your child does speak? When is that? Who is your child with? _____

1. *Does the child report consistent failure to speak in social situations in which there is an expectation for speaking (e.g., at school) despite speaking in other situations?*	*Yes*	*No* *Skip to item 6 and circle "No"*

- **In the past month, does this problem make things harder for your child, like make it hard to do well in school or at work, cause problems with your friends or family, or get in the way of doing fun or important things?**

☐ Problems at school
☐ Problems with family
☐ Legal problems
☐ Other functional impairment _____
☐ Problems with work or role functioning
☐ Problems with home responsibilities
☐ Problems with social life
☐ Problems with leisure activities
☐ Problems of health or safety

[Note: this criterion is met if school, work or role functioning, or social impairment is endorsed.]

2. *Does the disturbance interfere with educational or occupational achievement, or with social communication?*	*Yes*	*No* *Skip to item 6 and circle "No"*

- **When did this problem speaking start?** _____
  - ⇨ Has it been at least 1 month? _____
  - ⇨ How many months has your child been in school so far this year? _____

3. *Has the disturbance been present for at least 1 month (not limited to the first month of school)?*	*Yes*	*No* *Skip to item 6 and circle "No"*

- **Can your child speak and understand the language being spoken in the situations in which s/he has trouble talking?** _____

4. Is the failure to speak attributable to a lack of knowledge of, or comfort with, the spoken language required in the social situation?	*No*	*Yes* *Skip to item 6 and circle "No"*

- **Has your child had any educational or speech and language testing?** _____
  - ⇨ Did the testing determine whether your child has any language-based or cognitive reasons for having difficulty speaking? _____
  - ⇨ If your child has not had any testing, do you have any reason to suspect that there are cognitive or language-based reasons for why your child does not speak? Does he/she appear to speak normally when around people s/he is comfortable with? _____

5. Is the behavior attributable to a medical condition or another mental disorder such as autism spectrum disorder, schizophrenia, or another psychotic disorder? (See Optional Information; If yes, complete applicable module)	*No*	*Yes* *Skip to item 6 and circle "No"*

6. SELECTIVE MUTISM	*Yes*	*No*

Current Severity of Selective Mutism (circle number):

	Distress	Impairment
1. Normal	• No distress at all or full remission	• No impairment at all or full remission
2. Borderline	• Between Normal and Mild, or subthreshold	• Between Normal and Mild, or subthreshold
3. Mild	• Fairly infrequent distress OR • Brief duration of distress OR • Distress is slight	• Impairment is slight in 1 domain of functioning (e.g., taking longer to complete school tasks, occasional social avoidance) OR • Still generally able to meet obligations
4. Moderate	• Between Mild and Marked	• Between Mild and Marked
5. Marked	• Very frequent distress OR • Very long-lasting distress OR • Distress is substantial	• Impairment is significant in many domains of functioning (e.g., school, social, family life) OR • Some failure to meet role obligations (e.g., poor school performance, missing days of school) OR • Symptoms pose a minor risk of harm to self or others
6. Severe	• Between Marked and Extreme	• Between Marked and Extreme
7. Extreme	• Distress occurs constantly without relief OR • Distress is extremely intense or unbearable	• Impairment is extreme in most or all domains of functioning (e.g., completely unable to perform in school or engage in social interactions) OR • Patient is considered incapacitated OR • Symptoms pose a severe risk of harm to self or others OR • Acutely psychotic OR • In need of hospitalization or residential care

Optional Information: Selective Mutism
Possible rule-outs (check if likely):

- ☐ Communication disorders: Communication disorders are characterized by pervasive difficulties with speech and language across *all* contexts. In selective mutism the communication difficulties only occur in certain situations (for example, outside the home), and the ability to speak has been demonstrated elsewhere.
- ☐ Autism: Failure to speak due to an Autism Spectrum Disorder is characterized by difficulties with speech and language across *all* contexts. In selective mutism the communication difficulties only occur in certain situations, and the ability to speak has been demonstrated in other contexts.
- ☐ Schizophrenia or other psychotic disorders: Selective mutism should not be diagnosed if the failure to speak only occurs in the context of schizophrenia or another psychotic disorder.
- ☐ Lack of language proficiency: Selective mutism should not be diagnosed if the failure to speak is solely due to lack of proficiency in the spoken language.
- ☐ Intellectual disability: Selective mutism should not be diagnosed if the difficulty speaking is solely due to an intellectual disability.

Associated Features:

- ☐ Shyness, easily embarrassed
- ☐ Social withdrawal or isolation
- ☐ Has few friendships or relationships outside of those with family members
- ☐ Clings to those s/he feels safe around
- ☐ Exhibits temper tantrums or mild oppositionality, particularly when faced with social stressors
- ☐ Exhibits a negative attitude toward social situations

SOCIAL ANXIETY DISORDER (SOCIAL PHOBIA)

Best source: Child with or without parent, depending on age and developmental level

- **In the past month, do you[3] worry a lot that you will embarrass yourself in front of other people? Do you worry a lot that people will laugh at you or think badly about you?** _____

- **In the past month, do you feel very afraid or anxious in places where other people could watch what you're doing?** _____
  - ⇨ Can you tell me about that fear or anxiety?
    _____
  - ⇨ What kind of places or activities are you afraid of? _____

☐ Public speaking
☐ Meeting people you don't know well
☐ Asserting one's self
☐ Eating, writing, or performing other activities in public
☐ Other _____
☐ Starting or maintaining conversations
☐ Talking to authority figures
☐ Being watched while working or performing
☐ Using public restrooms

- **When you have to (social situation), or when you think about (social situation), what are you afraid will happen?** _____
  - ⇨ Are you afraid that you will do something embarrassing? _____
  - ⇨ Are you afraid that others will see that you're anxious and think badly about you? _____
  - ⇨ Are you afraid that others will make fun of you? _____
  - ⇨ Are you afraid that you will act in a way that makes other people upset? _____
  - ⇨ Are you afraid that you will act in a way that makes others not want to be your friend? _____

1. Does the child report marked fear or anxiety about one or more social situations in which the child is exposed to possible scrutiny or judgment from others?	*Yes*	*No* *Skip to item 9 and circle "No"*

- **In the past month, do you almost always feel scared when you (situation)?** _____
  - ⇨ Are there times when you (situation) and don't feel scared? _____

2. Do the social situations almost always provoke fear or anxiety?	*Yes*	*No* *Skip to item 9 and circle "No"*

- **In the past month, do you try really hard to stay away from (social situation)?** _____
  - ⇨ How do you try to stay away from it? _____
- **In the past month, if you have to (social situation), how scared do you feel?** _____

☐ Social situation is actively avoided
☐ Social situation is endured with intense anxiety

(Note: this criterion is met if at least one of the above is checked.)

[3] Or "your child;" continue as appropriate.

3. Are the social situations avoided or endured with intense anxiety?	*Yes*	*No* *Skip to item 9 and circle "No"*

- **In the past month, how much does this problem bother or upset you?**
  - ⇨ How often do you feel upset?_____
  - ⇨ When you feel upset, how long does it last? _____
  - ⇨ How bad does it feel? _____

- **In the past month, does this problem make things harder for you, like make it hard to do well in school or at work, cause problems with your friends or family, or get in the way of doing fun or important things?**
  - ⇨ Are there things you don't do, or places you won't go, because of this problem? _____
  - ⇨ Does this problem make it hard to focus or concentrate? _____

☐ Problems at school
☐ Problems with family
☐ Legal problems
☐ Other functional impairment _____
☐ Problems with work or role functioning
☐ Problems with home responsibilities
☐ Problems with social life
☐ Problems with leisure activities
☐ Problems of health or safety

4. Does the fear or avoidance cause significant distress, or cause impairment in important areas of functioning?	*Yes*	*No* *Skip to item 9 and circle "No"*

5. Is the fear or anxiety out of proportion to the actual threat posed by the social situation and sociocultural context?	*Yes*	*No* *Skip to item 9 and circle "No"*

- **How long have you been afraid of (social situation)? How long have you been staying away from (social situation)?** _____

6. Is the fear or avoidance persistent (typically defined as 6 months or more)?	*Yes*	*No* *Skip to item 9 and circle "No"*

7. Is the fear and avoidance attributable to another mental disorder (see Optional Information)?	*No*	*Yes* *Skip to item 9 and circle "No"*

8. If another medical condition is present, is the fear or avoidance clearly unrelated or excessive?	*Yes*	*No* *Skip to item 9 and circle "No"*

9. SOCIAL ANXIETY DISORDER (SOCIAL PHOBIA)	*Yes*	*No*

Current Severity of Social Anxiety Disorder (Social Phobia) (circle number):

	Distress	Impairment
1. Normal	• No distress at all or full remission	• No impairment at all or full remission
2. Borderline	• Between Normal and Mild, or subthreshold	• Between Normal and Mild, or subthreshold
3. Mild	• Fairly infrequent distress OR • Brief duration of distress OR • Distress is slight	• Impairment is slight in 1 domain of functioning (e.g., taking longer to complete school tasks, occasional social avoidance) OR • Still generally able to meet obligations
4. Moderate	• Between Mild and Marked	• Between Mild and Marked
5. Marked	• Very frequent distress OR • Very long-lasting distress OR • Distress is substantial	• Impairment is significant in many domains of functioning (e.g., school, social, family life) OR • Some failure to meet role obligations (e.g., poor school performance, missing days of school) OR • Symptoms pose a minor risk of harm to self or others
6. Severe	• Between Marked and Extreme	• Between Marked and Extreme
7. Extreme	• Distress occurs constantly without relief OR • Distress is extremely intense or unbearable	• Impairment is extreme in most or all domains of functioning (e.g., completely unable to perform in school or engage in social interactions) OR • Patient is considered incapacitated OR • Symptoms pose a severe risk of harm to self or others OR • Acutely psychotic OR • In need of hospitalization or residential care

Optional Information: Social Anxiety Disorder (Social Phobia)

Possible rule-outs (check if likely):

- ☐ Normative shyness: Normative shyness does not have a significant adverse impact on important areas of functioning.
- ☐ Agoraphobia: Individuals with agoraphobia avoid situations because of thoughts that escape would be difficult or that help might not be available in case of panic-like symptoms, not solely because of fear of negative evaluation by others.
- ☐ Panic disorder (PD): In social anxiety disorder, the primary fear is of negative evaluation by others, whereas in PD the primary fear is of the panic attacks themselves.
- ☐ Generalized anxiety disorder (GAD): Social worries in GAD are usually about the nature of ongoing relationships, rather than fear of negative evaluation by others. GAD is characterized by a range of worries other than social concerns.
- ☐ Separation anxiety disorder: In separation anxiety, situations are feared because of concerns about being separated from an attachment figure; social situations are usually not feared in the presence of an attachment figure.
- ☐ Specific phobia: Although individuals with specific phobia may fear being embarrassed when they have an anxious reaction, they do not fear negative evaluation in other social situations.
- ☐ Depression: Individuals with social anxiety fear negative evaluation because of certain social behaviors or physical symptoms, whereas depressed individuals may have social concerns due to feelings that they are bad or unworthy.
- ☐ Body dysmorphic disorder (BDD): Social anxiety in BDD is due to perceived defects or flaws in physical appearance, rather than due to certain social behaviors or physical symptoms.
- ☐ Psychotic disorders: Fear and avoidance in social anxiety disorder are not the result of delusional beliefs. Individuals with social anxiety disorder usually are aware that their fear is out of proportion to the actual degree of social threat.
- ☐ Autism spectrum disorder: Individuals with social anxiety disorder usually have adequate age-appropriate social relationships and capacity for social communication.
- ☐ Personality disorders: Avoidant personality disorder is characterized by a broader avoidance pattern than social anxiety disorder, although they can overlap.
- ☐ Obsessive-compulsive disorder (OCD): In OCD, fears of social situations are the result of obsessions, and are usually accompanied by compulsive behaviors or mental acts.
- ☐ Eating disorders: In social anxiety disorder, fear of negative evaluation is not limited to concerns about weight, body shape, or eating disorder behaviors.
- ☐ Other medical conditions: If the individual is embarrassed about symptoms of a medical condition such as tremors from Parkinson's disease, obesity, or disfigurement from injury, the fear and avoidance must either be unrelated to the medical condition, or be clearly in excess of what would normally be expected from that condition.

Associated Features:

- ☐ Inadequately assertive, excessively submissive, or (less frequently) highly controlling of the conversation
- ☐ Rigid body posture, poor eye contact, or overly soft voice
- ☐ Shy, withdrawn, or non-self-disclosing
- ☐ Seeks jobs or roles that require little social interaction
- ☐ Delayed leaving the home, marrying, or seeking employment
- ☐ Self-medication with substances
- ☐ Blushing
- ☐ Exacerbation of medical issues when anxious (e.g., increased tremor or tachycardia)

Specifiers:

- ☐ Performance only

PANIC DISORDER

Best source: Child with or without parent, depending on age and developmental level

Have you[4] ever suddenly felt really afraid, or suddenly had a lot of really uncomfortable feelings inside your body? _____

⇨ Can you tell me about what happened? _____

💎 **Did it feel like a sudden rush of fear or bad feelings?** _____

⇨ How long did it take from the time it started to when it was the worst? _____

☐ The attack is experienced as an abrupt surge of intense fear or intense discomfort

☐ The attack reaches a peak within minutes of onset

(Note: continue only if the answer to both of the above is "Yes")

💎 **Did these scared feelings happen because you were worrying about something or because something made you scared? Did they ever happen without a reason?** _____

☐ At least some of the panic attacks have been unexpected (no obvious trigger)

(Note: continue only if the above is checked)

💎 **When this happens…**

☐ Does your heart beat really fast or really hard? [Heart palpitations, pounding, or increased heart rate]

☐ Do you feel shaky? [Trembling or shaking]

☐ Do you feel like you're choking or you can't swallow? [Choking feelings]

☐ Do you feel dizzy, lightheaded, or like you might faint? [Dizziness, lightheadedness, or feeling faint]

☐ Did you worry that you are going crazy or might do something really weird or embarrassing? [Fear of losing control or going crazy]

☐ Does your stomach feel upset? Does it feel like you might throw up? Does it feel like you might have diarrhea? [Abdominal distress (e.g., nausea, upset stomach, feeling of diarrhea)]

☐ Do you feel like the world isn't real or like you're outside your body? [Derealization (feeling that things are not real) or depersonalization (feeling like you are not yourself or "out of body" feelings)]

☐ Do you sweat? [Sweating]

☐ Does it feel like you can't get enough air to breathe? [Shortness of breath or a feeling of suffocation]

☐ Does your chest hurt or feel tight? [Chest pain or discomfort]

☐ Do you feel really cold or really hot? [Feeling chills or heat flashes]

☐ Do you worry that you might die? [Fear of dying]

☐ Do any parts of your body tingle or lose feeling? [Paresthesias (numbness or tingling sensations, usually in fingers, toes, or face)]

💎 **Which of these things happen at the same time [*prompt with symptoms as needed*]?** _____

(Note: continue only if at least four or more of the above symptoms are present, within a single episode)

[4] Or "your child;" continue as appropriate.

- **How many times has this happened?** _____

1. *Does the child report recurrent (i.e., more than one), unexpected panic attacks?*[5]	*Yes*	*No* *Skip to item 4 and circle "No"*

- **After any of these times, did you worry a lot that it was going to happen again? Did you have worries about when it might happen or where it might happen?** _____
  - ⇨ Did you worry about this for at least a month? _____
  - ⇨ Have you worried about this in the past month? _____

- **After any of these times, did you worry a lot about what might happen to you because of those feelings? For example, did you worry that there was something wrong with you and you would have to go to the hospital? Did you worry that you wouldn't be in control of what you were doing? Did you worry you would get sick?** _____
  - ⇨ Did you worry about this for at least a month? _____
  - ⇨ Have you worried about this in the past month? _____

- **Did you do things differently after any of these times? For example, did you do things to try to stop them from happening again? Did you stop playing sports? Did you stop going to places where you were afraid it would happen? Did you make someone stay with you to make you feel safer?** _____
  - ⇨ Did you change your activities for at least a month? _____
  - ⇨ Are your activities changed in the past month? _____

☐ At least 1 month of persistent concern about additional panic attacks, present within past month
☐ At least 1 month of persistent concern about the consequences of having panic attacks, present within past month
☐ At least 1 month of maladaptive behavior change due to the attacks, present within past month

(Note: this criterion is met if any of the above are checked)

2. *Was at least one panic attack followed by 1 month or more of persistent concern about additional panic attacks or their consequences, and/or a significant maladaptive change in behavior related to the attacks?*	*Yes*	*No* *Skip to item 4 and circle "No"*

- **Just before you started having this problem, did your doctor change any medicine you were taking, did you use any drugs, or did you have an illness or injury?** _____
  - ⇨ Do you think this problem was caused by an illness, drugs, or changes in your medicine? _____
  - ⇨ Have you or your parents talked to a medical doctor about this? _____

3. *Are the panic attacks attributable to the physiological effects of a substance, another medical condition, or another mental disorder? (See Optional Information; If yes, complete applicable substance-induced or general medical condition module)*	*No*	*Yes* *Skip to item 4 and circle "No"*

4. PANIC DISORDER	*Yes*	*No*

[5] Note: Panic attacks can be listed as a specifier for any mental disorder.

- **In the past month, how much does this problem bother or upset you?**
  - ⇨ How often do you feel upset?_____
  - ⇨ When you feel upset, how long does it last? _____
  - ⇨ How bad does it feel? _____

- **In the past month, does this problem make things harder for you, like make it hard to do well in school or at work, cause problems with your friends or family, or get in the way of doing fun or important things?**
  - ⇨ Are there things you don't do, or places you won't go, because of this problem? _____
  - ⇨ Does this problem make it hard to focus or concentrate? _____

☐ Problems at school
☐ Problems with family
☐ Legal problems
☐ Other functional impairment _____
☐ Problems with work or role functioning
☐ Problems with home responsibilities
☐ Problems with social life
☐ Problems with leisure activities
☐ Problems of health or safety

Current Severity of Panic Disorder (circle number):

	Distress	Impairment
1. Normal	• No distress at all or full remission	• No impairment at all or full remission
2. Borderline	• Between Normal and Mild, or subthreshold	• Between Normal and Mild, or subthreshold
3. Mild	• Fairly infrequent distress OR • Brief duration of distress OR • Distress is slight	• Impairment is slight in 1 domain of functioning (e.g., taking longer to complete school tasks, occasional social avoidance) OR • Still generally able to meet obligations
4. Moderate	• Between Mild and Marked	• Between Mild and Marked
5. Marked	• Very frequent distress OR • Very long-lasting distress OR • Distress is substantial	• Impairment is significant in many domains of functioning (e.g., school, social, family life) OR • Some failure to meet role obligations (e.g., poor school performance, missing days of school) OR • Symptoms pose a minor risk of harm to self or others
6. Severe	• Between Marked and Extreme	• Between Marked and Extreme
7. Extreme	• Distress occurs constantly without relief OR • Distress is extremely intense or unbearable	• Impairment is extreme in most or all domains of functioning (e.g., completely unable to perform in school or engage in social interactions) OR • Patient is considered incapacitated OR • Symptoms pose a severe risk of harm to self or others OR • Acutely psychotic OR • In need of hospitalization or residential care

Optional Information: Panic Disorder (PD)

Possible rule-outs (check if likely):

- ☐ Hyperthyroidism or hyperparathyroidism
- ☐ Pheochromocytoma (adrenal tumor)
- ☐ Vestibular dysfunction/vertigo due to a medical condition
- ☐ Seizure disorder
- ☐ Cardiopulmonary condition
- ☐ CNS stimulant intoxication
- ☐ Cannabis intoxication
- ☐ CNS depressant withdrawal
- ☐ Other anxiety disorder: PD is characterized by the presence of unexpected panic attacks and persistent fear of further attacks or behavioral adaptation to panic attacks.
- ☐ Panic attacks as an associated feature of other mental disorders: In other disorders, panic attacks occur in response to predictable triggers (e.g., phobic stimuli). In PD, at least some panic attacks have occurred unexpectedly.

Associated Features:

- ☐ Nocturnal panic attacks (waking from sleep in a state of panic)
- ☐ Constant or intermittent feelings of anxiety related to health and mental health concerns
- ☐ Intolerance of medication side effects
- ☐ Pervasive concerns about ability to complete daily tasks or withstand daily stressors
- ☐ Excessive use of substances to control panic attacks
- ☐ Extreme behavior aimed at controlling panic attacks (e.g., restriction of foods or medicines that provoke panic)

AGORAPHOBIA

Best source: Child with or without parent, depending on age and developmental level

- **In the past month, do you[6] feel very afraid or nervous when…**
  - ☐ Being on a bus, train, or plane?
  - ☐ Being in open spaces, like parking lots or bridges?
  - ☐ Being in places you can't get out of easily, like stores or the movie theater?
  - ☐ Standing in line, or being in a crowded place?
  - ☐ Being by yourself outside of your home?

(Note: this criterion is met only if two or more of the above are checked)

⇨ Can you tell me about that fear or anxiety? _____

1. Does the child report marked fear about two or more of the situations described above?	*Yes*	*No* *Skip to item 10 and circle "No"*

- **In the past month, do you try really hard to stay away from (situation)?** _____
  - ⇨ What do you do to stay away from (situation)? _____
- **In the past month, do you need to have someone with you if you're going to (feared situation)?** _____
- **In the past month, if you can't stay away from (situation), do you feel really afraid or nervous?** _____

☐ Feared situation is actively avoided
☐ Feared situation is endured with intense anxiety
☐ Feared situation requires a companion

(Note: this criterion is met if at least one of the above is checked.)

2. Are the feared situations avoided, require the presence of a companion, or endured with intense anxiety?	*Yes*	*No* *Skip to item 10 and circle "No"*

- **What do you worry will happen if you (situation)?**
  - ☐ Do you worry that you will feel really anxious? Do you worry you will have a lot of really uncomfortable feelings inside your body, like your heart racing, feeling you can't catch your breath, or stomach problems? Do you worry that you might embarrass yourself, like look really scared, throw up, or pass out? [Fears having panic-like, incapacitating, or embarrassing symptoms]
  - ☐ Do you worry that it would be hard to get away or to get help? [Fears that they would have difficulty escaping from the situation, or that help would not be available]

(Note: this criterion is met if at least one of the above is checked.)

3. Does the child fear or avoid these situations because of concern that escape might be difficult, or that help might not be available in the event of panic-like symptoms or other incapacitating or embarrassing symptoms?	*Yes*	*No* *Skip to item 10 and circle "No"*

- **In the past month, how much does this problem bother or upset you?**
  - ⇨ How often do you feel upset?_____
  - ⇨ When you feel upset, how long does it last? _____
  - ⇨ How bad does it feel? _____

[6] Or "your child;" continue as appropriate.

- **In the past month, does this problem make things harder for you, like make it hard to do well in school or at work, cause problems with your friends or family, or get in the way of doing fun or important things?**
  - ⇨ Are there things you don't do, or places you won't go, because of this problem? _____
  - ⇨ Does this problem make it hard to focus or concentrate? _____

☐ Problems at school ☐ Problems with work or role functioning ☐ Problems with social life
☐ Problems with family ☐ Problems with home responsibilities ☐ Problems with leisure activities
☐ Legal problems ☐ Problems of health or safety
☐ Other functional impairment _____

4. Does the fear or avoidance cause significant distress, or cause impairment in important areas of functioning?	*Yes*	*No* *Skip to item 10 and circle "No"*

5. Is the fear or avoidance out of proportion to the actual danger and sociocultural context?	*Yes*	*No* *Skip to item 10 and circle "No"*

- **In the past month, do you almost always feel scared when you (feared situation)?** _____
  - ⇨ Are there times when you can (feared situation) and not feel scared? _____

- **In the past month, when (feared situation) scares you, does the fear start right away?** _____
  - ⇨ Are there times when the fear comes on much later? _____

☐ Situation almost always provokes fear or anxiety ☐ Phobic fear or anxiety is almost always immediate

(Note: this criterion is met if both of the above are checked.)

6. Do the feared situations almost always provoke immediate fear or anxiety?	*Yes*	*No* *Skip to item 10 and circle "No"*

- **How long has this been going on?** _____

(Note: typically, though not always, "persistent" is defined as 6 months or more.)

7. Is the fear or avoidance persistent?	*Yes*	*No* *Skip to item 10 and circle "No"*

8. If another medical condition is present, is the fear or avoidance clearly unrelated or excessive?	*Yes*	*No* *Skip to item 10 and circle "No"*

9. Is the fear and avoidance attributable to another mental disorder (see Optional Information)?	*No*	*Yes* *Skip to item 10 and circle "No"*

10. AGORAPHOBIA	*Yes*	*No*

Current Severity of Agoraphobia (circle number):

	Distress	Impairment
1. Normal	• No distress at all or full remission	• No impairment at all or full remission
2. Borderline	• Between Normal and Mild, or subthreshold	• Between Normal and Mild, or subthreshold
3. Mild	• Fairly infrequent distress OR • Brief duration of distress OR • Distress is slight	• Impairment is slight in 1 domain of functioning (e.g., taking longer to complete school tasks, occasional social avoidance) OR • Still generally able to meet obligations
4. Moderate	• Between Mild and Marked	• Between Mild and Marked
5. Marked	• Very frequent distress OR • Very long-lasting distress OR • Distress is substantial	• Impairment is significant in many domains of functioning (e.g., school, social, family life) OR • Some failure to meet role obligations (e.g., poor school performance, missing days of school) OR • Symptoms pose a minor risk of harm to self or others
6. Severe	• Between Marked and Extreme	• Between Marked and Extreme
7. Extreme	• Distress occurs constantly without relief OR • Distress is extremely intense or unbearable	• Impairment is extreme in most or all domains of functioning (e.g., completely unable to perform in school or engage in social interactions) OR • Patient is considered incapacitated OR • Symptoms pose a severe risk of harm to self or others OR • Acutely psychotic OR • In need of hospitalization or residential care

Optional Information: Agoraphobia

Possible rule-outs (check if likely):

- ☐ Specific phobia: In agoraphobia, the fear and avoidance is directed toward at least two of the situations listed above. Situations are avoided because of a fear of panic-like, incapacitating, or embarrassing symptoms, rather than being harmed by the situation itself.
- ☐ Separation anxiety disorder: In agoraphobia, situations are avoided because of a fear of panic-like, incapacitating, or embarrassing symptoms, rather than separation from an attachment figure.
- ☐ Social anxiety disorder: In agoraphobia, situations (including non-social situations) are avoided because of a fear of being unable to escape or obtain help in the event of panic-like, incapacitating, or embarrassing symptoms, rather than solely due to fear of negative evaluation by others.
- ☐ Panic disorder: Agoraphobia can only be diagnosed (potentially in addition to panic disorder) if two or more of the situations listed above are feared or avoided.
- ☐ Posttraumatic stress disorder: In PTSD, avoidance is limited to situations that remind the child of a traumatic event, and are not avoided because of fear of developing panic-like, incapacitating, or embarrassing symptoms.
- ☐ Depression: Depressed individuals may avoid situations due to apathy, low energy, low self-esteem, or anhedonia, but not because of a fear of developing panic-like, incapacitating, or embarrassing symptoms.
- ☐ Other medical disorder: If the individual is embarrassed about symptoms of a medical condition such as inflammatory bowel disease or Parkinson's disease, the fear and avoidance must either be unrelated to the medical condition, or be clearly in excess of what would normally be expected from that condition.

Associated Features:

- ☐ Panic attacks or panic disorder preceding onset of agoraphobia
- ☐ Homebound or dependent on others for services or assistance
- ☐ Depressive symptoms
- ☐ Self-medication with substances

GENERALIZED ANXIETY DISORDER

Best source: Child with or without parent, depending on age and developmental level

- **In the past month, do you[7] feel very worried about a lot of things?** _____
  - ⇨ Can you tell me about your worries? _____
  - ⇨ Do you worry a lot about…

☐ Work or school?
☐ Your health?
☐ The health of people in your family?
☐ Money?
☐ Something bad happening to people you care about?
☐ Getting things done, or being on time for things?
☐ Other worries? _____

(Note: continue only if two or more of the above are checked)

- **Do you think that you worry more than you need to worry?** _____
  - ⇨ Do other people think that you worry too much? _____
- **In the past month, do you worry most days?** _____
- **Have you worried about these things most days for 6 months or more?** _____
  - ☐ The worry about two or more domains is excessive, in the patient's or clinician's judgment
  - ☐ Worrying about two or more domains occurs more days than not
  - ☐ Worrying about two or more domains has occurred more days than not for at least 6 months

(Note: this criterion is met if all three of the above are checked.)

1. Does the child report excessive anxiety and worry, occurring more days than not for at least 6 months, about a number of events or activities?	*Yes*	*No* *Skip to item 6 and circle "No"*

- **Do you worry even when you don't want to worry?** _____
  - ⇨ Do you worry even when you're trying to think about something else? _____
  - ⇨ Is it hard to stop worrying once you have started? _____

2. Does the child find it difficult to control the worry?	*Yes*	*No* *Skip to item 6 and circle "No"*

- **In the past month, do you notice any of these problems?**

☐ Feeling antsy or restless?
☐ Getting tired easily?
☐ Trouble concentrating on other things, or your mind going blank?
☐ Feeling irritable or grouchy?
☐ Tension in your muscles?
☐ Trouble sleeping, like having a hard time falling asleep or staying asleep, or waking up too early?

(Note: continue only if one or more of the above are checked.)

- **In the past month, do you feel (physical symptoms) on most days?** _____
- **Have you felt (physical symptoms) on most days for 6 months or more?** _____
  - ☐ Physical symptoms occur more days than not
  - ☐ Physical symptoms have occurred more days than not for at least 6 months

(Note: this criterion is met if both of the above are checked.)

[7] Or "your child;" continue as appropriate.

3. Is the anxiety and worry associated with at least one of the symptoms described above, occurring more days than not for at least 6 months?	*Yes*	*No* *Skip to item 6 and circle "No"*

- **In the past month, how much does this problem bother or upset you?**
  - ⇨ How often do you feel upset?_____
  - ⇨ When you feel upset, how long does it last? _____
  - ⇨ How bad does it feel? _____

- **In the past month, does this problem make things harder for you, like make it hard to do well in school or at work, cause problems with your friends or family, or get in the way of doing fun or important things?**
  - ⇨ Are there things you don't do, or places you won't go, because of this problem? _____
  - ⇨ Does this problem make it hard to focus or concentrate? _____

☐ Problems at school
☐ Problems with family
☐ Legal problems
☐ Other functional impairment _____
☐ Problems with work or role functioning
☐ Problems with home responsibilities
☐ Problems with social life
☐ Problems with leisure activities
☐ Problems of health or safety

4. Do the anxiety, worry, or physical symptoms cause significant distress, or cause impairment in important areas of functioning?	*Yes*	*No* *Skip to item 6 and circle "No"*

- **Just before you started having this problem, did your doctor change any medicine you were taking, did you use any drugs, or did you have an illness or injury?** _____
  - ⇨ Do you think this problem was caused by an illness, drugs, or changes in your medicine? _____
  - ⇨ Have you or your parents talked to a medical doctor about this? _____

5. Is the anxiety, worry, or physical symptoms attributable to the effects of a substance, a medical condition, or another mental disorder? (See Optional Information; If yes, complete applicable substance-induced or general medical condition module)	*No*	*Yes* *Skip to item 6 and circle "No"*

6. GENERALIZED ANXIETY DISORDER	*Yes*	*No*

Current Severity of Generalized Anxiety Disorder (circle number):

	Distress	Impairment
1. Normal	• No distress at all or full remission	• No impairment at all or full remission
2. Borderline	• Between Normal and Mild, or subthreshold	• Between Normal and Mild, or subthreshold
3. Mild	• Fairly infrequent distress OR • Brief duration of distress OR • Distress is slight	• Impairment is slight in 1 domain of functioning (e.g., taking longer to complete school tasks, occasional social avoidance) OR • Still generally able to meet obligations
4. Moderate	• Between Mild and Marked	• Between Mild and Marked
5. Marked	• Very frequent distress OR • Very long-lasting distress OR • Distress is substantial	• Impairment is significant in many domains of functioning (e.g., school, social, family life) OR • Some failure to meet role obligations (e.g., poor school performance, missing days of school) OR • Symptoms pose a minor risk of harm to self or others
6. Severe	• Between Marked and Extreme	• Between Marked and Extreme
7. Extreme	• Distress occurs constantly without relief OR • Distress is extremely intense or unbearable	• Impairment is extreme in most or all domains of functioning (e.g., completely unable to perform in school or engage in social interactions) OR • Patient is considered incapacitated OR • Symptoms pose a severe risk of harm to self or others OR • Acutely psychotic OR • In need of hospitalization or residential care

Optional Information: Generalized Anxiety Disorder (GAD)
Possible rule-outs (check if likely):

- ☐ Obsessive-compulsive disorder: GAD is typically characterized by excessive worry about upcoming problems. In OCD, obsessions take the form of intrusive and unwanted thoughts, urges, or images.
- ☐ Posttraumatic stress disorder: In PTSD, anxiety and worry are about trauma-related events or situations, whereas in GAD the worries are more general. If criteria for PTSD are met and the worries and physical symptoms can be explained by that diagnosis, PTSD but not GAD should be diagnosed.
- ☐ Adjustment disorder: Adjustment disorder is diagnosed only when criteria for GAD are not met, and the anxiety in adjustment disorder does not persist for more than 6 months after termination of the stressor or its consequences.
- ☐ Hyperthyroidism or hyperparathyroidism
- ☐ Pheochromocytoma
- ☐ CNS stimulant intoxication
- ☐ Cannabis intoxication
- ☐ CNS depressant withdrawal
- ☐ Psychotic and mood disorders: If anxiety, worry, and physical symptoms have occurred only during the course of a psychotic or mood disorder but are still sufficient to warrant clinical attention, then both the psychotic or mood disorder and GAD may be diagnosed.
- ☐ Social anxiety disorder: In GAD, worry is about a number of events or situations that are not limited to fears of being negatively evaluated by others.

Associated Features:

- ☐ Trembling, twitching, feeling shaky, or muscle aches due to muscle tension
- ☐ Somatic symptoms (e.g., sweating, nausea, diarrhea)
- ☐ Symptoms of autonomic hyperarousal (e.g., exaggerated startle response, tachycardia, shortness of breath, dizziness)
- ☐ Somatic disorders associated with stress (e.g., irritable bowel syndrome, headaches)

SPECIFIC PHOBIA

Best source: Child with or without parent, depending on age and developmental level

- **In the past month, are there certain objects, situations, or activities that you[8] are very afraid of?**
  - ⇨ What are you afraid of? _____
  - ⇨ Are you afraid of:
    - ☐ Animals? [Animals (e.g., spiders, insects, dogs, snakes)]
    - ☐ Situations like being up high, storms, or water? [Natural environment (e.g., heights, storms, water)]
    - ☐ Seeing blood, getting a shot, or seeing someone who is hurt? [Blood, injections, or injuries]
    - ☐ Situations like being in a plane, in an elevator, or in a small space? [Situations (e.g., flying, elevators, enclosed spaces)]
    - ☐ Other situations like choking, getting sick, loud sounds or people in costumes? [Other (e.g., choking or vomiting, loud sounds, costumed characters)] _____

1. Does the child report marked fear or anxiety about a specific object or situation?	*Yes*	*No* *Skip to item 8 and circle "No"*

- **In the past month, do you try really hard to stay away from (situation)?** _____
  - ⇨ What do you do to stay away from (situation)? _____
- **In the past month, if you can't stay away from (situation), do you feel really afraid or nervous?** _____
  - ☐ Object or situation is actively avoided
  - ☐ Object or situation is endured with intense anxiety

(Note: this criterion is met if at least one of the above is checked.)

2. Is the fear or anxiety avoided or endured with intense anxiety?	*Yes*	*No* *Skip to item 8 and circle "No"*

- **In the past month, how much does this problem bother or upset you?**
  - ⇨ How often do you feel upset?_____
  - ⇨ When you feel upset, how long does it last? _____
  - ⇨ How bad does it feel? _____
- **In the past month, does this problem make things harder for you, like make it hard to do well in school or at work, cause problems with your friends or family, or get in the way of doing fun or important things?**
  - ⇨ Are there things you don't do, or places you won't go, because of this problem? _____
  - ⇨ Does this problem make it hard to focus or concentrate? _____
  - ☐ Problems at school
  - ☐ Problems with work or role functioning
  - ☐ Problems with social life
  - ☐ Problems with family
  - ☐ Problems with home responsibilities
  - ☐ Problems with leisure activities
  - ☐ Legal problems
  - ☐ Problems of health or safety
  - ☐ Other functional impairment _____

[8] Or "your child;" continue as appropriate.

3. Does the fear or avoidance cause significant distress, or cause impairment in important areas of functioning?	*Yes*	*No* *Skip to item 8 and circle "No"*

4. Is the fear or anxiety out of proportion to the actual danger and sociocultural context?	*Yes*	*No* *Skip to item 8 and circle "No"*

💎 **In the past month, do you almost always feel scared when you (object or situation)?** _____

⇨ Are there times when you can (object or situation) and not feel scared? _____

💎 **In the past month, when (object or situation) scares you, does the fear come on right away?** _____

⇨ Are there times when the fear comes on much later? _____

☐ Object or situation almost always provokes fear or anxiety

☐ Phobic fear or anxiety is almost always immediate

(Note: this criterion is met if both of the above are checked.)

5. Does the feared object or situation almost always provoke immediate fear or anxiety?	*Yes*	*No* *Skip to item 8 and circle "No"*

💎 **How long has this been going on?** _____

6. Is the fear or avoidance persistent (typically defined as 6 months or more)?	*Yes*	*No* *Skip to item 8 and circle "No"*

7. Is the fear attributable to another mental disorder (see Optional Information)?	*No*	*Yes* *Skip to item 8 and circle "No"*

8. SPECIFIC PHOBIA	*Yes*	*No*

Current Severity of Specific Phobia (circle number):

	Distress	Impairment
1. Normal	• No distress at all or full remission	• No impairment at all or full remission
2. Borderline	• Between Normal and Mild, or subthreshold	• Between Normal and Mild, or subthreshold
3. Mild	• Fairly infrequent distress OR • Brief duration of distress OR • Distress is slight	• Impairment is slight in 1 domain of functioning (e.g., taking longer to complete school tasks, occasional social avoidance) OR • Still generally able to meet obligations
4. Moderate	• Between Mild and Marked	• Between Mild and Marked
5. Marked	• Very frequent distress OR • Very long-lasting distress OR • Distress is substantial	• Impairment is significant in many domains of functioning (e.g., school, social, family life) OR • Some failure to meet role obligations (e.g., poor school performance, missing days of school) OR • Symptoms pose a minor risk of harm to self or others
6. Severe	• Between Marked and Extreme	• Between Marked and Extreme
7. Extreme	• Distress occurs constantly without relief OR • Distress is extremely intense or unbearable	• Impairment is extreme in most or all domains of functioning (e.g., completely unable to perform in school or engage in social interactions) OR • Patient is considered incapacitated OR • Symptoms pose a severe risk of harm to self or others OR • Acutely psychotic OR • In need of hospitalization or residential care

Optional Information: Specific Phobia

Possible rule-outs (check if likely):

- ☐ Agoraphobia: Individuals with agoraphobia usually avoid more than one feared situation, and avoid these situations because of thoughts that escape would be difficult or that help might not be available in case of panic-like, incapacitating, or embarrassing symptoms.
- ☐ Social anxiety disorder: In social anxiety, situations are avoided due to fear of negative evaluation by others.
- ☐ Separation anxiety disorder: In separation anxiety, situations are feared because of concerns about being separated from an attachment figure.
- ☐ Panic disorder (PD): In specific phobia, panic attacks occur only in response to the feared object or situation, whereas in PD, panic attacks also occur unexpectedly.
- ☐ Obsessive-compulsive disorder (OCD): In OCD, fears of objects or situations are the result of obsessions, and are usually accompanied by compulsive behaviors or mental acts.
- ☐ Posttraumatic stress disorder (PTSD): In addition to fear and avoidance, PTSD is characterized by other symptoms such as emotional numbing and persistent hyperarousal.
- ☐ Eating disorders: In specific phobia, avoidance behavior is not limited to food and food-related cues and is not in response to fear of weight gain.
- ☐ Psychotic disorders: Fear and avoidance in specific phobia are not the result of delusional beliefs.

Associated Features:

- ☐ Increase in physiological arousal in anticipation of or during exposure to feared object or situation
- ☐ For blood-injection-injury subtype, vasovagal fainting or near-fainting

Specifiers:

- ☐ Animal type
- ☐ Blood-injection-injury type
- ☐ Other type _____
- ☐ Natural environment type
- ☐ Situational type

SEPARATION ANXIETY DISORDER

Best source: Child with or without parent, depending on age and developmental level

- **In the past month, are you[9] very afraid to be away from anyone?** _____
  - ⇨ Tell me about that fear. _____
  - ⇨ Who do you find it hard to be away from? _____
  - ⇨ What do you worry will happen if you are away from that person or people?_____
  - ⇨ Because you are afraid of being away from (person)…

- ☐ Do you often become very upset when you are away from (person), or if you think you're going to have to be away from (person)? [Recurrent excessive distress when experiencing or anticipating separation from home or attachment figure(s)]
- ☐ Do you often worry that you will lose (person) or that something bad will happen to him/her? [Persistent and excessive worry about losing attachment figure(s) or possible harm coming to them]
- ☐ Do you often worry that you'll get lost or kidnapped, or that something else will happen that takes you away from (person)? [Persistent and excessive worry about experiencing an aversive event (e.g., getting lost, being kidnapped) that causes separation from attachment figure(s)]
- ☐ Is it hard for you to go away from (person), like to go to school or work? [Persistent reluctance or refusal to go away from home, to school or work, or otherwise separate from attachment figure(s)]
- ☐ Is it hard for you to be alone, or without (person)? [Persistent and excessive fear of or reluctance to being alone or without attachment figure(s)]
- ☐ Is it hard for you to sleep alone, or to sleep away from home? [Persistent reluctance or refusal to sleep away from home or without attachment figure(s)]
- ☐ Do you often have bad dreams about something happening so you couldn't be with (person)? [Repeated nightmares about separation]
- ☐ Do you feel sick a lot, like have headaches or stomachaches, when you're away from (person) or when you are expecting to be away from him/her? [Repeated complaints about physical symptoms during or in anticipation of separation from attachment figure(s)]

(Note: this criterion is met if three or more of the above are present)

1. *Does the child report developmentally inappropriate, excessive fear or anxiety about separation from an attachment figure?*	*Yes*	*No* *Skip to item 5 and circle "No"*

2. *Is the fear attributable to another mental disorder (e.g., panic disorder, agoraphobia, generalized anxiety disorder, illness anxiety disorder, social anxiety disorder, obsessive-compulsive disorder, posttraumatic stress disorder)?*	*No*	*Yes* *Skip to item 5 and circle "No"*

- **In the past month, how much does this problem bother or upset you?**
  - ⇨ How often do you feel upset?_____
  - ⇨ When you feel upset, how long does it last? _____
  - ⇨ How bad does it feel? _____

[9] Or "your child;" continue as appropriate.

- **In the past month, does this problem make things harder for you, like make it hard to do well in school or at work, cause problems with your friends or family, or get in the way of doing fun or important things?**
  - ⇨ Are there things you don't do, or places you won't go, because of this problem? _____
  - ⇨ Does this problem make it hard to focus or concentrate? _____

☐ Problems at school
☐ Problems with work or role functioning
☐ Problems with social life
☐ Problems with family
☐ Problems with home responsibilities
☐ Problems with leisure activities
☐ Legal problems
☐ Problems of health or safety
☐ Other functional impairment _____

3. Does the fear or avoidance cause significant distress, or cause impairment in important areas of functioning?	*Yes*	*No* *Skip to item 5 and circle "No"*

- **How long has this been going on?** _____

4. Has the fear or avoidance lasted 4 weeks or more?	*Yes*	*No* *Skip to item 5 and circle "No"*

5. SEPARATION ANXIETY DISORDER	*Yes*	*No*

Current Severity of Separation Anxiety Disorder (circle number):

	Distress	Impairment
1. **Normal**	• No distress at all or full remission	• No impairment at all or full remission
2. **Borderline**	• Between Normal and Mild, or subthreshold	• Between Normal and Mild, or subthreshold
3. **Mild**	• Fairly infrequent distress OR • Brief duration of distress OR • Distress is slight	• Impairment is slight in 1 domain of functioning (e.g., taking longer to complete work tasks, occasional social avoidance) OR • Still generally able to meet obligations
4. **Moderate**	• Between Mild and Marked	• Between Mild and Marked
5. **Marked**	• Very frequent distress OR • Very long-lasting distress OR • Distress is substantial	• Impairment is significant in many domains of functioning (e.g., work, social, family life) OR • Some failure to meet role obligations (e.g., poor work performance, missing days of work) OR • Symptoms pose a minor risk of harm to self or others
6. **Severe**	• Between Marked and Extreme	• Between Marked and Extreme
7. **Extreme**	• Distress occurs constantly without relief OR • Distress is extremely intense or unbearable	• Impairment is extreme in most or all domains of functioning (e.g., completely unable to work or engage in social interactions) OR • Patient is considered incapacitated OR • Symptoms pose a severe risk of harm to self or others OR • Acutely psychotic OR • In need of hospitalization or residential care

Optional Information: Separation Anxiety Disorder (SAD)
Possible rule-outs (check if likely):

- ☐ Generalized anxiety disorder (GAD): SAD is not characterized by substantial worries other than separation from attachment figures.
- ☐ Panic disorder (PD): In PD, the primary fear is of being incapacitated by a panic attack, rather than separation from attachment figures.
- ☐ Agoraphobia: Individuals with SAD do not fear being in situations from which escape would be difficult in the event of panic-like symptoms.
- ☐ Social anxiety disorder: In social anxiety, school or work avoidance is due to fear of being judged negatively, rather than fear of separation from attachment figures.
- ☐ Posttraumatic stress disorder (PTSD): PTSD is primarily characterized by intrusive trauma memories and avoidance of trauma reminders, rather than fear of separation from attachment figures.
- ☐ Illness anxiety disorder: In illness anxiety disorder, the fear is primarily about the illness, rather than separation from attachment figures.
- ☐ Bereavement: Bereavement is characterized by yearning for, or preoccupation with, the deceased, rather than a fear of separation from attachment figures.
- ☐ Depression: Reluctance to leave home in depression is usually due to low motivation or energy, rather than fear of separation from attachment figures.
- ☐ Psychotic disorders: Unusual perceptual experiences in SAD are usually based on misperception of a stimulus, occur only in certain situations (e.g., night time), and cease in the presence of an attachment figure.
- ☐ Personality disorders: SAD is not characterized by an indiscriminate reliance on others (as in dependent personality disorder) or problems of identity, self-direction, interpersonal functioning, and impulsivity (as in borderline personality disorder).

Associated Features:

- ☐ Social withdrawal, apathy, sadness, or difficulty concentrating when separated from attachment figures
- ☐ Fears of animals, the dark, muggers, burglars, kidnappers, car accidents, plane travel, or other situations perceived as dangerous to the child or his/her family
- ☐ Homesick and uncomfortable to the point of misery when away from home
- ☐ Dependent on, or overprotective of, others (especially spouses or children)

MOOD DISORDERS

MANIC/HYPOMANIC EPISODE

Best source: Child with parent. Consider behavioral observations in addition to self-report.

- **Have you[10] ever had a time of at least four days when you felt so unusually happy or excited, like you were on top of the world, that it got you in trouble or people thought you weren't acting like you usually do?** _____
  - ⇨ Have you felt that way in the past month (current episode)? _____
- **Have you ever had a time of at least four days when you felt so good about yourself, or you felt so powerful or felt like taking on lots of new activities, that it got you in trouble or people thought you weren't acting like you usually do?** _____
  - ⇨ Have you felt that way in the past month (current episode)? _____
- **Have you ever had a time of at least four days when you felt so irritable or cranky that it got you in trouble or people thought you weren't acting like you usually do?** _____
  - ⇨ Have you felt that way in the past month (current episode)? _____
- **Can you tell me about the time when you felt really (happy/good about yourself/cranky)?**
  - ⇨ When did (it/they) start and end? _____
  - ⇨ Was that very different from how you are? _____
  - ⇨ Did you feel that way most of the day during that time? _____
  - ☐ Distinct period of abnormally and persistently elevated mood
  - ☐ Distinct period of abnormally and persistently expansive mood
  - ☐ Distinct period of abnormally and persistently irritable mood

(Note: continue only if at least one of the above is checked)

- **During any of those times, did you have a lot more energy than you usually do?** _____
- **During any of those times, did you do a lot more work, chores, projects, or other activity than you usually do?** _____
  - ⇨ Was that very different from how you usually are? _____
  - ⇨ Did you feel that way most of the day during that time? _____
  - ☐ Episode is accompanied by abnormally and persistently increased energy
  - ☐ Episode is accompanied by abnormally and persistently increased goal-directed activity

(Note: continue only if at least one of the above is checked)

1. Does the child report a distinct period of abnormally and persistently elevated, expansive, or irritable mood, and abnormally and persistently increased energy or goal-directed activity?	*Current episode*	*Yes*	*No* *Skip to items 7 and 8 and circle "No"*
	Past episode	*Yes*	*No* *Skip to items 7 and 8 and circle "No"*

(Note: query the current manic/hypomanic episode, if present, as well as the worst lifetime episode)

[10] Or "your child;" continue as appropriate.

- **Does/did this problem make things harder for you, like make it hard to do well in school or at work, cause problems with your friends or family, or get in the way of doing fun or important things?**
  - ☐ Problems at school
  - ☐ Problems with work or role functioning
  - ☐ Problems with social life
  - ☐ Problems with family
  - ☐ Problems with home responsibilities
  - ☐ Problems with leisure activities
  - ☐ Legal problems
  - ☐ Problems of health or safety
  - ☐ Other functional impairment _____

(Note: consider collateral reports and medical records in addition to interview responses)

- **Did you ever have to go to a hospital because of this?** _____
  - ⇨ Were you sent to the hospital in order to make sure that you didn't hurt yourself or others? _____
- **During this time, did you have any strange beliefs, like you had a special relationship with someone you didn't know or someone famous, that you had special powers, or that others were out to hurt you?** ____
- **During this time, did you hear things that others didn't seem to hear, like voices?** _____
  - ☐ Episode causes significant functional impairment
  - ☐ Episode necessitates hospitalization to prevent harm to self or others
  - ☐ Episode is accompanied by psychotic symptoms

(Note: this criterion is met if any of the above are checked)

2. Did the mood disturbance cause marked impairment in important areas of functioning, require hospitalization, or include psychotic features?	*Current episode*	*Yes*	*No* *Circle "No" for item 7 and continue to item 4*
	Past episode	*Yes*	*No* *Circle "No" for item 7 and continue to item 4*

- **Did you feel that way most of the day, nearly every day for at least 1 week?**
  - ☐ Symptoms were present most of the day, nearly every day for at least 1 week
  - ☐ Symptoms necessitated hospitalization

(Note: this criterion is met if at least one of the above is checked)

3. Did the episode last at least 1 week and was present for most of the day, nearly every day, or require hospitalization?	*Current episode*	*Yes* *Skip to item 5*	*No* *Circle "No" for item 7 and continue to item 4*
	Past episode	*Yes* *Skip to item 5*	*No* *Circle "No" for item 7 and continue to item 4*

- **Did you feel that way most of the day, nearly every day for at least 4 days in a row?** _____
  - ☐ Symptoms were present most of the day, nearly every day for at least 4 consecutive days
  - ☐ Symptoms did not necessitate hospitalization

(Note: this criterion is met if both of the above are checked)

4. Did the episode last at least 4 consecutive days and was present for most of the day, nearly every day, and did not require hospitalization?	*Current episode*	*Yes*	*No* *Skip to item 8 and circle "No"*
	Past episode	*Yes*	*No* *Skip to item 8 and circle "No"*

💎 **During this time, were there other changes, like…**

(Note: consider behavioral observations or collateral reports in addition to interview responses)

- ☐ Did you feel really great about yourself, like you had special powers, or were really important? [grandiose sense of self]
- ☐ Did you need a lot less sleep than normal—like feeling just fine even with very little sleep? [Decreased need for sleep]
- ☐ Were you more talkative than normal, or did you feel like you couldn't stop talking? [More talkative or pressured speech]
- ☐ Did it feel like your thoughts were racing, like you couldn't keep up with them? [Flight of ideas or racing thoughts]
- ☐ Were you easily distracted? [Distractibility]
- ☐ Did you do a lot more social activity, school or work activity, or sexual activity? Were you jittery, like you couldn't be still? [Increase in goal-directed activity or psychomotor agitation]
- ☐ Did you get really involved in activities that could turn out badly for you, like spending a lot of money or engaging in unsafe sexual behavior?[Excessive involvement in risky activities]

(Note: if the mood described in item 1 is only irritable, continue if at least 4 of the above are checked. If the mood described in item 1 includes elevated or expansive mood, continue if at least 3 of the above are checked)

💎 **Was that very different from how you usually are? _____**

💎 **Did anyone else ever say anything about the changes that they saw in you? Would someone else be able to tell that something was different about you? _____**

- ☐ The above symptoms represent a noticeable and unequivocal change from usual behavior
- ☐ The above symptoms were observed or observable by others

(Note: this criterion is met if both of the above are checked)

5. Does the child report at least 3 of the symptoms described above (4 if mood is only irritable) that present a noticeable change from baseline? Is the change in mood or behavior observable by others?	*Current episode*	*Yes*	*No* *Skip to items 7 and 8 and circle "No"*
	Past episode	*Yes*	*No* *Skip to items 7 and 8 and circle "No"*

💎 **Just before you started having this problem, did your doctor change any medicine you were taking, did you use any drugs, or did you have an illness or injury? _____**

- ⇨ Do you think this problem was caused by an illness, drugs, or changes in your medicine? _____
- ⇨ Have you or your parents talked to a medical doctor about this? _____

6. Is the mood disturbance attributable to the physiological effects of a substance or another medical condition? (If yes, complete applicable substance-induced or general medical condition module)	*Current episode*	*No Continue*	*Yes Continue*
	Past episode	*No Continue*	*Yes Continue*

7. MANIC EPISODE	*Current episode*	*Yes*	*No*
	Past episode	*Yes*	*No*

(Note: consider a hypomanic episode only if criteria for a manic episode are not met)

8. HYPOMANIC EPISODE	*Current episode*	*Yes*	*No*
	Past episode	*Yes*	*No*

PERSISTENT DEPRESSIVE DISORDER (DYSTHYMIA)

Best source: Child with or without parent, depending on age and developmental level
Administer if: There has never been a non-substance/medication-induced manic or hypomanic episode.

- **Have you[11] ever felt really sad or down most of the time for a whole year?** _____
- **Have you ever felt really grouchy or cranky most of the time for a whole year?** _____
  - ⇨ Tell me more about how you felt during that time. _____
- **Did you feel that way most of the day, most days, for at least a year?** _____
  - ⇨ When did these feelings start? _____
  - ⇨ Are you feeling that way now? If not, when did these feelings end? _____

1. *Does the child report depressed or irritable mood for most of the day, more days than not, for at least 1 year?*	*Current episode*	*Yes*	*No* *Skip to item 7 and circle "No"*
	Past episode	*Yes*	*No* *Skip to item 7 and circle "No"*

- ***(If querying a current episode)* Over the past year… *(If querying a past episode)* During the worst year of feeling sad or grouchy…**

(Note: consider behavioral observations or collateral reports in addition to interview responses)

- ☐ Did you eat a lot less? Did you eat too much? [Poor appetite or overeating]
- ☐ Did you have trouble falling asleep or staying asleep? Did you sleep a lot during the day? [Unable to fall asleep or stay asleep, or sleeping too much during the day]
- ☐ Did you feel really tired? [Fatigue or loss of energy]
- ☐ Did you feel really bad about yourself? [Low self-esteem]
- ☐ Was it hard for you to think, concentrate, or make decisions? [Poor concentration or difficulty making decisions]
- ☐ Did you feel hopeless, like things would never get better? [Feeling hopeless]

(Note: this criterion is met if at least 2 of the above symptoms are checked)

2. *Are at least two of the above symptoms endorsed during the period of depression?*	*Current episode*	*Yes*	*No* *Skip to item 7 and circle "No"*
	Past episode	*Yes*	*No* *Skip to item 7 and circle "No"*

- **How much does/did this problem bother or upset you?**
  - ⇨ How often do/did you feel upset? _____
  - ⇨ When you feel/felt upset, how long does/did it last? _____
  - ⇨ How bad does/did it feel? _____

[11] Or "your child;" continue as appropriate.

- **Does/did this problem make things harder for you, like make it hard to do well in school or at work, cause problems with your friends or family, or get in the way of doing fun or important things?**
  - ⇨ Are there things you don't do, or places you won't go, because of this problem? _____
  - ⇨ Does this problem make it hard to focus or concentrate? _____

☐ Problems at school
☐ Problems with family
☐ Legal problems
☐ Other functional impairment _____
☐ Problems with work or role functioning
☐ Problems with home responsibilities
☐ Problems with social life
☐ Problems with leisure activities
☐ Problems of health or safety

3. *Does the depression cause significant distress, or cause impairment in important areas of functioning?*	*Current episode*	*Yes*	*No* *Skip to item 7 and circle "No"*
	Past episode	*Yes*	*No* *Skip to item 7 and circle "No"*

- ***(If querying a current episode)*** **During the past year, was there ever a time when you didn't feel sad or grouchy, and you didn't have the kind of problems we just talked about? (symptoms from item 2)?** ____
  - ⇨ In the last year, what's the longest you have gone without feeling sad or grouchy and having the problems we just talked about (symptoms from item 2)? At least 2 months? _____

- ***(If querying a past episode)*** **During the worst year of feeling sad or grouchy, was there ever a time when you didn't feel sad or grouchy, and didn't have the problems we just talked about (symptoms from item 2)?** _____
  - ⇨ During the worst year of feeling sad or grouchy, what was the longest you went without feeling sad or grouchy and having the problems we just talked about? At least 2 months? _____

4. *During the 1-year period, has there been any period of 2 months or longer during which the child did not have depressed mood for most of the day, more days than not, and did not experience the symptoms from item 2?*	*Current episode*	*No*	*Yes* *Skip to item 7 and circle "No"*
	Past episode	*No*	*Yes* *Skip to item 7 and circle "No"*

5. *Is the depression better explained by a psychotic disorder (complete assessment at p. 123)?*	*Current episode*	*No*	*Yes* *Skip to item 7 and circle "No"*
	Past episode	*No*	*Yes* *Skip to item 7 and circle "No"*

- **Just before you started having this problem, did your doctor change any medicine you were taking, did you use any drugs, or did you have an illness or injury?** _____
  - ⇨ Do you think this problem was caused by an illness, drugs, or changes in your medicine? _____
  - ⇨ Have you or your parents talked to a medical doctor about this? _____

6. *Is the depression attributable to the physiological effects of a substance or another medical condition? (If yes, complete applicable substance-induced or general medical condition module)*	*Current episode*	*No*	*Yes* *Skip to item 7 and circle "No"*
	Past episode	*No*	*Yes* *Skip to item 7 and circle "No"*

7. **PERSISTENT DEPRESSIVE DISORDER (DYSTHYMIA)**	*Current episode*	*Yes*	*No*
	Past episode	*Yes*[12]	*No*

Current Severity of Persistent Depressive Disorder (Dysthymia) (circle number):

	Distress	Impairment
1. Normal	• No distress at all or full remission	• No impairment at all or full remission
2. Borderline	• Between Normal and Mild, or subthreshold	• Between Normal and Mild, or subthreshold
3. Mild	• Fairly infrequent distress OR • Brief duration of distress OR • Distress is slight	• Impairment is slight in 1 domain of functioning (e.g., taking longer to complete school tasks, occasional social avoidance) OR • Still generally able to meet obligations
4. Moderate	• Between Mild and Marked	• Between Mild and Marked
5. Marked	• Very frequent distress OR • Very long-lasting distress OR • Distress is substantial	• Impairment is significant in many domains of functioning (e.g., school, social, family life) OR • Some failure to meet role obligations (e.g., poor school performance, missing days of school) OR • Symptoms pose a minor risk of harm to self or others
6. Severe	• Between Marked and Extreme	• Between Marked and Extreme
7. Extreme	• Distress occurs constantly without relief OR • Distress is extremely intense or unbearable	• Impairment is extreme in most or all domains of functioning (e.g., completely unable to perform in school or engage in social interactions) OR • Patient is considered incapacitated OR • Symptoms pose a severe risk of harm to self or others OR • Acutely psychotic OR • In need of hospitalization or residential care

[12] If past but not current criteria are met, persistent depressive disorder should still be diagnosed with a remission specifier. Severity ratings should always be based on current symptoms.

Optional Information: Persistent Depressive Disorder (Dysthymia)

Possible rule-outs (check if likely):

- ☐ Major Depressive Disorder: If symptom criteria for a major depressive episode have been met at any time during the course of Persistent Depressive Disorder, PDD should be diagnosed and the appropriate specifier (see below) should be given.
- ☐ Psychotic disorders: Persistent Depressive Disorder should not be diagnosed if the symptoms occur only during the course or residual phases of a psychotic disorder.
- ☐ Substance-induced mood disorder or mood disorder due to another medical condition: Persistent Depressive Disorder should not be diagnosed if the symptoms are judged to be the pathophysiological result of a substance, medication, or medical illness.
- ☐ Personality disorders: If criteria for a personality disorder and Persistent Depressive Disorder are met, both diagnoses should be given.

Specifiers:

- ☐ Mild (few symptoms in excess of those required to meet diagnostic criteria, intensity is distressing but manageable, only minor impairment in functioning)
- ☐ Moderate (between mild and severe)
- ☐ Severe (number of symptoms much greater than those required to meet diagnostic criteria, intensity is seriously distressing and unmanageable, marked impairment in functioning)

- ☐ Early onset (onset before age 21)
- ☐ Late onset (onset age 21 or older)

- ☐ In partial remission (some symptoms are present but full criteria are not currently met, or a period of less than 2 months following an episode with no significant symptoms)
- ☐ In full remission (no significant symptoms for at least 2 months)

- ☐ With anxious distress
- ☐ With mixed features
- ☐ With melancholic features
- ☐ With atypical features
- ☐ With mood-congruent psychotic features
- ☐ With mood-incongruent psychotic features
- ☐ With peripartum onset

- ☐ With pure dysthymic syndrome (no major depressive episode in the past 2 years)
- ☐ With persistent major depressive episode (full criteria for a major depressive episode have been met throughout the past 2 years)
- ☐ With intermittent major depressive episodes, with current episode (currently meets full criteria for a major depressive episode, but there have been periods of at least 2 months within the past 2 years without meeting full criteria for a major depressive episode)
- ☐ With intermittent major depressive episodes, without current episode (does not currently meet full criteria for a major depressive episode, but has had at least one major depressive episode within the past 2 years)

MAJOR DEPRESSIVE EPISODE

Best source: Child with or without parent, depending on age and developmental level. Consider behavioral observations in addition to self-report.

- **Have you[13] ever had a time when you felt very sad, down, or depressed for at least two weeks—much worse than how you usually feel?** _____

- **Have you ever had a time when you felt very grouchy or cranky for at least two weeks—much worse than how you usually feel?** _____
  - ⇨ Have you felt that way in the past month (current episode)? _____
  - ⇨ *(If persistent depressive disorder has been diagnosed)* Was that much worse than how you usually feel?

- **What about a time when you didn't feel like doing anything, or nothing seemed fun?**
  - ⇨ Have you felt that way in the past month (current episode)? _____
  - ⇨ Tell me more about (that time/those times). _____
  - ⇨ When did (it/they) start and end? _____
  - ⇨ Was that very different from how you usually are? _____
  - ⇨ Did you feel that way all the time from _____ [the time the episode(s) started] to _____ [the time (it/they) ended]? _____
  - ⇨ Did you feel that way most of the day, nearly every day for at least 2 weeks?_____

☐ 2-week period of abnormally and persistently depressed or irritable mood
☐ 2-week period of abnormally and persistently decreased interest in activities or persistently diminished pleasure in activities

(Note: this criterion is satisfied if one or both of the above is checked).

1. Does the child report a 2-week-long or longer period of persistently depressed or irritable mood or loss of interest or pleasure in all or almost all activities that represents a change from usual functioning?	*Current episode*	*Yes*	*No* *Skip to item 5 and circle "No"*
	Past episode	*Yes*	*No* *Skip to item 5 and circle "No"*

- ⇨ How many times in your life have you felt really sad or grouchy for two weeks or more? _____

(Note: query the current depressive episode, if present, as well as the worst lifetime episode)

During the worst time you felt down or grouchy, or felt like nothing was fun, did you also…

- *(Note: consider behavioral observations or collateral reports in addition to interview responses)*

[13] Or "your child;" continue as appropriate.

☐ … eat a lot less or a lot more than usual? Did that happen almost every day? Did you stop gaining weight? [Significant weight loss (e.g., 5% of body weight in a month) when not dieting, significant weight gain (e.g., 5% of body weight in a month), failure to gain weight as expected, or decrease or increase in appetite nearly every day]

☐ … have trouble falling asleep or staying asleep? Did you sleep too much during the day? Was that almost every day? [Unable to fall asleep or stay asleep, of sleeping too much during the day, nearly every day]

☐ …feel restless or jumpy, like you couldn't keep still? Or did you move really slowly? Did anyone say that you seemed to be fidgety or that you were moving really slowly? Was that almost every day? [Being behaviorally restless or agitated, or slowed down, in a way that others could notice, nearly every day]

☐ … feel really tired? Was that almost every day? [Fatigue or loss of energy nearly every day]

☐ …feel like you were no good? Did you feel very guilty? What did you feel guilty about? Was that almost every day? [Feeling worthless or guilty nearly every day, not just feeling bad about being depressed]

☐ …have trouble thinking or concentrating? Was it hard to make decisions? Was that almost every day? [Decreased ability to think, concentrate, or make decisions, nearly every day]

☐ …think about death a lot? Did you think about hurting yourself or killing yourself? Did you ever plan to kill yourself or try to kill yourself? [Thinking about death a lot (not just fear of dying), thinking about suicide a lot, or making a plan or an attempt to commit suicide[14]]

⇨ Have you felt that way in the past month (current episode)? _____

(Note: this criterion is met if at least 5 of the symptoms from items 1 and 2, combined, are checked)

2. Does the child report at least 5 depressive symptoms, including any checked in item 1, during the same 2-week period?	*Current episode*	*Yes*	*No* *Skip to item 5 and circle "No"*
	Past episode	*Yes*	*No* *Skip to item 5 and circle "No"*

💎 **How much does/did this problem bother or upset you?**

⇨ How often do/did you feel upset?_____

⇨ When you feel/felt upset, how long does/did it last? _____

⇨ How bad does/did it feel? _____

💎 **Does/did this problem make things harder for you, like make it hard to do well in school or at work, cause problems with your friends or family, or get in the way of doing fun or important things?**

⇨ Are there things you don't do, or places you won't go, because of this problem? _____

⇨ Does this problem make it hard to focus or concentrate? _____

☐ Problems at school
☐ Problems with family
☐ Legal problems
☐ Other functional impairment _____
☐ Problems with work or role functioning
☐ Problems with home responsibilities
☐ Problems with social life
☐ Problems with leisure activities
☐ Problems of health or safety

[14] Complete the suicide screen on p. 146.

3. Do/did the symptoms cause significant distress or cause impairment in important areas of functioning?	*Current episode*	*Yes*	*No* *Skip to item 5 and circle "No"*
	Past episode	*Yes*	*No* *Skip to item 5 and circle "No"*

- **Just before you started having this problem, did your doctor change any medicine you were taking, did you use any drugs, or did you have an illness or injury?** _____
  - ⇨ Do you think this problem was caused by an illness, drugs, or changes in your medicine?[15] _____
  - ⇨ Have you or your parents talked to a medical doctor about this? _____

4. Is the mood disturbance attributable to the physiological effects of a substance or another medical condition? (If yes, complete applicable substance-induced or general medical condition module)	*Current episode*	*No*	*Yes* *Skip to item 5 and circle "No"*
	Past episode	*No*	*Yes* *Skip to item 5 and circle "No"*

5. MAJOR DEPRESSIVE EPISODE	*Current episode*	*Yes*	*No*
	Past episode	*Yes*	*No*

[15] A depressive episode that begins during or shortly after pregnancy does not rule out the diagnosis but does warrant a peripartum onset specifier.

BIPOLAR I DISORDER

Best source: Child with parent

1. *Is at least one current or past manic episode (see p. 37) endorsed?*	*Yes*	*No* *Skip to item 3 and circle "No"*

2. *Is the occurrence of the manic episode (and major depressive episode, if present) better explained by a psychotic disorder (complete assessment at p. 123)?*	*No*	*Yes* *Skip to item 3 and circle "No"*

3. **BIPOLAR I DISORDER**	*Yes*	*No*

- **In the past month, how much does this problem bother or upset you?**
  - ⇨ How often do you feel upset?_____
  - ⇨ When you feel upset, how long does it last? _____
  - ⇨ How bad does it feel? _____

- **In the past month, does this problem make things harder for you, like make it hard to do well in school or at work, cause problems with your friends or family, or get in the way of doing fun or important things?**
  - ⇨ Are there things you don't do, or places you won't go, because of this problem? _____
  - ⇨ Does this problem make it hard to focus or concentrate? _____

☐ Problems at school
☐ Problems with work or role functioning
☐ Problems with social life
☐ Problems with family
☐ Problems with home responsibilities
☐ Problems with leisure activities
☐ Legal problems
☐ Problems of health or safety
☐ Other functional impairment _____

Current Severity of Bipolar I Disorder (circle number):[16]

	Distress	Impairment
1. Normal	• No distress at all or full remission	• No impairment at all or full remission
2. Borderline	• Between Normal and Mild, or subthreshold	• Between Normal and Mild, or subthreshold
3. Mild	• Fairly infrequent distress OR • Brief duration of distress OR • Distress is slight	• Impairment is slight in 1 domain of functioning (e.g., taking longer to complete school tasks, occasional social avoidance) OR • Still generally able to meet obligations
4. Moderate	• Between Mild and Marked	• Between Mild and Marked
5. Marked	• Very frequent distress OR • Very long-lasting distress OR • Distress is substantial	• Impairment is significant in many domains of functioning (e.g., school, social, family life) OR • Some failure to meet role obligations (e.g., poor school performance, missing days of school) OR • Symptoms pose a minor risk of harm to self or others
6. Severe	• Between Marked and Extreme	• Between Marked and Extreme
7. Extreme	• Distress occurs constantly without relief OR • Distress is extremely intense or unbearable	• Impairment is extreme in most or all domains of functioning (e.g., completely unable to perform in school or engage in social interactions) OR • Patient is considered incapacitated OR • Symptoms pose a severe risk of harm to self or others OR • Acutely psychotic OR • In need of hospitalization or residential care

[16] Severity rating should be based on current distress and impairment related to this disorder, not the severity of previous episodes.

Optional Information: Bipolar I Disorder

Possible rule-outs (check if likely):

- ☐ Major depressive disorder: A diagnosis of Bipolar I disorder should be given if full criteria and duration for a manic episode are met.
- ☐ Anxiety disorders: Anxiety disorders are not characterized by episodes of elevated or expansive mood. Bipolar disorder is episodic, and symptoms are not limited to anxious rumination.
- ☐ Bipolar II disorder: A diagnosis of Bipolar I disorder should be given if full criteria for a manic episode are met.
- ☐ Personality disorders: Affective liability and impulsivity are usually chronic in personality disorders but episodic in bipolar disorder.
- ☐ Attention-deficit/hyperactivity disorder: Rapid speech and distractibility are usually chronic in ADHD but episodic in bipolar disorder.
- ☐ Substance/medication-induced bipolar and related disorder: A full manic episode that emerges during antidepressant treatment or during substance intoxication or withdrawal but persists at a fully syndromal level for approximately 1 month or more after discontinuation of the treatment, intoxication, or withdrawal, then bipolar I disorder rather than a substance/medication-induced bipolar and related disorder should be diagnosed.

Associated Features:

- ☐ Denial of illness or need for treatment during mania
- ☐ Change of appearance to be suggestive or flamboyant
- ☐ Hostility, threatening, or aggression during mania
- ☐ Perceived sharper senses during mania
- ☐ Gambling or antisocial behaviors during mania
- ☐ Rapid shifts of mood (e.g., mania, anger, depression)

Coding indicators:

☐ Single episode ☐ Recurrent episodes

☐ Most recent episode manic ☐ Most recent episode mixed ☐ Most recent episode depressed

- ☐ Mild (few symptoms in excess of those required for diagnosis, intensity is manageable, only minor impairment)
- ☐ Moderate (between mild and severe)
- ☐ Severe (number of symptoms much greater than those required for diagnosis, intensity is unmanageable, marked impairment)

- ☐ In partial remission (full criteria not currently met, or less than 2 months following an episode with no significant symptoms)
- ☐ In full remission (no significant symptoms for at least 2 months)

Specifiers:

- ☐ With anxious distress (at least 2 of feeling keyed up, restless, difficulty concentrating due to worry, fear something terrible might happen, worrying about losing control of self)
- ☐ With melancholic features (anhedonia or lack of reactivity to pleasurable stimuli, plus at least 3 of empty or despondent mood, worse depression in the morning, early-morning awakening, psychomotor agitation or retardation, anorexia/weight loss, guilt)
- ☐ With atypical features (mood reactivity plus at least 2 of increased appetite/weight gain, hypersomnia, heavy feeling, longstanding rejection sensitivity)
- ☐ With peripartum onset (onset during pregnancy or in the 4 weeks following delivery)
- ☐ With mixed features (during mania: at least 3 of depressed mood or affect, anhedonia, psychomotor retardation, fatigue, feelings of worthlessness or inappropriate guilt, recurrent thoughts of death)
- ☐ With seasonal pattern (regular onset/offset temporal pattern with particular times of year, no non-seasonal episodes within the past 2 years, lifetime seasonal episodes greatly outnumber non-seasonal episodes)
- ☐ With catatonia (at least 3 of stupor, catalepsy, waxy flexibility, mutism, negativism, posturing, odd mannerisms, stereotypy, agitation, grimacing, echolalia, echopraxia)
- ☐ With psychotic features (mood-congruent or mood-incongruent)
- ☐ With rapid cycling (at least 4 mood episodes in the previous 12 months)

BIPOLAR II DISORDER

Best source: Child with parent

(Note: if criteria for Bipolar I disorder are met, do not administer this module.)

1. *Is at least one current or past hypomanic episode (see p. 37) endorsed?*	*Yes*	*No* *Skip to item 3 and circle "No"*

2. *Is at least one current or past major depressive episode (see p. 44) endorsed?*	*Yes*	*No* *Skip to item 3 and circle "No"*

3. **BIPOLAR II DISORDER**	*Yes*	*No*

(Note: If there is a past but not current episode, query current severity as follows)

- **In the past month, how much does this problem bother or upset you?**
  - ⇨ How often do you feel upset?_____
  - ⇨ When you feel upset, how long does it last? _____
  - ⇨ How bad does it feel? _____

- **In the past month, does this problem make things harder for you, like make it hard to do well in school or at work, cause problems with your friends or family, or get in the way of doing fun or important things?**
  - ⇨ Are there things you don't do, or places you won't go, because of this problem? _____
  - ⇨ Does this problem make it hard to focus or concentrate? _____

☐ Problems at school
☐ Problems with work or role functioning
☐ Problems with social life
☐ Problems with family
☐ Problems with home responsibilities
☐ Problems with leisure activities
☐ Legal problems
☐ Problems of health or safety
☐ Other functional impairment _____

Current Severity of Bipolar II Disorder (circle number):[17]

	Distress	Impairment
1. Normal	• No distress at all or full remission	• No impairment at all or full remission
2. Borderline	• Between Normal and Mild, or subthreshold	• Between Normal and Mild, or subthreshold
3. Mild	• Fairly infrequent distress OR • Brief duration of distress OR • Distress is slight	• Impairment is slight in 1 domain of functioning (e.g., taking longer to complete school tasks, occasional social avoidance) OR • Still generally able to meet obligations
4. Moderate	• Between Mild and Marked	• Between Mild and Marked
5. Marked	• Very frequent distress OR • Very long-lasting distress OR • Distress is substantial	• Impairment is significant in many domains of functioning (e.g., school, social, family life) OR • Some failure to meet role obligations (e.g., poor school performance, missing days of school) OR • Symptoms pose a minor risk of harm to self or others
6. Severe	• Between Marked and Extreme	• Between Marked and Extreme
7. Extreme	• Distress occurs constantly without relief OR • Distress is extremely intense or unbearable	• Impairment is extreme in most or all domains of functioning (e.g., completely unable to perform in school or engage in social interactions) OR • Patient is considered incapacitated OR • Symptoms pose a severe risk of harm to self or others OR • Acutely psychotic OR • In need of hospitalization or residential care

[17] Severity rating should be based on current distress and impairment related to this disorder, not the severity of previous episodes.

Optional Information: Bipolar II Disorder

Possible rule-outs (check if likely):

- ☐ Major depressive disorder: A diagnosis of Bipolar II disorder should be given if full criteria and duration for a hypomanic episode are met.
- ☐ Anxiety disorders: Anxiety disorders are not characterized by episodes of elevated or expansive mood. Bipolar disorder is episodic, and symptoms are not limited to anxious rumination.
- ☐ Bipolar I disorder: A diagnosis of Bipolar I disorder should be given if full criteria for a manic episode are met.
- ☐ Personality disorders: Affective liability and impulsivity are usually chronic in personality disorders but episodic in bipolar disorder.
- ☐ Attention-deficit/hyperactivity disorder: Rapid speech and distractibility are usually chronic in ADHD but episodic in bipolar disorder.
- ☐ Substance/medication-induced bipolar and related disorder: A full hypomanic episode that emerges during antidepressant treatment or during substance intoxication or withdrawal but persists at a fully syndromal level for approximately 1 month or more after discontinuation of the treatment, intoxication, or withdrawal, then bipolar II disorder rather than a substance/medication-induced bipolar and related disorder should be diagnosed.

Associated Features:

- ☐ Impulsivity, possibly leading to suicide attempts or substance use during hypomania
- ☐ Heightened levels of creativity during hypomania

Coding indicators:

- ☐ Single episode
- ☐ Recurrent episodes
- ☐ Most recent episode hypomanic
- ☐ Most recent episode mixed
- ☐ Most recent episode depressed
- ☐ Mild (few symptoms in excess of those required for diagnosis, intensity is manageable, only minor impairment)
- ☐ Moderate (between mild and severe)
- ☐ Severe (number of symptoms much greater than those required for diagnosis, intensity is unmanageable, marked impairment)
- ☐ In partial remission (full criteria not currently met, or less than 2 months following an episode with no significant symptoms)
- ☐ In full remission (no significant symptoms for at least 2 months)

Specifiers:

- ☐ With anxious distress (at least 2 of feeling keyed up, restless, difficulty concentrating due to worry, fear something terrible might happen, worrying about losing control of self)
- ☐ With mixed features (during hypomania: at least 3 of depressed mood or affect, anhedonia, psychomotor retardation, fatigue, feelings of worthlessness or inappropriate guilt, recurrent thoughts of death)
- ☐ With seasonal pattern (regular onset/offset temporal pattern with particular times of year, no non-seasonal episodes within the past 2 years, lifetime seasonal episodes greatly outnumber non-seasonal episodes)
- ☐ With catatonia (at least 3 of stupor, catalepsy, waxy flexibility, mutism, negativism, posturing, odd mannerisms, stereotypy, agitation, grimacing, echolalia, echopraxia)
- ☐ With peripartum onset (onset during pregnancy or in the 4 weeks following delivery)
- ☐ With psychotic features (mood-congruent or mood-incongruent, occurring during depression only)
- ☐ With melancholic features (anhedonia or lack of reactivity to pleasurable stimuli, plus at least 3 of empty or despondent mood, worse depression in the morning, early-morning awakening, psychomotor agitation or retardation, anorexia/weight loss, guilt)
- ☐ With rapid cycling (at least 4 mood episodes in the previous 12 months)
- ☐ With atypical features (mood reactivity plus at least 2 of increased appetite/weight gain, hypersomnia, heavy feeling, longstanding interpersonal rejection sensitivity)

MAJOR DEPRESSIVE DISORDER

Best source: Child with or without parent, depending on age and developmental level
Administer if: the child does not meet criteria for Bipolar I Disorder or Bipolar II Disorder

1. *Is at least one current or past major depressive episode (see p. 44) endorsed?*	*Yes*	*No* *Skip to item 4 and circle "No"*

2. *Is the major depressive episode better explained by a psychotic disorder (complete assessment at p. 123)?*	*No*	*Yes* *Skip to item 4 and circle "No"*

3. *Has there ever been a manic or hypomanic episode (see p. 37)?*[18]	*No*	*Yes* *Skip to item 4 and circle "No"*

4. **MAJOR DEPRESSIVE DISORDER**	*Yes*	*No*

(Note: If there is a past but not current episode, query current severity as follows)

- **In the past month, how much does this problem bother or upset you?**
  - ⇨ How often do you feel upset?_____
  - ⇨ When you feel upset, how long does it last? _____
  - ⇨ How bad does it feel? _____

- **In the past month, does this problem make things harder for you, like make it hard to do well in school or at work, cause problems with your friends or family, or get in the way of doing fun or important things?**
  - ⇨ Are there things you don't do, or places you won't go, because of this problem? _____
  - ⇨ Does this problem make it hard to focus or concentrate? _____

☐ Problems at school
☐ Problems with family
☐ Legal problems
☐ Other functional impairment _____
☐ Problems with work or role functioning
☐ Problems with home responsibilities
☐ Problems with social life
☐ Problems with leisure activities
☐ Problems of health or safety

[18] The presence of a clearly substance-induced manic episode does not preclude the diagnosis of major depressive disorder.

Current Severity of Major Depressive Disorder (circle number):[19]

	Distress	Impairment
1. Normal	• No distress at all or full remission	• No impairment at all or full remission
2. Borderline	• Between Normal and Mild, or subthreshold	• Between Normal and Mild, or subthreshold
3. Mild	• Fairly infrequent distress OR • Brief duration of distress OR • Distress is slight	• Impairment is slight in 1 domain of functioning (e.g., taking longer to complete school tasks, occasional social avoidance) OR • Still generally able to meet obligations
4. Moderate	• Between Mild and Marked	• Between Mild and Marked
5. Marked	• Very frequent distress OR • Very long-lasting distress OR • Distress is substantial	• Impairment is significant in many domains of functioning (e.g., school, social, family life) OR • Some failure to meet role obligations (e.g., poor school performance, missing days of school) OR • Symptoms pose a minor risk of harm to self or others
6. Severe	• Between Marked and Extreme	• Between Marked and Extreme
7. Extreme	• Distress occurs constantly without relief OR • Distress is extremely intense or unbearable	• Impairment is extreme in most or all domains of functioning (e.g., completely unable to perform in school or engage in social interactions) OR • Patient is considered incapacitated OR • Symptoms pose a severe risk of harm to self or others OR • Acutely psychotic OR • In need of hospitalization or residential care

[19] Severity rating should be based on current distress and impairment related to this disorder, not the severity of previous episodes.

Optional Information: Major Depressive Disorder (MDD)

Possible rule-outs (check if likely):

- ☐ Manic episodes with irritable mood: If criteria for a manic or hypomanic episode are met, bipolar disorder rather than MDD should be diagnosed.
- ☐ Attention-deficit/hyperactivity disorder: ADHD and MDD may both include distractibility and poor frustration tolerance, and can co-occur if criteria for both disorders are met.
- ☐ Persistent Depressive Disorder: If symptom criteria for a major depressive episode have been met at any time during the course of Persistent Depressive Disorder, PDD should be diagnosed and the appropriate specifier should be given.
- ☐ Adjustment disorder with depressed mood: MDD can occur in response to a psychosocial stressor, but in adjustment disorder, full criteria for a major depressive episode are not met.
- ☐ Normative sadness: Periods of sad mood should not be diagnosed as major depressive episodes unless they meet criteria for severity, duration, and distress or impairment.

Associated Features:

- ☐ Tearful or irritable affect
- ☐ Brooding or obsessive rumination
- ☐ Anxiety, phobias, or health worries
- ☐ Complaints of pain

Coding indicators:

- ☐ Single episode
- ☐ Recurrent episodes

- ☐ Mild (few symptoms in excess of those required for diagnosis, intensity is manageable, only minor impairment in functioning)
- ☐ Moderate (between mild and severe)
- ☐ Severe (number of symptoms much greater than those required for diagnosis, intensity is unmanageable, marked impairment in functioning)

- ☐ In partial remission (some symptoms are present but full criteria are not currently met, or a period of less than 2 months following an episode with no significant symptoms)
- ☐ In full remission (no significant symptoms for at least 2 months)

Specifiers:

- ☐ With anxious distress (at least 2 of feeling keyed up, restless, difficulty concentrating due to worry, fear something terrible might happen, worrying about losing control of self)
- ☐ With melancholic features (anhedonia or lack of reactivity to pleasurable stimuli, plus at least 3 of empty or despondent mood, worse depression in the morning, early-morning awakening, psychomotor agitation or retardation, anorexia/weight loss, guilt)
- ☐ With atypical features (mood reactivity plus at least 2 of increased appetite/weight gain, hypersomnia, heavy feeling, longstanding interpersonal rejection sensitivity)
- ☐ With peripartum onset (onset during pregnancy or in the 4 weeks following delivery)
- ☐ With mixed features (at least 3 of elevated mood, inflated self-esteem or grandiosity, pressured speech, increase in energy or goal-directed activity, impulsive behavior, decreased need for sleep)
- ☐ With catatonia (at least 3 of stupor, catalepsy, waxy flexibility, mutism, negativism, posturing, odd mannerisms, stereotypy, agitation, grimacing, echolalia, echopraxia)
- ☐ With seasonal pattern (regular onset/offset temporal pattern with particular times of year, no non-seasonal episodes within the past 2 years, lifetime seasonal episodes greatly outnumber non-seasonal episodes)
- ☐ With psychotic features (mood-congruent or mood-incongruent)

CYCLOTHYMIC DISORDER

Best source: Child with parent

Administer if: the child reports significant depressive and manic/hypomanic symptoms, and the child does not meet lifetime criteria for a major depressive, manic, or hypomanic episode

- **Over the past year, how many times have you[20] had (*manic/hypomanic symptoms, see p. 37*)? _____**
- **How many times have you had (*depressive symptoms, see p. 44*)? _____**

1. *Does the child report numerous periods with hypomanic symptoms and numerous periods with depressive symptoms that have never met criteria for hypomanic or major depressive episode over the past year or more?*	*Yes*	*No* *Skip to item 5 and circle "No"*

- **Over the past year, have you had (*manic/hypomanic symptoms*) at least half of the time? _____**
- **Over the past year, have you had (*depressive symptoms*) at least half of the time? _____**

☐ Mood symptoms have been present for at least half of the time

(Note: Continue if the above is checked.)

- **Over the past year, was there a time when you did not have any of (*manic/hypomanic and depressive symptoms*) for 2 months or more? _____**

☐ Mood symptoms have not remitted for more than 2 months in the past year

(Note: This criterion is met if the above is checked.)

2. *Does the child report over the past year mood symptoms that have been present at least half the time and have not remitted for more than 2 months at a time?*	*Yes*	*No* *Skip to item 5 and circle "No"*

3. *Are the symptoms better explained by a psychotic disorder (complete assessment at p. 123)?*	*No*	*Yes* *Skip to item 5 and circle "No"*

- **Just before you started having this problem, did your doctor change any medicine you were taking, did you use any drugs, or did you have an illness or injury? _____**
  - ⇨ Do you think this problem was caused by an illness, drugs, or changes in your medicine? _____
  - ⇨ Have you or your parents talked to a medical doctor about this? _____

4. *Are the symptoms attributable to the physiological effects of a substance or another medical condition? (If yes, complete applicable substance-induced or general medical condition module)*	*No*	*Yes* *Skip to item 5 and circle "No"*

5. **CYCLOTHYMIC DISORDER**	*Yes*	*No*

[20] Or "your child;" continue as appropriate.

(Note: If there is a past but not current episode, query current severity as follows)

- **In the past month, how much does this problem bother or upset you?**
  - ⇨ How often do you feel upset?_____
  - ⇨ When you feel upset, how long does it last? _____
  - ⇨ How bad does it feel? _____

- **In the past month, does this problem make things harder for you, like make it hard to do well in school or at work, cause problems with your friends or family, or get in the way of doing fun or important things?**
  - ⇨ Are there things you don't do, or places you won't go, because of this problem? _____
  - ⇨ Does this problem make it hard to focus or concentrate? _____

☐ Problems at school
☐ Problems with family
☐ Legal problems
☐ Other functional impairment _____
☐ Problems with work or role functioning
☐ Problems with home responsibilities
☐ Problems with social life
☐ Problems with leisure activities
☐ Problems of health or safety

Current Severity of Cyclothymic Disorder (circle number):[21]

	Distress	Impairment
1. Normal	• No distress at all or full remission	• No impairment at all or full remission
2. Borderline	• Between Normal and Mild, or subthreshold	• Between Normal and Mild, or subthreshold
3. Mild	• Fairly infrequent distress OR • Brief duration of distress OR • Distress is slight	• Impairment is slight in 1 domain of functioning (e.g., taking longer to complete school tasks, occasional social avoidance) OR • Still generally able to meet obligations
4. Moderate	• Between Mild and Marked	• Between Mild and Marked
5. Marked	• Very frequent distress OR • Very long-lasting distress OR • Distress is substantial	• Impairment is significant in many domains of functioning (e.g., school, social, family life) OR • Some failure to meet role obligations (e.g., poor school performance, missing days of school) OR • Symptoms pose a minor risk of harm to self or others
6. Severe	• Between Marked and Extreme	• Between Marked and Extreme
7. Extreme	• Distress occurs constantly without relief OR • Distress is extremely intense or unbearable	• Impairment is extreme in most or all domains of functioning (e.g., completely unable to perform in school or engage in social interactions) OR • Patient is considered incapacitated OR • Symptoms pose a severe risk of harm to self or others OR • Acutely psychotic OR • In need of hospitalization or residential care

[21] Severity rating should be based on current distress and impairment related to this disorder, not the severity of previous episodes.

Optional Information: Cyclothymic Disorder

Possible rule-outs (check if likely):

- ☐ Substance-induced mood disorder or mood disorder due to another medical condition: Cyclothymic Disorder should not be diagnosed if the symptoms are judged to be the pathophysiological result of a substance, medication, or medical illness.
- ☐ Bipolar I Disorder or Bipolar II Disorder with Rapid Cycling: In Cyclothymic Disorder, the criteria for a major depressive, manic, or hypomanic episode have never been met.
- ☐ Borderline Personality Disorder: If criteria are met for both BPD and Cyclothymic Disorder, both diagnoses should be given.

Coding indicators:

- ☐ Single episode
- ☐ Recurrent episodes

- ☐ Most recent episode hypomanic
- ☐ Most recent episode mixed
- ☐ Most recent episode depressed

- ☐ Mild (few symptoms in excess of those required for diagnosis, intensity is manageable, only minor impairment)
- ☐ Moderate (between mild and severe)
- ☐ Severe (number of symptoms much greater than those required for diagnosis, intensity is unmanageable, marked impairment)

- ☐ In partial remission (full criteria not currently met, or less than 2 months following an episode with no significant symptoms)
- ☐ In full remission (no significant symptoms for at least 2 months)

Specifiers:

- ☐ With anxious distress (at least 2 of feeling keyed up, restless, difficulty concentrating due to worry, fear something terrible might happen, worrying about losing control of self)

DISRUPTIVE MOOD DYSREGULATION DISORDER

Best source: Child with parent. Consider behavioral observations in addition to self-report.
Administer if: The child has never had a manic or hypomanic episode, or a distinct period lasting longer than one day in which he/she met full criteria (other than duration) for a manic or hypomanic episode

- **In the past month, have you[22] had really bad temper outbursts?**
  - ⇨ What do you do during these outbursts? _____
  - ⇨ Do you yell or scream at other people? _____
  - ⇨ Do you end up hurting other people or yourself? Do you break things or throw things? _____
  - ⇨ When do you have these temper outbursts? What are they usually in response to? _____
  - ⇨ How long do the temper outbursts last? _____
  - ⇨ How often do you have these temper outbursts? _____
    - ☐ Temper outbursts manifested verbally or physically
    - ☐ Temper outbursts are grossly out of proportion in intensity or duration to situation or provocation
    - ☐ Temper outbursts are inconsistent with developmental age
    - ☐ Temper outburst occur three or more times per week

(Note: continue only if all four of the above are checked)

1. Does the child have severe temper outbursts, at least three times per week on average, that are out of proportion to the provoking situation and inconsistent with developmental age?	*Yes*	*No* *Skip to item 8 and circle "No"*

- **What is your mood usually like when you are not having a temper outburst?** _____
  - ⇨ **Are you often grumpy, grouchy, or angry?**_____
  - ⇨ **How much of the time are you grumpy, grouchy, or angry?** _____
  - ⇨ **Is it noticeable to other people?** _____
    - ☐ Persistently irritable or angry, most of the day, nearly every day
    - ☐ Angry/irritable mood is observed by others (e.g., parents, teachers, peers)

(Note: Continue only if both of the above are checked)

2. Does the child exhibit persistently irritable or angry mood most of the day, nearly every day that is observable by others?	*Yes*	*No* *Skip to item 8 and circle "No"*

- **How long have you been having these temper outbursts and feeling grumpy, grouchy, or angry?** _____

3. Have the symptoms been present and met full criteria as described in 1 & 2 for at least 12 months?	*Yes*	*No* *Skip to item 8 and circle "No"*

- **During the past year, was there ever a long time when you didn't feel grumpy, grouchy, or angry, and didn't have significant temper outbursts?** _____
  - ⇨ In the last year, what's the longest you have gone without feeling grumpy, grouchy, or angry and having temper outbursts? _____

[22] Or "your child;" continue as appropriate.

⇨ Did that period when you felt ok last at least 3 months? _____

8. *During the past year, has there been any period of 3 months or longer during which the child did not have irritable mood for most of the day, nearly every day, and did not exhibit temper outbursts?*	*Current episode*	*No*	*Yes* *Skip to item 8 and circle "No"*

- **Where do you have these temper outbursts or grumpy, grouchy, or angry mood?** _____
  - ⇨ Do they happen at home, at school, with friends? _____
  - ⇨ How bad does it get at _____ (at home, at school, with friends)? _____
    - ☐ Temper outbursts and irritable mood are present in at least two settings (i.e. at home, at school, with peers).
    - ☐ Temper outbursts and irritable mood are severe in at least one setting.

(Note: Continue only if both of the above are checked)

4. *Are the temper outbursts and irritable mood are present in at least two settings, and severe in at least one setting?*	*Yes*	*No* *Skip to item 8 and circle "No"*

- **When did these problems start?** _____
  - ⇨ Have these problems been present since you were younger than 10 years old? _____

5. *Did symptoms begin before age 10?*	*Yes*	*No* *Skip to item 8 and circle "No"*

- **Just before you started having this problem, did your doctor change any medicine you were taking, did you use any drugs, or did you have an illness or injury?** _____
  - ⇨ Do you think this problem was caused by an illness, drugs, or changes in your medicine? _____
  - ⇨ Have you or your parents talked to a medical doctor about this? _____

6. *Is the mood disturbance attributable to the physiological effects of a substance, another medical condition, or another mental disorder? (See optional information; If yes, complete applicable substance-induced or general medical condition module).*	*No*	*Yes* *Skip to item 8 and circle "No"*

7. *Do the symptoms occur exclusively during an episode of major depressive disorder (see p. 51)?*	*No*	*Yes* *Skip to item 8 and circle "No"*

8. DISRUPTIVE MOOD DYSREGULATION DISORDER	*Yes*	*No*

- **In the past month, how much does this problem bother or upset you?**
  - ⇨ How often do you feel upset?_____
  - ⇨ When you feel upset, how long does it last? _____
  - ⇨ How bad does it feel? _____

- **In the past month, does this problem make things harder for you, like make it hard to do well in school or at work, cause problems with your friends or family, or get in the way of doing fun or important things?**

☐ Problems at school
☐ Problems with work or role functioning
☐ Problems with social life
☐ Problems with family
☐ Problems with home responsibilities
☐ Problems with leisure activities
☐ Legal problems
☐ Problems of health or safety
☐ Other functional impairment _____

Current Severity of Disruptive Mood Dysregulation Disorder (circle number):

	Distress	Impairment
1. Normal	• No distress at all or full remission	• No impairment at all or full remission
2. Borderline	• Between Normal and Mild, or subthreshold	• Between Normal and Mild, or subthreshold
3. Mild	• Fairly infrequent distress OR • Brief duration of distress OR • Distress is slight	• Impairment is slight in 1 domain of functioning (e.g., taking longer to complete school tasks, occasional social avoidance) OR • Still generally able to meet obligations
4. Moderate	• Between Mild and Marked	• Between Mild and Marked
5. Marked	• Very frequent distress OR • Very long-lasting distress OR • Distress is substantial	• Impairment is significant in many domains of functioning (e.g., school, social, family life) OR • Some failure to meet role obligations (e.g., poor school performance, missing days of school) OR • Symptoms pose a minor risk of harm to self or others
6. Severe	• Between Marked and Extreme	• Between Marked and Extreme
7. Extreme	• Distress occurs constantly without relief OR • Distress is extremely intense or unbearable	• Impairment is extreme in most or all domains of functioning (e.g., completely unable to perform in school or engage in social interactions) OR • Patient is considered incapacitated OR • Symptoms pose a severe risk of harm to self or others OR • Acutely psychotic OR • In need of hospitalization or residential care

Optional Information: Disruptive Mood Dysregulation Disorder

Possible rule-outs (check if likely):

- ☐ Bipolar disorders: Bipolar disorders are characterized by distinct episodes that are different from the child's usual presentation. Bipolar disorder also features elevated or expansive mood or grandiosity which is not characteristic of disruptive mood dysregulation disorder.
- ☐ Major depressive disorder/persistent depressive disorder: Disruptive mood dysregulation disorder should not be diagnosed if irritability is present only during the course of MDD, can be better explained by persistent depressive disorder.
- ☐ Autism Spectrum Disorder: Disruptive mood dysregulation disorder should not be diagnosed if temper outbursts are secondary to autism spectrum disorder (e.g., tantrum in response to changes in routine).
- ☐ Oppositional defiant disorder: Children with disruptive mood dysregulation disorder display severe and frequent temper outbursts and persistent mood disruption between outbursts, not solely oppositional behaviors. If criteria for disruptive mood dysregulation disorder are met, a diagnosis of oppositional defiant disorder cannot be made.
- ☐ Anxiety Disorder: Disruptive mood dysregulation disorder should not be diagnosed if irritability is present only in an anxiety provoking context.
- ☐ Intermittent explosive disorder: Children with intermittent explosive disorder do not exhibit persistent mood disruption (i.e., irritability) in between temper outbursts. Intermittent explosive disorder requires only a three month period of symptoms. If a child meets criteria for disruptive mood dysregulation disorder, a diagnosis of intermittent explosive disorder should not be made.

PREMENSTRUAL DYSPHORIC DISORDER

Best source: Child with or without parent, depending on age and developmental level. For a definitive diagnosis, DSM-5 specifies that the symptoms in this criterion are confirmed by daily prospective ratings of mood during at least 2 menstrual cycles.
Administer if applicable.

- **Do you[23] get really depressed, irritable, anxious, or have mood swings in the week prior to menstruation (your period)?** _____
  - ⇨ What kind of things do you experience? _____
  - ☐ Do you have mood swings, get suddenly sad or tearful, or feel especially sensitive to rejection? [Marked affective lability]
  - ☐ Do you get very irritable or angry, or get into arguments? [Marked irritability, anger, or increased interpersonal conflicts]
  - ☐ Do you feel very depressed, hopeless, or bad about yourself? [Marked depressed mood, feeling hopeless, or self-deprecating thoughts]
  - ☐ Do you feel very anxious, tense, keyed up, or on edge? [Marked anxiety or tension]

(Note: continue if at least 1 of the above symptoms is checked)

1. *Does the child report marked depression, irritability, mood swings, or anxiety that begins the week prior to menses?*	*Yes*	*No* *Skip to item 7 and circle "No"*

- **Have you felt this way for most of your menstrual cycles over the past year?** _____
- **When, in relation to your menstrual cycle, do the mood problems start and stop?** _____
  - ⇨ Do these symptoms begin within the week before you start your period? _____
  - ⇨ Do these symptoms start to get better within a few days after you start your period? _____
  - ⇨ Do these symptoms go away or become minimal within the week after your period ends? _____

☐ Symptoms are present in the majority of menstrual cycles
☐ Symptoms are present in the final week before the start of menses
☐ Symptoms start to improve within a few days after the start of menses
☐ Symptoms become absent or minimal in the week after menses

(Note: this criterion is met if all 4 of the above are checked)

2. *Does the mood disturbance occur in the majority of menstrual cycles, begin within the week prior to menses, start to improve within a few days after the onset of menses, and become minimal or absent in the week post-menses?*	*Yes*	*No* *Skip to item 7 and circle "No"*

- **Around the time of menstruation (your period), do you also commonly experience any of the following concerns?**

(Note: consider behavioral observations or collateral reports in addition to interview responses)

[23] Or "your child;" continue as appropriate.

- ☐ Do you lose interest in most of your usual activities, such as work, school, friends, or hobbies? [Losing interest in all or almost all usual activities]
- ☐ Is it hard for you to concentrate? [Decreased ability to concentrate]
- ☐ Do you feel tired, or have low energy? [Fatigue or loss of energy]
- ☐ Do you notice a change in your appetite or your eating? [Marked change in appetite, overeating, or food cravings]
- ☐ Do you have trouble sleeping? Do you sleep too much during the day? [Unable to fall asleep or stay asleep, of sleeping too much during the day]
- ☐ Do you feel overwhelmed? Do you feel out of control? [Feeling overwhelmed or out of control]
- ☐ Do you have physical symptoms, like tenderness or bloating? Do you have joint or muscle pain? Does your weight go up? [Physical symptoms (e.g., breast tenderness or swelling, joint or muscle pain, feeling bloated, or weight gain)]

(Note: this criterion is met if at least 5 of the symptoms from items 1 and 3, combined, are checked)

3. *Does the child report at least 5 depressive symptoms, including any checked in item 1, during the same 2-week period?*	*Yes*	*No* *Skip to item 7 and circle "No"*

(Note: consider all diagnostic information and course to determine whether the disturbance reflects an exacerbation of another psychiatric disorder.)

- **In the past month, how much does this problem bother or upset you?**
  - ⇨ How often do you feel upset? _____
  - ⇨ When you feel upset, how long does it last? _____
  - ⇨ How bad does it feel? _____

- **In the past month, does this problem make things harder for you, like make it hard to do well in school or at work, cause problems with your friends or family, or get in the way of doing fun or important things?**
  - ⇨ Are there things you don't do, or places you won't go, because of this problem? _____
  - ⇨ Does this problem make it hard to focus or concentrate? _____

☐ Problems at school
☐ Problems with family
☐ Legal problems
☐ Other functional impairment _____
☐ Problems with work or role functioning
☐ Problems with home responsibilities
☐ Problems with social life
☐ Problems with leisure activities
☐ Problems of health or safety

4. *Do the symptoms cause significant distress, or cause impairment in important areas of functioning?*	*Yes*	*No* *Skip to item 7 and circle "No"*

5. *Is the disturbance merely an exacerbation of symptoms of another disorder?*	*No*	*Yes* *Skip to item 7 and circle "No"*

- **Just before you started having this problem, did your doctor change any medicine you were taking, did you use any drugs, or did you have an illness or injury?** _____
  - ⇨ Do you think this problem was caused by an illness, drugs, or changes in your medicine? _____
  - ⇨ Have you or your parents talked to a medical doctor about this? _____

6. *Is the depression attributable to the physiological effects of a substance or another medical condition? (If yes, complete applicable substance-induced or general medical condition module)*	*No*	*Yes* *Skip to item 7 and circle "No"*

7. **PREMENSTRUAL DYSPHORIC DISORDER**	*Yes* *(confirmed by daily prospective ratings of mood during at least 2 menstrual cycles)*	*No*	*Provisional* *(not confirmed by daily prospective ratings of mood during at least 2 menstrual cycles)*

Current Severity of Premenstrual Dysphoric Disorder (circle number):[24]

	Distress	Impairment
1. Normal	• No distress at all or full remission	• No impairment at all or full remission
2. Borderline	• Between Normal and Mild, or subthreshold	• Between Normal and Mild, or subthreshold
3. Mild	• Fairly infrequent distress OR • Brief duration of distress OR • Distress is slight	• Impairment is slight in 1 domain of functioning (e.g., taking longer to complete school tasks, occasional social avoidance) OR • Still generally able to meet obligations
4. Moderate	• Between Mild and Marked	• Between Mild and Marked
5. Marked	• Very frequent distress OR • Very long-lasting distress OR • Distress is substantial	• Impairment is significant in many domains of functioning (e.g., school, social, family life) OR • Some failure to meet role obligations (e.g., poor school performance, missing days of school) OR • Symptoms pose a minor risk of harm to self or others
6. Severe	• Between Marked and Extreme	• Between Marked and Extreme
7. Extreme	• Distress occurs constantly without relief OR • Distress is extremely intense or unbearable	• Impairment is extreme in most or all domains of functioning (e.g., completely unable to perform in school or engage in social interactions) OR • Patient is considered incapacitated OR • Symptoms pose a severe risk of harm to self or others OR • Acutely psychotic OR • In need of hospitalization or residential care

[24] Severity rating should be based on current distress and impairment related to this disorder, not the severity of previous episodes.

Optional Information: Premenstrual Dysphoric Disorder (PMDD)

Possible rule-outs (check if likely):

- ☐ Premenstrual syndrome: Premenstrual syndrome does not require the presence of mood disturbance or a minimum of five PMDD symptoms.
- ☐ Dysmenorrhea: Dysmenorrhea consists of painful menses without the presence of significant mood disturbance. Symptoms of dysmenorrhea begin at the onset of menses, whereas PMDD symptoms begin before the onset of menses.
- ☐ Use of hormonal treatments: Depressive symptoms caused by the use of hormonal treatments will begin after the initiation of hormones, and remit upon cessation of hormones. In such cases, a substance/medication-induced depressive disorder should be diagnosed.
- ☐ Other mood disorders: In other mood disorders (e.g., Bipolar Disorder, Major Depressive Disorder, Persistent Depressive Disorder) the symptoms do not follow a premenstrual pattern. This should be confirmed using daily prospective ratings rather than by retrospective self-report. PMDD may be diagnosed concurrently with other depressive disorders (e.g., Major Depressive Disorder or Persistent Depressive Disorder) if the premenstrual mood disturbance does not occur exclusively during the course of the other depressive disorder, and is not simply an exacerbation of the other depressive disorder.

Associated Features:

- ☐ Delusions or hallucinations

Coding indicators:

- ☐ Provisional (mood disturbance has not been confirmed by daily prospective ratings of mood during at least 2 menstrual cycles)

OBSESSIVE-COMPULSIVE AND RELATED DISORDERS

OBSESSIVE-COMPULSIVE DISORDER

Best source: Child with or without parent, depending on age and developmental level

Consider behavioral observations in addition to self-report.

- **In the past month, do you[25] have a lot of thoughts, worries, or images in your mind that you don't want to have? Some examples are thoughts that you will get dirt or germs on you, that you will make a terrible mistake, or being very uncomfortable if things aren't just right.**
  - ⇨ What kind of thoughts do you have? _____
  - ⇨ Do these thoughts come into your mind even when you don't want them to? _____
  - ⇨ Do they come into your mind again and again and bother you for some time? _____

- **Do you…**
  - ☐ Worry a lot about germs and being clean?
  - ☐ Worry a lot about hurting yourself or others by mistake?
  - ☐ Worry a lot about people or pets getting hurt?
  - ☐ Need things to be lined up just right, or for things to be even?
  - ☐ Worry a lot that you will make mistakes?
  - ☐ Worry a lot that you will do something that makes God angry at you?
  - ☐ Have uncomfortable thoughts about sex or violence?
  - ☐ Have good or bad numbers, words, colors, etc.?
  - ☐ Have scary or gross pictures in your mind?
  - ☐ Worry that you will do something that is really out of control, embarrassing, or dangerous?
  - ☐ Worry that something bad is going to happen in the future if you do not do things a certain way?
  - ☐ Have other thoughts or pictures that get stuck in your mind, or that bother you?

    _____

1. Does the child have recurrent, persistent thoughts, urges, or images that are perceived as intrusive?	*Yes*	*No* *Skip to item 3 and circle "No"*

- **When these thoughts come into your mind, what do you do?**
  - ⇨ Do you try to ignore them, push them out of your mind, or "fix" them by doing or thinking something?

    _____

2. Does the child try to ignore, suppress, or neutralize the thoughts?	*Yes*	*No* *Skip to item 3 and circle "No"*

3. Are obsessions present ("Yes" to items 1 and 2)?	*Yes*	*No*

- **In the past month, are there things that you do over and over again when you have these thoughts? Some examples are washing your hands or cleaning things, ordering or lining things up, checking things, repeating an action over and over again, or having to think a good or safe thought.**
  - ⇨ What kind of things do you do? _____

[25] Or "your child;" continue as appropriate.

- **Do you…**
  - ☐ Wash your hands or body a lot? Clean things a lot?
  - ☐ Check things over and over?
  - ☐ Line things up or make sure things are put in just the right place?
  - ☐ Say or think certain words, phrases, prayers, or numbers?
  - ☐ Count?
  - ☐ Repeat an action over and over?
  - ☐ Try to have "good" thoughts or images?
  - ☐ Seek reassurance from others, or reassure yourself over and over?
  - ☐ Insist others engage in ritualized behavior?
  - ☐ Try to do or think things in a "just right" way?
  - ☐ Touch or tap things in a certain way?
  - ☐ Other behaviors or mental acts?_____

- **Do you feel like you have to do these behaviors or mental acts, like it's very hard to stop or resist them?**

4. Does the child have repetitive behaviors or mental acts that he/she feels compelled to perform in response to obsessive thoughts, or according to rigid rules?	*Yes*	*No* *Skip to item 6 and circle "No"*

- **Do these behaviors or mental acts make you feel less uncomfortable? Do you fear something will happen if you don't do these behaviors?** _____

5. Do the behaviors function to prevent or reduce anxiety or to prevent a feared event, yet are not realistically preventative or are clearly excessive?	*Yes*	*No* *Skip to item 6 and circle "No"*

6. Are compulsions present ("Yes" to items 4 and 5)?	*Yes*	*No*

7. Are obsessions (item 3) and/or compulsions (item 6) present?	*Yes*	*No* *Skip to item 10 and circle "No"*

- **If you added up all of the time per day you spent having these thoughts and performing these behaviors or mental acts over the past month, would it add up to at least an hour each day?** _____

- **In the past month, how much does this problem bother or upset you?**
  - ⇨ How often do you feel upset?_____
  - ⇨ When you feel upset, how long does it last? _____
  - ⇨ How bad does it feel? _____

- **In the past month, does this problem make things harder for you, like make it hard to do well in school or at work, cause problems with your friends or family, or get in the way of doing fun or important things?**
  - ⇨ Are there things you don't do, or places you won't go, because of this problem? _____
  - ⇨ Does this problem make it hard to focus or concentrate? _____
  - ☐ Problems at school
  - ☐ Problems with family
  - ☐ Legal problems
  - ☐ Other functional impairment _____
  - ☐ Problems with work or role functioning
  - ☐ Problems with home responsibilities
  - ☐ Problems with social life
  - ☐ Problems with leisure activities
  - ☐ Problems of health or safety

8. Are the symptoms time consuming (e.g., more than 1 hour per day), distressing, or cause impairment in important areas of functioning?	*Yes*	*No* *Skip to item 10 and circle "No"*

- **How old were you when you started having this problem?** _____
- **Just before you started having this problem, did your doctor change any medicine you were taking, did you use any drugs, or did you have an illness or injury?** _____
  - ⇨ Do you think this problem was caused by an illness, drugs, or changes in your medicine? _____
  - ⇨ Have you or your parents talked to a medical doctor about this? _____

9. Are the obsessions and/or compulsions attributable to drug effects, a medical condition, or another mental disorder? (See Optional Information; If yes, complete applicable substance-induced or general medical condition module)	*No*	*Yes* *Skip to item 10 and circle "No"*

10. OBSESSIVE-COMPULSIVE DISORDER[26]	*Yes*	*No*

Current Severity of Obsessive-Compulsive Disorder (circle number):

	Distress	Impairment
1. Normal	• No distress at all or full remission	• No impairment at all or full remission
2. Borderline	• Between Normal and Mild, or subthreshold	• Between Normal and Mild, or subthreshold
3. Mild	• Fairly infrequent distress OR • Brief duration of distress OR • Distress is slight	• Impairment is slight in 1 domain of functioning (e.g., taking longer to complete school tasks, occasional social avoidance) OR • Still generally able to meet obligations
4. Moderate	• Between Mild and Marked	• Between Mild and Marked
5. Marked	• Very frequent distress OR • Very long-lasting distress OR • Distress is substantial	• Impairment is significant in many domains of functioning (e.g., school, social, family life) OR • Some failure to meet role obligations (e.g., poor school performance, missing days of school) OR • Symptoms pose a minor risk of harm to self or others
6. Severe	• Between Marked and Extreme	• Between Marked and Extreme
7. Extreme	• Distress occurs constantly without relief OR • Distress is extremely intense or unbearable	• Impairment is extreme in most or all domains of functioning (e.g., completely unable to perform in school or engage in social interactions) OR • Patient is considered incapacitated OR • Symptoms pose a severe risk of harm to self or others OR • Acutely psychotic OR • In need of hospitalization or residential care

[26] If clinically significant obsessions or compulsions are present, regardless of diagnosis, complete the PANS screener on p. 144.

Optional Information: Obsessive-Compulsive Disorder (OCD)
Possible rule-outs (check if likely):

- ☐ Anxiety disorders: In OCD, obsessions are usually not limited to real-life concerns, and can be bizarre. When rituals are present in other anxiety disorders, they tend to be limited to checking and reassurance-seeking.
- ☐ Depression: Obsessions in OCD are not mood-congruent, are perceived as intrusive, and are associated with compulsions.
- ☐ Body dysmorphic disorder (BDD): In BDD the obsessions and compulsions are limited to concerns about appearance.
- ☐ Trichotillomania (TTM) or skin picking disorder (SPD): In TTM and SPD the compulsions are limited to hair pulling or skin picking.
- ☐ Hoarding disorder (HD): In HD, the obsessive thoughts are related solely to difficulty discarding or need to acquire objects, and compulsive behaviors are related to discarding and acquiring.
- ☐ Eating disorders: In OCD the obsessions and compulsions are not predominantly about concerns with body shape, size, or weight.
- ☐ Tics and stereotyped movements: Tics and stereotyped movements are typically not complex and are not aimed at neutralizing obsessions or preventing something bad from happening.
- ☐ Psychotic disorders: OCD is not characterized by hallucinations or formal thought disorder.
- ☐ Impulse control or substance use disorders: Compulsions do not result in pleasure or gratification.
- ☐ Obsessive-compulsive personality disorder (OCPD): OCPD is not characterized by intrusive thoughts or repetitive behaviors.
- ☐ Autism spectrum disorder (ASD): Individuals with ASD may exhibit fixed interests, but these are not usually associated with fear or discomfort, and are not perceived as intrusive. They may engage in rigid or stereotyped behavior, but they do not usually feel compelled to perform these behaviors in response to obsessions.

Associated Features:

- ☐ Typical dimensions of obsessions and compulsions (many patients have more than one)
  - ☐ Contamination obsessions and washing or cleaning compulsions
  - ☐ Symmetry obsessions and repeating, ordering, or counting compulsions
  - ☐ "Forbidden" thoughts and related compulsions
  - ☐ Fears of harm to self or others and checking compulsions
- ☐ Strong affective response when confronted with situations that trigger obsessions and compulsions
  - ☐ Anxiety or panic
  - ☐ Feeling incomplete or "not just right"
  - ☐ Disgust
- ☐ Avoidance of people, places, things, or activities that trigger obsessions and compulsions

Specifiers:

- ☐ Good or fair insight: The child thinks that the obsessive beliefs are probably not true, or may or may not be true and considers their behaviors to be unreasonable
- ☐ Poor insight: The child thinks that the obsessive beliefs are probably true and thinks that their behaviors are probably reasonable
- ☐ Absent insight/delusional beliefs: The child is completely convinced that the obsessive beliefs are true and does not consider their behaviors to be excessive or unreasonable.
- ☐ Tic-related: The child has a current or past tic disorder (see p. 113).

BODY DYSMORPHIC DISORDER

Best source: Child with or without parent, depending on age and developmental level

- **In the past month, have you[27] spent a lot of time worrying about how you look, or feeling like something is wrong with how your body looks?** _____
  - ⇨ What are the worries that you have? _____
  - ⇨ What do you think is wrong with how your body looks? What parts of your body do you worry most about?

☐ Eyes	☐ Ears	☐ Breasts	☐ Skin
☐ Nose	☐ Mouth	☐ Buttocks	☐ Body fat[28]
☐ Hair	☐ Muscle mass or tone	☐ Genitalia	☐ Other _____

  - ⇨ If you added up all of the time per day you spent worrying about how you look, would it add up to at least an hour each day? _____
  - ⇨ Do you find that you can't concentrate on other things because of your thoughts or worries about how you look? _____

1. Does the child have a preoccupation with perceived defect(s) or flaw(s) in physical appearance that are either not observable, or appear slight?	*Yes*	*No* *Skip to item 5 and circle "No"*

- **Are there certain things that you do over and over again, to try to feel better, when you feel worried about how you look? Some examples are looking in the mirror a lot, asking other people if you look OK, picking at your skin, or things like that?** _____
  - ⇨ What kinds of things do you do? _____
- **Are there certain things you do in your mind, to try to feel better, when you have these worries?** _____
  - ⇨ What kinds of things do you do? _____
- **Do you…**

☐ Look at yourself over and over again in the mirror, on your phone, or in other places?
☐ Check the way you look, measure parts of your body, or look closely at the areas you are worried about?
☐ Ask other people how you look?
☐ Wear a lot of makeup or special clothes to hide how you look?
☐ Spend a lot of time getting dressed, putting on makeup, doing your hair, etc?
☐ Pick at your skin to try to fix how it looks?
☐ Spend a lot of time planning to get plastic surgery, or actually get it?
☐ Do any other things to change or hide how you look?
☐ Compare how you look to how other people look?
☐ Tell yourself you look OK?
☐ Other _____

2. Has the child ever engaged in repetitive behaviors or mental acts in response to concerns about appearance?	*Yes*	*No* *Skip to item 5 and circle "No"*

[27] Or "your child;" continue as appropriate.

[28] Note: if concern is limited to body fat or weight *and* the child meets diagnostic criteria for an eating disorder (see p. 96), Body Dysmorphic Disorder cannot be diagnosed.

- **In the past month, how much does this problem bother or upset you?**
  - ⇨ How often do you feel upset? _____
  - ⇨ When you feel upset, how long does it last? _____
  - ⇨ How bad does it feel? _____

- **In the past month, does this problem make things harder for you, like make it hard to do well in school or at work, cause problems with your friends or family, or get in the way of doing fun or important things?**
  - ⇨ Are there things you don't do, or places you won't go, because of this problem? _____
  - ⇨ Does this problem make it hard to focus or concentrate? _____

☐ Problems at school
☐ Problems with work or role functioning
☐ Problems with social life
☐ Problems with family
☐ Problems with home responsibilities
☐ Problems with leisure activities
☐ Legal problems
☐ Problems of health or safety
☐ Other functional impairment _____

3. Does the preoccupation cause significant distress, or cause impairment in important areas of functioning?	*Yes*	*No* *Skip to item 5 and circle "No"*

4. If the child has an eating disorder (see p. 96), is the preoccupation attributable to concerns about weight or body fat?	*No*	*Yes* *Skip to item 5 and circle "No"*

5. BODY DYSMORPHIC DISORDER	*Yes*	*No*

Current Severity of Body Dysmorphic Disorder (circle number):

	Distress	Impairment
1. Normal	• No distress at all or full remission	• No impairment at all or full remission
2. Borderline	• Between Normal and Mild, or subthreshold	• Between Normal and Mild, or subthreshold
3. Mild	• Fairly infrequent distress OR • Brief duration of distress OR • Distress is slight	• Impairment is slight in 1 domain of functioning (e.g., taking longer to complete school tasks, occasional social avoidance) OR • Still generally able to meet obligations
4. Moderate	• Between Mild and Marked	• Between Mild and Marked
5. Marked	• Very frequent distress OR • Very long-lasting distress OR • Distress is substantial	• Impairment is significant in many domains of functioning (e.g., school, social, family life) OR • Some failure to meet role obligations (e.g., poor school performance, missing days of school) OR • Symptoms pose a minor risk of harm to self or others
6. Severe	• Between Marked and Extreme	• Between Marked and Extreme
7. Extreme	• Distress occurs constantly without relief OR • Distress is extremely intense or unbearable	• Impairment is extreme in most or all domains of functioning (e.g., completely unable to perform in school or engage in social interactions) OR • Patient is considered incapacitated OR • Symptoms pose a severe risk of harm to self or others OR • Acutely psychotic OR • In need of hospitalization or residential care

Optional Information: Body Dysmorphic Disorder (BDD)

Possible rule-outs (check if likely):

- ☐ Eating disorders: Preoccupation in eating disorder is limited to thoughts about fat, weight gain, and body shape only.
- ☐ Normal appearance concerns or clearly noticeable physical defect: BDD is characterized by a level of preoccupation about a *perceived* physical defect and subsequent behavior that is time-consuming, difficult to control, and causes significant distress or impairment.
- ☐ Obsessive-compulsive disorder (OCD): BDD preoccupation and behaviors are limited to appearance-related concerns.
- ☐ Trichotillomania (TTM) or Skin-Picking Disorder (SPD): In TTM and SPD, the hair pulling or skin picking behaviors are not performed solely for the purpose of improving physical appearance.
- ☐ Depression: BDD is characterized by a predominant preoccupation with appearance and associated repetitive behaviors.
- ☐ Anxiety disorders: Anxiety disorders are not characterized by preoccupation with appearance and associated repetitive behaviors. In BDD, social anxiety and avoidance are due to concerns that others will see physical defects.
- ☐ Psychotic disorders: BDD is not characterized by hallucinations or formal thought disorder, although appearance-related beliefs can be of delusional intensity.
- ☐ Gender dysphoria: Preoccupation in BDD is not limited to discomfort with and desire to be rid of primary or secondary sex characteristics.
- ☐ Illness anxiety disorder: BDD does not include preoccupation with having a serious medical illness or high levels of somatization.

Associated Features:

- ☐ Ideas or delusions of reference (e.g., others take special notice of them because of appearance)
- ☐ High levels of anxiety, social anxiety, social avoidance, or perfectionism
- ☐ Depressed mood or low self-esteem
- ☐ Shame or reluctance to reveal problem to others
- ☐ History of cosmetic surgery without resolution of the preoccupation
- ☐ Tendency to focus on and remember details of visual stimuli rather than the whole
- ☐ Bias for negative and threatening interpretations of ambiguous scenarios (e.g., facial expressions)

Specifiers:

- ☐ Good or fair insight: The child thinks that their appearance related beliefs are probably not true, or may or may not be true and considers their behaviors to be unreasonable or excessive
- ☐ Poor insight: The child thinks that their appearance related beliefs are probably true and thinks that their behaviors are probably reasonable
- ☐ Absent insight/delusional beliefs: The child is completely convinced that their appearance related beliefs are true and does not consider their behaviors to be excessive or unreasonable
- ☐ Muscle dysmorphia: Part of the preoccupation is that the child believes that their body build is too small or not muscular enough.

HOARDING DISORDER

Best source: Child with or without parent, depending on age and developmental level. Consider obtaining observations or photographs of the home.

- **In the past month, is it hard for you[29] to throw things away?** _____
  - ⇨ Do you save things that other people would throw away? _____
  - ⇨ What kinds of things do you save? _____

1. Does the child have persistent difficulty discarding or parting with possessions, regardless of their real value?	*Yes*	*No* *Skip to item 6 and circle "No"*

- **In the past month, do you feel like it is very important to save things?** _____
  - ⇨ Why is that? _____

- ☐ Do you save because you might need your things in the future? Do you feel like you need to save things in case someone else needs it?
- ☐ Do you have strong feelings about the right way to get rid of things?
- ☐ Do you save because your stuff is very important?
- ☐ Do you save so that you don't forget an important memory?
- ☐ Do you save because you don't want to waste things?
- ☐ Do you save so that you don't make a mistake?
- ☐ Other reason _____

- **In the past month, do you feel very upset when you throw things away?** _____

2. Is the child's difficulty discarding or parting with possessions due to a perceived need to save them and to distress associated with discarding?	*Yes*	*No* *Skip to item 6 and circle "No"*

- **In the past month, is there a lot of stuff in your house?** _____
  - ⇨ How much of the stuff is yours? _____

- **Is there a lot of your stuff in your room, your locker, your car, or other spaces?** _____
  - ⇨ What does your [house/room/locker/_____] look like? _____
  - ⇨ Can you walk around? _____
  - ⇨ Can you use those places? _____
  - ⇨ Do other people clean up your stuff, or throw it out?_____

Cluttered Active Living Areas

- ☐ Kitchen
- ☐ Bedroom
- ☐ Stairs or hallways
- ☐ Living room
- ☐ Bathroom
- ☐ Other active living area _____

[29] Or "your child;" continue as appropriate.

Cluttered Non-Active Living Areas[30]

- ☐ Garage
- ☐ Car
- ☐ Exterior of home
- ☐ Basement
- ☐ Attic
- ☐ Other non-active living area _____

(Note: in children, clutter may be more contained due to the interventions of others)

3. Does the child have clutter in the active living areas of the home that compromises their intended use (or if living areas are not cluttered, this is only because of the intervention of others)?	*Yes*	*No* *Skip to item 6 and circle "No"*

- **In the past month, how much does this problem bother or upset you?**
  - ⇨ How often do you feel upset? _____
  - ⇨ When you feel upset, how long does it last? _____
  - ⇨ How bad does it feel? _____

- **In the past month, does this problem make things harder for you, like make it hard to do well in school or at work, cause problems with your friends or family, or get in the way of doing fun or important things?**
  - ⇨ Are there things you don't do, or places you won't go, because of this problem? _____
  - ⇨ Does this problem make it hard to focus or concentrate? _____

- ☐ Problems at school
- ☐ Problems with work or role functioning
- ☐ Problems with social life
- ☐ Problems with family
- ☐ Problems with home responsibilities
- ☐ Problems with leisure activities
- ☐ Legal problems
- ☐ Problems of health or safety
- ☐ Other functional impairment _____

4. Does the clutter or associated saving behavior cause significant distress, or cause impairment in important areas of functioning (including a safe environment)?	*Yes*	*No* *Skip to item 6 and circle "No"*

- **Just before you started having this problem, did your doctor change any medicine you were taking, did you use any drugs, or did you have an illness or injury?** _____
  - ⇨ Do you think this problem was caused by an illness, drugs, or changes in your medicine? _____
  - ⇨ Have you or your parents talked to a medical doctor about this? _____

5. Is the hoarding behavior attributable to a medical condition or another mental disorder? (See Optional Information; If yes, complete applicable substance-induced or general medical condition module)	*No*	*Yes* *Skip to item 6 and circle "No"*

6. HOARDING DISORDER	*Yes*	*No*

[30] For hoarding disorder to be diagnosed, significant clutter must be present in the living areas of the home, not limited to non-living areas.

Current Severity of Hoarding Disorder (circle number):

	Distress	Impairment
1. Normal	• No distress at all or full remission	• No impairment at all or full remission
2. Borderline	• Between Normal and Mild, or subthreshold	• Between Normal and Mild, or subthreshold
3. Mild	• Fairly infrequent distress OR • Brief duration of distress OR • Distress is slight	• Impairment is slight in 1 domain of functioning (e.g., taking longer to complete school tasks, occasional social avoidance) OR • Still generally able to meet obligations
4. Moderate	• Between Mild and Marked	• Between Mild and Marked
5. Marked	• Very frequent distress OR • Very long-lasting distress OR • Distress is substantial	• Impairment is significant in many domains of functioning (e.g., school, social, family life) OR • Some failure to meet role obligations (e.g., poor school performance, missing days of school) OR • Symptoms pose a minor risk of harm to self or others
6. Severe	• Between Marked and Extreme	• Between Marked and Extreme
7. Extreme	• Distress occurs constantly without relief OR • Distress is extremely intense or unbearable	• Impairment is extreme in most or all domains of functioning (e.g., completely unable to perform in school or engage in social interactions) OR • Patient is considered incapacitated OR • Symptoms pose a severe risk of harm to self or others OR • Acutely psychotic OR • In need of hospitalization or residential care

Optional Information: Hoarding Disorder (HD)

Possible rule-outs (check if likely):

- ☐ Neurodevelopmental disorders: HD is not diagnosed if it is the direct result of a neurodevelopmental disorder such as autism or intellectual disability.
- ☐ Psychotic disorders: HD is not characterized by hallucinations or formal thought disorder.
- ☐ Depression: Clutter in HD is not solely due to psychomotor retardation, fatigue, or loss of energy.
- ☐ Attention-deficit/hyperactivity disorder (ADHD): Individuals with ADHD may be highly disorganized, but do not have difficulty discarding items due to perceived need to save or distress when discarding.
- ☐ Obsessive-compulsive disorder (OCD): Saving behaviors in HD are not solely due to obsessions such as fears of contamination, harm, or incompleteness; or the need to avoid performing time-consuming compulsions.
- ☐ Other medical conditions: HD is not diagnosed if it is the direct result of a medical condition such as brain injury, neurosurgery, cerebrovascular disease, or neurogenetic condition (e.g., Prader-Willi syndrome).

Associated Features:

- ☐ Animal hoarding
  - Accumulation of a large number of animals
  - Failure to provide minimal standards of nutrition, sanitation, and veterinary care
  - Failure to act on the deteriorating condition of the animals or the environment
- ☐ Indecisiveness or perfectionism
- ☐ Avoidance or procrastination
- ☐ Living in unsanitary conditions
- ☐ Difficulty planning or organizing tasks
- ☐ Distractibility

Specifiers:

- ☐ Good or fair insight: The child thinks that the hoarding beliefs and behaviors are a problem.
- ☐ Poor insight: The child thinks that the hoarding beliefs and behaviors are probably not a problem despite contradicting evidence.
- ☐ Absent insight/delusional beliefs: The child is completely convinced that the hoarding beliefs and behaviors are not a problem despite contradicting evidence.
- ☐ Excessive acquisition: The child excessively acquires objects that are not needed or for which there is no space.

TRICHOTILLOMANIA
EXCORIATION (SKIN-PICKING) DISORDER

Best source: Child with or without parent, depending on age and developmental level

- **In the past month, do you[31] often pull out hair from your scalp or your body?** _____
  - ⇨ Are there places where you have less hair, or where the hair is all gone, because of the pulling? _____
- **In the past month, do you[32] often pick at your skin?** _____
  - ⇨ Do you have sores or scars from the picking? _____

Hair pulling

- ☐ Partial hair loss in the pulling area
- ☐ Total hair loss in the pulling area

Skin picking

- ☐ Sores in the picked area
- ☐ Scarring in the picked area

⇨ Can you tell me what happens when you are (hair pulling/skin picking)? How do you do it? Do you know when it's happening? _____

⇨ Where do you (pull/pick) from? _____

- ☐ Scalp
- ☐ Eyelashes
- ☐ Chest/torso
- ☐ Legs
- ☐ Eyebrows
- ☐ Face
- ☐ Arms
- ☐ Pubic region
- ☐ Neck
- ☐ Hands
- ☐ Feet
- ☐ Other _____

1. ***Trichotillomania:*** *Does the child report recurrent pulling out of his/her own hair, resulting in hair loss?*	*Yes*	*No* *Skip to item 5 and circle "No"*
Excoriation (Skin Picking) Disorder*: Does the child report recurrent skin picking, resulting in skin lesions?*	*Yes*	*No* *Skip to item 6 and circle "No"*

- **In the past month, how much does this problem bother or upset you?**
  - ⇨ How often do you feel upset? _____
  - ⇨ When you feel upset, how long does it last? _____
  - ⇨ How bad does it feel? _____

- **In the past month, does this problem make things harder for you, like make it hard to do well in school or at work, cause problems with your friends or family, or get in the way of doing fun or important things?**
  - ⇨ Are there things you don't do, or places you won't go, because of this problem? _____
  - ⇨ Does this problem make it hard to focus or concentrate? _____

- ☐ Problems at school
- ☐ Problems with family
- ☐ Legal problems
- ☐ Other functional impairment _____
- ☐ Problems with work or role functioning
- ☐ Problems with home responsibilities
- ☐ Problems with social life
- ☐ Problems with leisure activities
- ☐ Problems of health or safety

[31] Or "your child;" continue as appropriate.
[32] Or "your child;" continue as appropriate.

2. ***Trichotillomania:*** *Does the hair pulling or resulting hair loss cause significant distress, or cause impairment in important areas of functioning?*	*Yes*	*No* *Skip to item 5 and circle "No"*
***Excoriation (Skin Picking) Disorder**: Does the skin picking or resulting skin lesions cause significant distress, or cause impairment in important areas of functioning?*	*Yes*	*No* *Skip to item 6 and circle "No"*

- **Have you ever tried to stop (pulling/picking), or to do it less often?** _____
  - ⇨ How many times did you try? _____
  - ⇨ What happened when you tried? Were you able to stop? _____

☐ Unable to decrease or stop pulling
☐ Able to decrease pulling but not stop altogether
☐ Able to stop pulling for a while but the problem returned
☐ Other _____

3. ***Trichotillomania:*** *Has the child made repeated attempts to decrease or stop pulling?*	*Yes*	*No* *Skip to item 5 and circle "No"*
***Excoriation (Skin Picking) Disorder**: Has the child made repeated attempts to decrease or stop picking?*	*Yes*	*No* *Skip to item 6 and circle "No"*

- **Just before you started having this problem, did your doctor change any medicine you were taking, did you use any drugs, or did you have an illness or injury?** _____
  - ⇨ Do you think this problem was caused by an illness, drugs, or changes in your medicine? _____
  - ⇨ Have you or your parents talked to a medical doctor about this? _____

4. ***Trichotillomania:*** *Is the hair pulling or hair loss attributable to a medical condition or another mental disorder? (See Optional Information; If yes, complete applicable substance-induced or general medical condition module)*	*No*	*Yes* *Skip to item 5 and circle "No"*
***Excoriation (Skin Picking) Disorder**: Is the skin picking or skin lesions attributable to a medical condition or another mental disorder? (See Optional Information; If yes, complete applicable substance-induced or general medical condition module)*	*No*	*Yes* *Skip to item 6 and circle "No"*

5. TRICHOTILLOMANIA	*Yes*	*No*

6. EXCORIATION (SKIN-PICKING) DISORDER	*Yes*	*No*

Current Severity of Trichotillomania and Excoriation (Skin-Picking) Disorder (circle number):

Trichotillomania	Excoriation (Skin-Picking) Disorder	Distress	Impairment
1. Normal	**1. Normal**	• No distress at all or full remission	• No impairment at all or full remission
2. Borderline	**2. Borderline**	• Between Normal and Mild, or subthreshold	• Between Normal and Mild, or subthreshold
3. Mild	**3. Mild**	• Fairly infrequent distress OR • Brief duration of distress OR • Distress is slight	• Impairment is slight in 1 domain of functioning (e.g., taking longer to complete work tasks, occasional social avoidance) OR • Still generally able to meet obligations
4. Moderate	**4. Moderate**	• Between Mild and Marked	• Between Mild and Marked
5. Marked	**5. Marked**	• Very frequent distress OR • Very long-lasting distress OR • Distress is substantial	• Impairment is significant in many domains of functioning (e.g., work, social, family life) OR • Some failure to meet role obligations (e.g., poor work performance, missing days of work) OR • Symptoms pose a minor risk of harm to self or others
6. Severe	**6. Severe**	• Between Marked and Extreme	• Between Marked and Extreme
7. Extreme	**7. Extreme**	• Distress occurs constantly without relief OR • Distress is extremely intense or unbearable	• Impairment is extreme in most or all domains of functioning (e.g., completely unable to work or engage in social interactions) OR • Patient is considered incapacitated OR • Symptoms pose a severe risk of harm to self or others OR • Acutely psychotic OR • In need of hospitalization or residential care

Optional Information: Trichotillomania and Excoriation (Skin-Picking) Disorder

Possible rule-outs (check if likely):

- ☐ Other medical conditions: Trichotillomania and excoriation disorder are not diagnosed if it is the direct result of a medical condition such as a dermatological condition. When skin picking is related to acne, excoriation disorder can be diagnosed only if the skin picking has become independent of the acne.
- ☐ Substance use disorders: Although hair pulling and skin picking can be exacerbated by some substances (e.g., stimulants), the substance is usually not the primary cause.
- ☐ Obsessive-compulsive disorder: Hair pulling in trichotillomania and skin picking in excoriation disorder are not performed solely to achieve a sense of symmetry or perfection, to reduce feelings of contamination, or in response to other obsessive thoughts.
- ☐ Somatic symptom and related disorders. Trichotillomania and excoriation disorder are not diagnosed if hair loss or skin lesions are attributable to deceptive behaviors in factitious disorders.
- ☐ Body dysmorphic disorder (BDD): Hair pulling in trichotillomania and skin picking in excoriation disorder are not performed solely because of preoccupation about perceived defects in appearance.
- ☐ Neurodevelopmental disorders: Trichotillomania and excoriation disorder are not diagnosed if the behavior is the direct result of a neurodevelopmental disorder such as autism or intellectual disability. Skin picking in neurodevelopmental disorders (e.g., Prader-Willi syndrome) typically has onset during early development
- ☐ Psychotic disorders: Trichotillomania and excoriation disorder are not characterized by hallucinations, delusions, or formal thought disorder (e.g. picking at skin due to beliefs that bugs are under the skin).
- ☐ Nonsuicidal self-injury: Hair pulling in trichotillomania and skin picking in excoriation disorder are not attributable to an intention to harm oneself.

Associated features:

- ☐ Searching for particular types of hair to pull or skin to pick (e.g., hairs with a certain texture or color, particular types of scab)
- ☐ Trying to pull hair out in a certain way (e.g., leaving the root intact)
- ☐ Post-pulling/picking manipulation of the hair or scab (e.g., visual inspection, rolling the hair or scab between fingers, rubbing the hair or scab on the lips, biting or swallowing the hair or scab)
- ☐ Pulling/picking is preceded by anxiety, boredom, or tension
- ☐ Pulling/picking leads to feelings of gratification or relief
- ☐ Varying levels of attention on the behavior
  - Focused attention
  - Unfocused or automatic
- ☐ Hair pulling/skin picking is inhibited in the presence of others outside of the immediate family
- ☐ Pulling or picking from other people, pets, dolls, or fibrous materials
- ☐ Presence of other body-focused repetitive behaviors (e.g., nail biting, lip chewing)

SOMATIC SYMPTOM AND RELATED DISORDERS

SOMATIC SYMPTOM DISORDER

Best source: Child with or without parent, depending on age and developmental level. Consider medical records and physical examination in addition to self-report.

- **In the past month, have you[33] had anything really wrong with your body? Do any problems in your body bother you a lot?** _____
  - ⇨ Do you have any physical problems, like pain or feeling really tired? _____

☐ One or more somatic symptom is present

(Note: continue if the above is checked.)

- **In the past month, how much does this problem bother or upset you?**
  - ⇨ How often do you feel upset?_____
  - ⇨ When you feel upset, how long does it last? _____
  - ⇨ How bad does it feel? _____

- **In the past month, does this problem make things harder for you, like make it hard to do well in school or at work, cause problems with your friends or family, or get in the way of doing fun or important things?**
  - ⇨ Are there things you don't do, or places you won't go, because of this problem? _____
  - ⇨ Does this problem make it hard to focus or concentrate? _____

☐ Problems at school
☐ Problems with work or role functioning
☐ Problems with social life
☐ Problems with family
☐ Problems with home responsibilities
☐ Problems with leisure activities
☐ Legal problems
☐ Problems of health or safety
☐ Other functional impairment _____

1. Are there one or more somatic symptoms that cause distress or significant impairment in daily life?	*Yes*	*No* *Skip to item 4 and circle "No"*

(Note: consider all available medical information, collateral reports, and other data in determining whether the thoughts, feelings, and behaviors are excessive. The presence of a diagnosed medical condition linked to the somatic symptom does not rule out the diagnosis of somatic symptom disorder.)

- **In the past month…**

☐ Do you think or worry a lot about this problem with your body? [Excessive thoughts about the symptom(s)]
☐ Do you feel very worried or upset about this problem with your body? [Excessive feelings about the symptom(s)]
☐ Do you have to see a lot of doctors because of this problem with your body? [Excessive behaviors related to the symptom(s)]

(Note: this criterion is met if any of the above are checked.)

[33] Or "your child;" continue as appropriate.

2. Are there excessive thoughts, feelings, or behaviors related to the somatic symptoms or associated health concerns?	*Yes*	*No* *Skip to item 4 and circle "No"*

💎 **How long have you been bothered by this problem with your body ?**
(Note: typically, though not always, "persistent" is defined as 6 months or more.)

3. Are some symptoms and associated excessive thoughts, feelings, or behaviors persistent?	*Yes*	*No* *Skip to item 4 and circle "No"*

4. SOMATIC SYMPTOM DISORDER	*Yes*	*No*

Current Severity of Somatic Symptom Disorder (circle number):

	Distress	Impairment
1. Normal	• No distress at all or full remission	• No impairment at all or full remission
2. Borderline	• Between Normal and Mild, or subthreshold	• Between Normal and Mild, or subthreshold
3. Mild	• Fairly infrequent distress OR • Brief duration of distress OR • Distress is slight	• Impairment is slight in 1 domain of functioning (e.g., taking longer to complete school tasks, occasional social avoidance) OR • Still generally able to meet obligations
4. Moderate	• Between Mild and Marked	• Between Mild and Marked
5. Marked	• Very frequent distress OR • Very long-lasting distress OR • Distress is substantial	• Impairment is significant in many domains of functioning (e.g., school, social, family life) OR • Some failure to meet role obligations (e.g., poor school performance, missing days of school) OR • Symptoms pose a minor risk of harm to self or others
6. Severe	• Between Marked and Extreme	• Between Marked and Extreme
7. Extreme	• Distress occurs constantly without relief OR • Distress is extremely intense or unbearable	• Impairment is extreme in most or all domains of functioning (e.g., completely unable to perform in school or engage in social interactions) OR • Patient is considered incapacitated OR • Symptoms pose a severe risk of harm to self or others OR • Acutely psychotic OR • In need of hospitalization or residential care

ILLNESS ANXIETY DISORDER

Best source: Child with or without parent, depending on age and developmental level

- **In the past month, do you[34] worry a lot that you are sick or have a serious disease, or that you are going to get sick?** _____
  - ⇨ How much of your day is spent thinking about this? _____

(Note: consider an hour or more per day to be clinically significant)

- ⇨ Do you find that you can't concentrate on other things because of your thoughts or worries about being sick or getting sick? _____

1. Is there a preoccupation with having or acquiring a serious illness?	*Yes*	*No* *Skip to item 7 and circle "No"*

(Note: consider collateral reports, medical records, and physical examination in addition to interview responses.)

- **How is your physical health in general?** _____
  - ⇨ Do you have any physical problems, like pain or feeling really tired?
  - ⇨ *(If symptoms are present)* How bad are these problems in your body? _____

☐ No somatic symptoms are present

☐ If somatic symptoms are present, they are no more than mild

(Note: continue if either of the above is checked.)

- **Has a doctor told you that you have a disease or that you are sick?** _____

(Note: consider all available medical information, collateral reports, and other data in determining whether the preoccupation is excessive. The presence of a diagnosed medical condition or known medical risk does not rule out the diagnosis of illness anxiety disorder.)

☐ There is no known medical condition or medical risk associated with the preoccupation

☐ If a known medical condition or medical risk is associated with the preoccupation, the preoccupation is clearly excessive or disproportionate

(Note: this criterion is met if either of the above is checked.)

2. Are somatic symptoms absent or mild, or if another medical condition or risk is present, is the preoccupation clearly excessive or disproportionate?	*Yes*	*No* *Skip to item 7 and circle "No"*

- **In the past month, do you worry a lot about sickness or disease?** _____
- **In the past month, do you get really upset if you get some bad news about your health, or if you notice an uncomfortable feeling in your body?** _____

[34] Or "your child;" continue as appropriate.

- ☐ High level of anxiety about illness
- ☐ Easily alarmed about personal health status

(Note: this criterion is met if both of the above are checked.)

3. Is there a high level of anxiety about health, and is the child easily alarmed about personal health status?	*Yes*	*No* *Skip to item 7 and circle "No"*

- **In the past month, do you have to do things to make sure you don't have a disease? Do you have to do things to make sure you don't get sick?** _____
  - ⇨ Do you have to see a lot of doctors because you're worried about your health? _____
  - ⇨ Do you check yourself a lot for signs of disease? _____
  - ⇨ Do you do a lot of research about diseases, like on the internet? _____
  - ⇨ Do you often ask other people, like friends, family members, or doctors, to tell you that you're not sick? _____

- **In the past month, do you try really hard to stay away from any activities or people because of your worries about getting a disease or being sick?**
  - ⇨ Do you try really hard to stay away from sick people? _____
  - ⇨ Do you try really hard to stay away from doctors or hospitals? _____
  - ⇨ Do you try really hard not to hear or see information about disease? _____
- ☐ Excessive health-related behaviors
- ☐ Maladaptive avoidance

(Note: this criterion is met if either of the above is checked.

4. Does the child perform excessive health-related behaviors or exhibit maladaptive avoidance?	*Yes*	*No* *Skip to item 7 and circle "No"*

- **Have you been experiencing worries about sickness or disease for at least 6 months?**

5. Has some form of illness-related preoccupation been present for at least 6 months?	*Yes*	*No* *Skip to item 7 and circle "No"*

6. Is the preoccupation attributable to another mental disorder?	*No*	*Yes* *Skip to item 7 and circle "No"*

7. ILLNESS ANXIETY DISORDER	*Yes*	*No*

- **In the past month, how much does this problem bother or upset you?**
  - ⇨ How often do you feel upset?_____
  - ⇨ When you feel upset, how long does it last? _____
  - ⇨ How bad does it feel? _____

- **In the past month, does this problem make things harder for you, like make it hard to do well in school or at work, cause problems with your friends or family, or get in the way of doing fun or important things?**
  - ⇨ Are there things you don't do, or places you won't go, because of this problem? _____
  - ⇨ Does this problem make it hard to focus or concentrate? _____

☐ Problems at school
☐ Problems with work or role functioning
☐ Problems with social life
☐ Problems with family
☐ Problems with home responsibilities
☐ Problems with leisure activities
☐ Legal problems
☐ Problems of health or safety
☐ Other functional impairment _____

Current Severity of Illness Anxiety Disorder (circle number):

	Distress	Impairment
1. **Normal**	• No distress at all or full remission	• No impairment at all or full remission
2. **Borderline**	• Between Normal and Mild, or subthreshold	• Between Normal and Mild, or subthreshold
3. **Mild**	• Fairly infrequent distress OR • Brief duration of distress OR • Distress is slight	• Impairment is slight in 1 domain of functioning (e.g., taking longer to complete work tasks, occasional social avoidance) OR • Still generally able to meet obligations
4. **Moderate**	• Between Mild and Marked	• Between Mild and Marked
5. **Marked**	• Very frequent distress OR • Very long-lasting distress OR • Distress is substantial	• Impairment is significant in many domains of functioning (e.g., work, social, family life) OR • Some failure to meet role obligations (e.g., poor work performance, missing days of work) OR • Symptoms pose a minor risk of harm to self or others
6. **Severe**	• Between Marked and Extreme	• Between Marked and Extreme
7. **Extreme**	• Distress occurs constantly without relief OR • Distress is extremely intense or unbearable	• Impairment is extreme in most or all domains of functioning (e.g., completely unable to work or engage in social interactions) OR • Patient is considered incapacitated OR • Symptoms pose a severe risk of harm to self or others OR • Acutely psychotic OR • In need of hospitalization or residential care

TRAUMA- AND STRESSOR-RELATED DISORDERS

POTENTIALLY TRAUMATIC EVENT

Best source: Child with or without parent, depending on age and developmental level

- **Have you[35] ever had something really bad happen to you, where you thought you might die or be really badly hurt? For example, have you ever been in a really bad accident? Has anyone ever hurt you really badly or threatened to hurt you really badly? Has anyone ever touched you in a way that made you uncomfortable, or made you do sexual things that you weren't comfortable with?**

- **Have you ever seen things like these happen to another person? Have you ever heard that something like this happened to a close family member or close friend?**

- **Have you ever heard very awful details about something bad happening? Did you hear those details over and over again?[36]**
  - ⇨ What did you hear? _____

Experienced	Witnessed directly or learned of	Received repeated or extreme details	
☐	☐	☐	Exposure to war or combat
☐	☐	☐	Physical assault
☐	☐	☐	Threatened physical assault
☐	☐	☐	Sexual violence
☐	☐	☐	Threatened sexual violence
☐	☐	☐	Being kidnapped or held hostage
☐	☐	☐	Terrorist attack
☐	☐	☐	Being tortured or a prisoner of war
☐	☐	☐	Natural or man-made disaster
☐	☐	☐	Serious motor vehicle accident
☐	☐	☐	A sudden, terrible medical event
☐	☐	☐	Other traumatic experience _____

(Note: this criterion is met if any of the above are checked.)

1. *Does the child report exposure to actual or threatened death, serious injury, or sexual violence?*	*Yes*	*No*

- **When did (event/events) happen?** _____
  - ☐ Less than 1 month ago: administer the module for Acute Stress Disorder (p. 85)
  - ☐ More than 1 month ago: administer the module for Posttraumatic Stress Disorder (p. 87)

[35] Or "your child;" continue as appropriate.

[36] Repeated or extreme exposure to details of a traumatic event through the media should not be counted here, unless such exposure is work-related.

ACUTE STRESS DISORDER

Best source: Child with or without parent, depending on age and developmental level. Consider behavioral observations in addition to self-report.

1. *Does the child report a significant potentially traumatic event within the past month (see p. 84)?*	*Yes*	*No* *Skip to item 6 and circle "No"*

- **Sometimes when someone has something really upsetting happen to them, it can still bother them even later on. I'd like to ask you about that.**
- **Since the (event), do you[37] think or dream about it a lot, even when you don't want to?** _____

☐ Do memories of (the event) pop into your mind even when you don't want them to and bother you? [Recurrent, involuntary, intrusive, and distressing memories of the event]

☐ Do you have bad dreams? [Recurrent, distressing dreams that are related to the event in content or affect]

☐ When something reminds you of (the event), do you get really upset? Do you have a lot of changes in your body when that happens? [Intense or prolonged psychological distress or strong physiological reactions to cues that resemble the event]

☐ Do you sometimes feel like (the event) is happening again? [Dissociative flashbacks in which it feels as if the event is happening again]

- **Since the (event), do you stay away from things that remind you of what happened or try not to think about it?** _____

☐ Do you try not to think about (the event)? How do you try? [Efforts to avoid unpleasant memories thoughts, or feelings related to the event]

☐ Are there parts of (the event) that you can't remember, even if you try? Is that because you hurt your head or were using alcohol or drugs that made you forget? [Inability to remember an important aspect of the event, not due to head injury, alcohol, or drugs]

☐ Do you try to stay away from certain people, places, or things that remind you of (the event)? How do you try? [Efforts to avoid external reminders (e.g., certain people, places, conversations, activities, objects, or situations) related to the event]

- **Since the (event), have your feelings changed a lot?** _____

☐ Do you feel like you can't have any good feelings, like happiness or love? [Persistent inability to experience positive emotions (e.g., happiness, satisfaction, love)]

☐ Do you sometimes feel like you're really "spaced out" or that you're outside of your own body? [Altered sense of reality (e.g., "out of body experience," being in a daze, time slowing down)]

[37] Or "your child;" continue as appropriate.

- **Since the (event), have you been more cranky or jumpy? Have you had a lot of trouble sleeping or concentrating?** _____

☐ Are you very jumpy if something surprises you? [Exaggerated startle response]
☐ Do you feel like you're always "on guard" or looking for danger? [Hypervigilance or excessive scanning of the environment for threat]
☐ Do you have trouble falling asleep or staying asleep? [Sleep disturbance (difficulty falling asleep, difficulty staying asleep, restless sleep)]
☐ Do you get really cranky for no good reason? Do you "blow up" in anger for no good reason? [Irritable behavior and angry or aggressive outbursts, with little or no provocation]
☐ Is it hard for you to pay attention to what you're doing, like at school? [Difficulty concentrating]

2. *Does the child report at least 9 of the above symptoms that began or worsened after the event?*	*Yes*	*No* *Skip to item 6 and circle "No"*

- **In the past month, how much does this problem bother or upset you?**
  - ⇨ How often do you feel upset?_____
  - ⇨ When you feel upset, how long does it last? _____
  - ⇨ How bad does it feel? _____

- **In the past month, does this problem make things harder for you, like make it hard to do well in school or at work, cause problems with your friends or family, or get in the way of doing fun or important things?**
  - ⇨ Are there things you don't do, or places you won't go, because of this problem? _____
  - ⇨ Does this problem make it hard to focus or concentrate? _____

☐ Problems at school
☐ Problems with work or role functioning
☐ Problems with social life
☐ Problems with family
☐ Problems with home responsibilities
☐ Problems with leisure activities
☐ Legal problems
☐ Problems of health or safety
☐ Other functional impairment _____

3. *Do the symptoms cause significant distress, or cause impairment in important areas of functioning?*	*Yes*	*No* *Skip to item 6 and circle "No"*

- **How long has this been happening?** _____

4. *Have the symptoms been present for 3 days to 1 month?*	*Yes*	*No* *Skip to item 6 and circle "No"*

- **Just before you started having this problem, did your doctor change any medicine you were taking, did you use any drugs, or did you have an illness or injury?** _____
  - ⇨ Do you think this problem was caused by an illness, drugs, or changes in your medicine? _____
  - ⇨ Have you or your parents talked to a medical doctor about this? _____

5. *Are the symptoms attributable to the physiological effects of a substance or another medical condition? (If yes, complete applicable substance-induced or general medical condition module)*	*No*	*Yes* *Skip to item 6 and circle "No"*

6. **ACUTE STRESS DISORDER**	*Yes*	*No*

Current Severity of Acute Stress Disorder (circle number):

	Distress	Impairment
1. Normal	• No distress at all or full remission	• No impairment at all or full remission
2. Borderline	• Between Normal and Mild, or subthreshold	• Between Normal and Mild, or subthreshold
3. Mild	• Fairly infrequent distress OR • Brief duration of distress OR • Distress is slight	• Impairment is slight in 1 domain of functioning (e.g., taking longer to complete school tasks, occasional social avoidance) OR • Still generally able to meet obligations
4. Moderate	• Between Mild and Marked	• Between Mild and Marked
5. Marked	• Very frequent distress OR • Very long-lasting distress OR • Distress is substantial	• Impairment is significant in many domains of functioning (e.g., school, social, family life) OR • Some failure to meet role obligations (e.g., poor school performance, missing days of school) OR • Symptoms pose a minor risk of harm to self or others
6. Severe	• Between Marked and Extreme	• Between Marked and Extreme
7. Extreme	• Distress occurs constantly without relief OR • Distress is extremely intense or unbearable	• Impairment is extreme in most or all domains of functioning (e.g., completely unable to perform in school or engage in social interactions) OR • Patient is considered incapacitated OR • Symptoms pose a severe risk of harm to self or others OR • Acutely psychotic OR • In need of hospitalization or residential care

POSTTRAUMATIC STRESS DISORDER (AGES 7 AND UP)

Best source: Child with or without parent, depending on age and developmental level. Consider behavioral observations in addition to self-report.

1. *Does the child report a significant potentially traumatic event more than 1 month ago (see p. 84)?*	*Yes*	*No* *Skip to item 9 and circle "No"*

- **Sometimes when someone has something really upsetting happen to them, it can still bother them even later on. I'd like to ask you about that.**
- **In the past month, do you[38] think or dream about it a lot, even when you don't want to?** _____

- ☐ Do memories of (the event) pop into your mind even when you don't want them to and bother you? (for younger children: Does your child's play often seem to be about it)? [Recurrent, involuntary, intrusive, and distressing memories of the event]
- ☐ Do you have bad dreams? [Recurrent, distressing dreams that may or may not be related to the event in content or affect]
- ☐ Do you sometimes feel like (the event) is happening again? (for younger children: Does your child's play often seem to be repeating what happened?) [Dissociative flashbacks in which it feels as if the event is happening again]
- ☐ When something reminds you of (the event), do you get really upset? [Intense or prolonged psychological distress to cues that resemble the event]
- ☐ When something reminds you of (the event), do you have a lot of changes in your body? [Strong physiological reactions to internal or external cues that resemble the event]

2. *Does the child report at least one of the above intrusive mental or physical symptoms related to the event?*	*Yes*	*No* *Skip to item 9 and circle "No"*

- **In the past month, do you try to stay away from things that remind you of what happened, or do you try not to think about it?** _____

- ☐ Do you try not to think about (the event)? How do you try? [Efforts to avoid unpleasant memories thoughts, or feelings related to the event]
- ☐ Do you try to stay away from certain people, places, or situations that remind you of (the event)? How do you try? [Efforts to avoid external reminders (e.g., certain people, places, conversations, activities, objects, or situations) related to the event]

3. *Does the child report at least one of the above symptoms of persistent avoidance of stimuli associated with the event?*	*Yes*	*No* *Skip to item 9 and circle "No"*

[38] Or "your child;" continue as appropriate.

- **In the past month, has there been a big change in your feelings? Have you changed the way you think about yourself, the world, or the future?** _____

- Are there parts of (the event) that you can't remember, even if you try? Is that because you hurt your head or were using alcohol or drugs that made you forget? [Inability to remember an important aspect of the event, not due to head injury, alcohol, or drugs]
- Do you feel really bad about yourself? Do you think that other people, or the world, are dangerous? [Persistent and exaggerated negative beliefs about one's self, others, or the world]
- Do you spend a lot of time blaming someone for (the event)? Whom do you blame for (the event)? [Persistent, distorted cognitions about the cause or consequences of the event, leading the child to blame self or others]
- Do you feel unhappy most of the time? [Persistent negative emotional state]
- Do you not feel like doing anything, or does nothing seem fun? [Marked decrease in interest or participation in significant activities]
- Do you feel like no one understands you or that you can't talk to them? [Feeling detached or estranged from others]
- Do you feel like you can't have any good feelings, like happiness or love? [Persistent inability to experience positive emotions (e.g., happiness, satisfaction, love)]

4. *Does the child report at least two of the above symptoms of negative alterations in mood or cognitions associated with the event?*	*Yes*	*No* *Skip to item 9 and circle "No"*

- **In the past month, have you been more cranky or jumpy? Have you done dangerous things? Have you had a lot of trouble with things like sleep or paying attention?** _____

- Do you get really cranky for no good reason? Do you "blow up" in anger for no good reason? [Irritable behavior and angry or aggressive outbursts, with little or no provocation]
- Do you do things that are dangerous or harmful to you? [Reckless or self-destructive behavior]
- Do you feel like you're always "on guard" or looking for danger? [Hypervigilance or excessive scanning of the environment for threat]
- Are you very jumpy if something surprises you? [Exaggerated startle response]
- Is it hard for you to pay attention to what you're doing, like at school? [Difficulty concentrating]
- Do you have trouble falling asleep or staying asleep? [Sleep disturbance (difficulty falling asleep, difficulty staying asleep, restless sleep)]

5. *Does the child report at least two of the above symptoms of marked alterations in arousal and reactivity associated with the event?*	*Yes*	*No* *Skip to item 9 and circle "No"*

- **In the past month, how much does this problem bother or upset you?**
  - ⇨ How often do you feel upset?_____
  - ⇨ When you feel upset, how long does it last? _____
  - ⇨ How bad does it feel? _____

- **In the past month, does this problem make things harder for you, like make it hard to do well in school or at work, cause problems with your friends or family, or get in the way of doing fun or important things?**
  - ⇨ Are there things you don't do, or places you won't go, because of this problem? _____

⇨ Does this problem make it hard to focus or concentrate? _____

- ☐ Problems at school
- ☐ Problems with work or role functioning
- ☐ Problems with social life
- ☐ Problems with family
- ☐ Problems with home responsibilities
- ☐ Problems with leisure activities
- ☐ Legal problems
- ☐ Problems of health or safety
- ☐ Other functional impairment _____

6. *Do the symptoms cause significant distress, or cause impairment in important areas of functioning?*	*Yes*	*No* *Skip to item 9 and circle "No"*

💎 **How long has this been happening?** _____

7. *Have the symptoms been present for more than 1 month?*	*Yes*	*No* *Skip to item 9 and circle "No"*

💎 **Just before you started having this problem, did your doctor change any medicine you were taking, did you use any drugs, or did you have an illness or injury?** _____

⇨ Do you think this problem was caused by an illness, drugs, or changes in your medicine? _____

⇨ Have you or your parents talked to a medical doctor about this? _____

8. *Are the symptoms attributable to the physiological effects of a substance or another medical condition? (If yes, complete applicable substance-induced or general medical condition module)*	*No*	*Yes* *Skip to item 9 and circle "No"*

9. **POSTTRAUMATIC STRESS DISORDER**	*Yes*	*No*

POSTTRAUMATIC STRESS DISORDER (AGE 6)

Best source: Child with parent. Consider behavioral observations in addition to self-report.

1. *Does the child report a significant potentially traumatic event more than 1 month ago (see p. 84)?*	*Yes*	*No* *Skip to item 8 and circle "No"*

- **Sometimes when someone has something really upsetting happen to them, it can still bother them even later on. I'd like to ask you about that.**
- **In the past month, do you[39] think or dream about it a lot, even when you don't want to?** _____

- ☐ Do you think about (the event) even when you don't want to? Does it pop into your mind and surprise you? (for parents: Does your child's play often seem to be about it)? [Recurrent, involuntary, and intrusive memories of the event]
- ☐ Do you have bad dreams? [Recurrent, distressing dreams that may or may not be related to the event in content or affect]
- ☐ Do you sometimes feel like (the event) is happening again? (for parents: Does your child's play often seem to be repeating what happened?) [Dissociative flashbacks in which it feels as if the event is happening again]
- ☐ When something reminds you of (the event), do you get really upset? [Intense or prolonged psychological distress to cues that resemble the event]
- ☐ When something reminds you of (the event), do you have a lot of changes in how your body feels? [Strong physiological reactions to internal or external cues that resemble the event]

2. *Does the child report at least one of the above intrusive mental or physical symptoms related to the event?*	*Yes*	*No* *Skip to item 8 and circle "No"*

- **In the past month, do you try to stay away from things that remind you of what happened, or do you try not to think about it?** _____
- **In the past month, has there been a big change in your feelings? Have you changed the way you think about yourself, the world, or the future?** _____

- ☐ Do you try to stay away from things that remind you of (the event)? How do you try? [Efforts to avoid external reminders (e.g., certain people, places, conversations, activities, objects, or situations) related to the event]
- ☐ Do you spend less time with other people, like friends? [Social withdrawal]
- ☐ Do you feel unhappy most of the time? [Persistent negative emotional state]
- ☐ (parent): Does your child seem a lot less happy, or show fewer positive emotions? [Persistent inability to express positive emotions]
- ☐ Do you not feel like doing anything, like playing, or does nothing seem fun? [Marked decrease in interest or participation in significant activities, or constriction of play]

[39] Or "your child;" continue as appropriate.

3. *Does the child report at least one of the above symptoms of persistent avoidance or negative alterations in cognitions?*	*Yes*	*No* *Skip to item 8 and circle "No"*

- **In the past month, have you been cranky or jumpy? Have you done dangerous things? Have you had a lot of trouble with things like sleep or paying attention?** _____

- ☐ Do you get really cranky for no good reason? Do you "blow up" in anger for no good reason? (parents: does your child have extreme temper tantrums?) [Irritable behavior and angry or aggressive outbursts, with little or no provocation]
- ☐ Do you feel like you're always looking for danger? [Hypervigilance or excessive scanning of the environment for threat]
- ☐ Are you very jumpy if something surprises you? [Exaggerated startle response]
- ☐ Is it hard for you to pay attention to what you're doing, like at school? [Difficulty concentrating]
- ☐ Do you have trouble falling asleep or staying asleep? [Sleep disturbance (difficulty falling asleep, difficulty staying asleep, restless sleep)]

4. *Does the child report at least two of the above symptoms of marked alterations in arousal and reactivity associated with the event?*	*Yes*	*No* *Skip to item 8 and circle "No"*

- **In the past month, how much does this problem bother or upset you?**
  - ⇨ How often do you feel upset?_____
  - ⇨ When you feel upset, how long does it last? _____
  - ⇨ How bad does it feel? _____

- **In the past month, does this problem make things harder for you, like make it hard to do well in school or at work, cause problems with your friends or family, or get in the way of doing fun or important things?**
  - ⇨ Are there things you don't do, or places you won't go, because of this problem? _____
  - ⇨ Does this problem make it hard to focus or concentrate? _____

☐ Problems at school
☐ Problems with family
☐ Legal problems
☐ Other functional impairment _____
☐ Problems with work or role functioning
☐ Problems with home responsibilities
☐ Problems with social life
☐ Problems with leisure activities
☐ Problems of health or safety

5. *Do the symptoms cause significant distress, or cause impairment in important areas of functioning?*	*Yes*	*No* *Skip to item 8 and circle "No"*

- **How long have you been experiencing these problems?** _____

6. *Have the symptoms been present for more than 1 month?*	*Yes*	*No* *Skip to item 8 and circle "No"*

- **Just before you started having this problem, did your doctor change any medicine you were taking, did you use any drugs, or did you have an illness or injury?** _____

⇨ Do you think this problem was caused by an illness, drugs, or changes in your medicine? _____
⇨ Have you or your parents talked to a medical doctor about this? _____

7. *Are the symptoms attributable to the physiological effects of a substance or another medical condition? (If yes, complete applicable substance-induced or general medical condition module)*	*No*	*Yes* *Skip to item 8 and circle "No"*

8. **POSTTRAUMATIC STRESS DISORDER**	*Yes*	*No*

Current Severity of Posttraumatic Stress Disorder (circle number):

	Distress	Impairment
1. Normal	• No distress at all or full remission	• No impairment at all or full remission
2. Borderline	• Between Normal and Mild, or subthreshold	• Between Normal and Mild, or subthreshold
3. Mild	• Fairly infrequent distress OR • Brief duration of distress OR • Distress is slight	• Impairment is slight in 1 domain of functioning (e.g., taking longer to complete school tasks, occasional social avoidance) OR • Still generally able to meet obligations
4. Moderate	• Between Mild and Marked	• Between Mild and Marked
5. Marked	• Very frequent distress OR • Very long-lasting distress OR • Distress is substantial	• Impairment is significant in many domains of functioning (e.g., school, social, family life) OR • Some failure to meet role obligations (e.g., poor school performance, missing days of school) OR • Symptoms pose a minor risk of harm to self or others
6. Severe	• Between Marked and Extreme	• Between Marked and Extreme
7. Extreme	• Distress occurs constantly without relief OR • Distress is extremely intense or unbearable	• Impairment is extreme in most or all domains of functioning (e.g., completely unable to perform in school or engage in social interactions) OR • Patient is considered incapacitated OR • Symptoms pose a severe risk of harm to self or others OR • Acutely psychotic OR • In need of hospitalization or residential care

ADJUSTMENT DISORDER

Best source: Child with or without parent, depending on age and developmental level

Administer if: The child does not meet criteria for Posttraumatic Stress Disorder or Acute Stress Disorder

- **Has anything really upsetting happened within the past 6 months? Have there been any big events or changes in your[40] life within the past 6 months?** _____
  - ⇨ What kind of stressful or unpleasant things have happened? _____

☐ Work stressors ☐ School stressors ☐ Medical stressors
☐ Social stressors ☐ Family stressors ☐ Legal stressors
☐ Financial stressors ☐ Other stressors _____

1. *Does the child report identifiable stressor(s)?*	*Yes*	*No* *Skip to item 7 and circle "No"*

- **Since (event) and in the past month, have you noticed a big difference in how you feel or act?** _____
  - ⇨ What kinds of changes have you noticed? _____

☐ Depressed mood ☐ Anxious mood
☐ Disturbance of conduct ☐ Other change _____

2. *Does the child report development of emotional or behavioral symptoms in response to the stressor(s)?*	*Yes*	*No* *Skip to item 7 and circle "No"*

3. *Do the symptoms represent normal bereavement?*	*No*	*Yes* *Skip to item 7 and circle "No"*

- **When did you first notice those changes?** _____

4. *Did the emotional or behavioral symptoms begin within 3 months of the onset of the stressor(s)?*	*Yes*	*No* *Skip to item 7 and circle "No"*

5. *Is the reaction attributable to another mental disorder, or is simply an exacerbation of a pre-existing mental disorder?*	*No*	*Yes* *Skip to item 7 and circle "No"*

- **In the past month, how much does this problem bother or upset you?**
  - ⇨ How often do you feel upset?_____
  - ⇨ When you feel upset, how long does it last? _____
  - ⇨ How bad does it feel? _____

[40] Or "your child;" continue as appropriate.

- **In the past month, does this problem make things harder for you, like make it hard to do well in school or at work, cause problems with your friends or family, or get in the way of doing fun or important things?**
  - ⇨ Are there things you don't do, or places you won't go, because of this problem? _____
  - ⇨ Does this problem make it hard to focus or concentrate? _____

☐ Problems at school
☐ Problems with work or role functioning
☐ Problems with social life
☐ Problems with family
☐ Problems with home responsibilities
☐ Problems with leisure activities
☐ Legal problems
☐ Problems of health or safety
☐ Other functional impairment _____

6. *Do the emotional or behavioral symptoms cause significant distress that is out of proportion to the stressor in your judgment, or cause impairment in important areas of functioning?*	*Yes*	*No* *Skip to item 7 and circle "No"*

7. **ADJUSTMENT DISORDER**	*Yes*	*No*

Current Severity of Adjustment Disorder (circle number):

	Distress	Impairment
1. Normal	• No distress at all or full remission	• No impairment at all or full remission
2. Borderline	• Between Normal and Mild, or subthreshold	• Between Normal and Mild, or subthreshold
3. Mild	• Fairly infrequent distress OR • Brief duration of distress OR • Distress is slight	• Impairment is slight in 1 domain of functioning (e.g., taking longer to complete school tasks, occasional social avoidance) OR • Still generally able to meet obligations
4. Moderate	• Between Mild and Marked	• Between Mild and Marked
5. Marked	• Very frequent distress OR • Very long-lasting distress OR • Distress is substantial	• Impairment is significant in many domains of functioning (e.g., school, social, family life) OR • Some failure to meet role obligations (e.g., poor school performance, missing days of school) OR • Symptoms pose a minor risk of harm to self or others
6. Severe	• Between Marked and Extreme	• Between Marked and Extreme
7. Extreme	• Distress occurs constantly without relief OR • Distress is extremely intense or unbearable	• Impairment is extreme in most or all domains of functioning (e.g., completely unable to perform in school or engage in social interactions) OR • Patient is considered incapacitated OR • Symptoms pose a severe risk of harm to self or others OR • Acutely psychotic OR • In need of hospitalization or residential care

FEEDING AND EATING DISORDERS

ANOREXIA NERVOSA

Best source: Child with or without parent, depending on age and developmental level. Consider measuring height and weight in addition to self-report.

- Do you[41] eat 3 meals a day? What do you eat for breakfast? For lunch? For dinner? _____
  - ⇨ Has anyone ever told you that you were too thin, or that you didn't eat enough? _____
  - ⇨ Do you try to eat very little? _____
  - ⇨ Do you count how many calories you eat? How many calories do you eat per day? _____
  - ⇨ What is your height? _____ What is your weight? _____

(Note: BMI of 17 or lower is considered to represent moderate to severe thinness, although this need not be the sole criterion for determining low body weight.)

☐ Restricted food intake ☐ Significantly low body weight resulting from restricted food intake

Body Mass Index (BMI) Table

		Height (feet/inches on top, centimeters on bottom)																						
Weight		4'8"	4'9"	4'10"	4'11"	5'0"	5'1"	5'2"	5'3"	5'4"	5'5"	5'6"	5'7"	5'8"	5'9"	5'10"	5'11"	6'0"	6'1"	6'2"	6'3"	6'4"	6'5"
lb	Kg	142 cm	145	147	150	152	155	157	160	163	165	168	170	173	175	178	180	183	185	188	191	193	196
260	117.9	58	56	54	52	51	49	48	46	45	43	42	41	40	38	37	36	35	34	33	32	32	31
250	113.4	56	54	52	50	49	47	46	44	43	42	40	39	38	37	36	35	34	33	32	31	30	30
240	108.9	54	52	50	48	47	45	44	43	41	40	39	38	37	35	34	33	33	32	31	30	29	28
230	104.3	52	50	48	46	45	43	42	41	39	38	37	36	35	34	33	32	31	30	30	29	28	27
220	99.8	49	48	46	44	43	42	40	39	38	37	36	34	33	32	32	31	30	29	28	28	27	26
210	95.3	47	45	44	42	41	40	38	37	36	35	34	33	32	31	30	29	28	28	27	26	26	25
200	90.7	45	43	42	40	39	38	37	35	34	33	32	31	30	30	29	28	27	26	26	25	24	24
190	86.2	43	41	40	38	37	36	35	34	33	32	31	30	29	28	27	27	26	25	24	24	23	23
180	81.6	40	39	38	36	35	34	33	32	31	30	29	28	27	27	26	25	24	24	23	22	22	21
170	77.1	38	37	36	34	33	32	31	30	29	28	27	27	26	25	24	24	23	22	22	21	21	20
160	72.6	36	35	33	32	31	30	29	28	27	27	26	25	24	24	23	22	22	21	21	20	19	19
150	68.0	34	32	31	30	29	28	27	27	26	25	24	23	23	22	22	21	20	20	19	19	18	18
140	63.5	31	30	29	28	27	26	26	25	24	23	23	22	21	21	20	20	19	18	18	17	17	17
130	59.0	29	28	27	26	25	25	24	23	22	22	21	20	20	19	19	18	18	17	17	16	16	15
120	54.4	27	26	25	24	23	23	22	21	21	20	19	19	18	18	17	17	16	16	15	15	15	14
110	49.9	25	24	23	22	21	21	20	19	19	18	18	17	17	16	16	15	15	15	14	14	13	13
100	45.4	22	22	21	20	20	19	18	18	17	17	16	16	15	15	14	14	14	13	13	13	12	12
90	40.8	20	19	19	18	18	17	16	16	15	15	15	14	14	13	13	13	12	12	12	11	11	11
80	36.3	18	17	17	16	16	15	15	14	14	13	13	13	12	12	11	11	11	11	10	10	10	9

[41] Or "your child;" continue as appropriate.

(Note: this criterion is met if both of the above are checked.)

1. *Is food intake restricted, leading to significantly low body weight?*	*Yes*	*No* *Skip to item 4 and circle "No"*

- **In the past month, are you very afraid of gaining weight or becoming fat?** _____

- **In the past month, besides eating very little, are there other things that you do so you won't gain weight?** _____

☐ Do you throw up on purpose? [Vomiting]
☐ Do you take medicines that make you go to the bathroom a lot? [Misuse of laxatives or diuretics]
☐ Do you go for a long time without eating? [Fasting]
☐ Do you exercise a lot? [Excessive exercise]
☐ Do you have to eat in a certain way or at a certain time? [Ritualized eating pattern]
☐ Other behavior to prevent weight gain _____

☐ Intense fear of gaining weight or becoming fat
☐ Persistent behaviors that interfere with weight gain

(Note: this criterion is met if either of the above is checked.)

2. *Is there intense fear of gaining weight or becoming fat, or persistent behavior that interferes with weight gain?*	*Yes*	*No* *Skip to item 4 and circle "No"*

- **What do you think about how your body looks now?**
  - ⇨ Do you think you are overweight or fat? _____
  - ⇨ Do you think that parts of your body are fat? _____

- **In the past month, how do you feel about yourself in general?**
  - ⇨ How important is it for you to be thin? _____
  - ⇨ How does your weight or body shape affect how you feel about yourself? _____
  - ⇨ Do you spend a lot of time checking your weight or your body shape? _____
  - ⇨ Do you think that your weight is so low that it's bad for your health? _____

☐ Disturbed experience of body weight or shape
☐ Undue influence of body weight or shape on self-evaluation
☐ Persistent lack of recognition of the seriousness of low body weight

(Note: this criterion is met if any of the above are checked.)

3. *Is there a disturbed experience of body weight or shape, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight?*	*Yes*	*No* *Skip to item 4 and circle "No"*

4. **ANOREXIA NERVOSA**[42]	*Yes*	*No*

[42] If clinically significant restricted food intake is present, regardless of diagnosis, complete the PANS screener on p. 143.

- **In the past month, how much does this problem bother or upset you?**
  - ⇨ How often do you feel upset?_____
  - ⇨ When you feel upset, how long does it last? _____
  - ⇨ How bad does it feel? _____

- **In the past month, does this problem make things harder for you, like make it hard to do well in school or at work, cause problems with your friends or family, or get in the way of doing fun or important things?**
  - ⇨ Are there things you don't do, or places you won't go, because of this problem? _____
  - ⇨ Does this problem make it hard to focus or concentrate? _____

☐ Problems at school
☐ Problems with work or role functioning
☐ Problems with social life
☐ Problems with family
☐ Problems with home responsibilities
☐ Problems with leisure activities
☐ Legal problems
☐ Problems of health or safety
☐ Other functional impairment _____

Current Severity of Anorexia Nervosa (circle number):

	Distress	Impairment
1. Normal	• No distress at all or full remission	• No impairment at all or full remission
2. Borderline	• Between Normal and Mild, or subthreshold	• Between Normal and Mild, or subthreshold
3. Mild	• Fairly infrequent distress OR • Brief duration of distress OR • Distress is slight	• Impairment is slight in 1 domain of functioning (e.g., taking longer to complete school tasks, occasional social avoidance) OR • Still generally able to meet obligations
4. Moderate	• Between Mild and Marked	• Between Mild and Marked
5. Marked	• Very frequent distress OR • Very long-lasting distress OR • Distress is substantial	• Impairment is significant in many domains of functioning (e.g., school, social, family life) OR • Some failure to meet role obligations (e.g., poor school performance, missing days of school) OR • Symptoms pose a minor risk of harm to self or others
6. Severe	• Between Marked and Extreme	• Between Marked and Extreme
7. Extreme	• Distress occurs constantly without relief OR • Distress is extremely intense or unbearable	• Impairment is extreme in most or all domains of functioning (e.g., completely unable to perform in school or engage in social interactions) OR • Patient is considered incapacitated OR • Symptoms pose a severe risk of harm to self or others OR • Acutely psychotic OR • In need of hospitalization or residential care

BINGE EATING

Best source: Child with or without parent, depending on age and developmental level. Consider medical records and physical examination in addition to self-report.

- **In the past month, do you[43] often have times when you eat a lot of food at once? Or times when it feels like your eating is out of control?** _____
  - ⇨ How often has this happened? _____
  - ⇨ How much do you eat during these times? _____
  - ⇨ During these times, does it feel like you can't stop eating, or that you can't control how much you are eating? _____
  - ⇨ How long do they last? Do they have a clear beginning and end? _____

☐ Eating an amount of food that is definitely larger than what most people would eat in a similar period under similar circumstances, during a discrete period of time (e.g., a 2-hour period)

☐ A sense of lack of control over eating during the episode

(Note: this criterion is met if both of the above are checked.)

1. *Are there recurrent episodes of binge eating?*	*Yes*	*No*

[43] Or "your child;" continue as appropriate.

BULIMIA NERVOSA

Best source: Child with or without parent, depending on age and developmental level
Administer if: The patient does not meet criteria for Anorexia Nervosa.

1. *Are there recurrent episodes of binge eating? (see p. 99)*	*Yes*	*No* *Skip to item 6 and circle "No"*

- **In the past month, do you[44] do anything to make sure you don't gain weight?** _____
  - ☐ Do you throw up on purpose? [Vomiting]
  - ☐ Do you take medicines that make you go to the bathroom a lot? [Misuse of laxatives or diuretics]
  - ☐ Do you go for a long time without eating? [Fasting]
  - ☐ Do you exercise a lot? [Excessive exercise]
  - ☐ Do you have to eat in a certain way or at a certain time? [Ritualized eating pattern]
  - ☐ Other behavior to prevent weight gain _____

(Note: continue if any of the above is checked.)

- **How often do you do these things?** _____

2. *Are there recurrent, inappropriate compensatory behaviors in order to prevent weight gain?*	*Yes*	*No* *Skip to item 6 and circle "No"*

Over the past 3 months, have you had those times of overeating and (behaviors from item 2) at least once per week? _____

3. *Do binge eating and compensatory behaviors both occur an average of at least once a week for 3 months?*	*Yes*	*No* *Skip to item 6 and circle "No"*

- **In the past month, how do you feel about yourself in general?** _____
  - ⇨ How important is it for you to be thin? _____
  - ⇨ How does your weight or body shape affect how you feel about yourself? _____
  - ⇨ Do you spend a lot of time checking your weight or your body shape? _____

4. *Is there an undue influence of body weight or shape on self-evaluation?*	*Yes*	*No* *Skip to item 6 and circle "No"*

5. *Does the disturbance occur exclusively during the course of anorexia nervosa (see p. 96)?*	*No*	*Yes* *Skip to item 6 and circle "No"*

6. **BULIMIA NERVOSA**	*Yes*	*No*

[44] Or "your child;" continue as appropriate.

- **In the past month, how much does this problem bother or upset you?**
  - ⇨ How often do you feel upset?_____
  - ⇨ When you feel upset, how long does it last? _____
  - ⇨ How bad does it feel? _____

- **In the past month, does this problem make things harder for you, like make it hard to do well in school or at work, cause problems with your friends or family, or get in the way of doing fun or important things?**
  - ⇨ Are there things you don't do, or places you won't go, because of this problem? _____
  - ⇨ Does this problem make it hard to focus or concentrate? _____

☐ Problems at school
☐ Problems with work or role functioning
☐ Problems with social life
☐ Problems with family
☐ Problems with home responsibilities
☐ Problems with leisure activities
☐ Legal problems
☐ Problems of health or safety
☐ Other functional impairment _____

Current Severity of Bulimia Nervosa (circle number):

	Distress	Impairment
1. Normal	• No distress at all or full remission	• No impairment at all or full remission
2. Borderline	• Between Normal and Mild, or subthreshold	• Between Normal and Mild, or subthreshold
3. Mild	• Fairly infrequent distress OR • Brief duration of distress OR • Distress is slight	• Impairment is slight in 1 domain of functioning (e.g., taking longer to complete school tasks, occasional social avoidance) OR • Still generally able to meet obligations
4. Moderate	• Between Mild and Marked	• Between Mild and Marked
5. Marked	• Very frequent distress OR • Very long-lasting distress OR • Distress is substantial	• Impairment is significant in many domains of functioning (e.g., school, social, family life) OR • Some failure to meet role obligations (e.g., poor school performance, missing days of school) OR • Symptoms pose a minor risk of harm to self or others
6. Severe	• Between Marked and Extreme	• Between Marked and Extreme
7. Extreme	• Distress occurs constantly without relief OR • Distress is extremely intense or unbearable	• Impairment is extreme in most or all domains of functioning (e.g., completely unable to perform in school or engage in social interactions) OR • Patient is considered incapacitated OR • Symptoms pose a severe risk of harm to self or others OR • Acutely psychotic OR • In need of hospitalization or residential care

BINGE-EATING DISORDER

Best source: Child with or without parent, depending on age and developmental level
Administer if: The patient does not meet criteria for Anorexia Nervosa or Bulimia Nervosa

1. Are there recurrent episodes of binge eating? (see p. 99)	*Yes*	*No* *Skip to item 6 and circle "No"*

- ☐ In the past month, when you've had those times of overeating, how quickly do you eat? [Eats much more rapidly than usual]
- ☐ How full do you get? [Eats until uncomfortably full]
- ☐ Do you have these times of overeating even when you don't feel hungry? [Eats large amounts of food even when not physically hungry]
- ☐ Do you eat by yourself, or with others? Why is that? [Eats alone due to embarrassment about the amount of food eaten]
- ☐ How do you feel afterwards? Do you feel sad, guilty, or bad about yourself? [Feels disgusted with self, depressed, or very guilty after binges]

(Note: this criterion is met if 3 or more of the above are checked.)

2. Are the binge-eating episodes associated with at least 3 of the above symptoms?	*Yes*	*No* *Skip to item 6 and circle "No"*

💎 **In the past month, how much does this problem bother or upset you?**

- ⇨ How often do you feel upset?_____
- ⇨ When you feel upset, how long does it last? _____
- ⇨ How bad does it feel? _____

3. Does the binge eating cause significant distress?	*Yes*	*No* *Skip to item 6 and circle "No"*

💎 **Over the past 3 months, in an average week, have you had these eating "binges" at least once per week?**

4. Has the binge eating occurred an average of at least once a week for 3 months?	*Yes*	*No* *Skip to item 6 and circle "No"*

5. Does the disturbance occur exclusively during the course of bulimia nervosa (see p. 99) or anorexia nervosa (see p. 96)?	*No*	*Yes* *Skip to item 6 and circle "No"*

6. BINGE-EATING DISORDER	*Yes*	*No*

- **In the past month, does this problem make things harder for you, like make it hard to do well in school or at work, cause problems with your friends or family, or get in the way of doing fun or important things?**
  - ⇨ Are there things you don't do, or places you won't go, because of this problem? _____
  - ⇨ Does this problem make it hard to focus or concentrate? _____

☐ Problems at school ☐ Problems with work or role functioning ☐ Problems with social life
☐ Problems with family ☐ Problems with home responsibilities ☐ Problems with leisure activities
☐ Legal problems ☐ Problems of health or safety
☐ Other functional impairment _____

Current Severity of Binge Eating Disorder (circle number):

	Distress	Impairment
1. Normal	• No distress at all or full remission	• No impairment at all or full remission
2. Borderline	• Between Normal and Mild, or subthreshold	• Between Normal and Mild, or subthreshold
3. Mild	• Fairly infrequent distress OR • Brief duration of distress OR • Distress is slight	• Impairment is slight in 1 domain of functioning (e.g., taking longer to complete school tasks, occasional social avoidance) OR • Still generally able to meet obligations
4. Moderate	• Between Mild and Marked	• Between Mild and Marked
5. Marked	• Very frequent distress OR • Very long-lasting distress OR • Distress is substantial	• Impairment is significant in many domains of functioning (e.g., school, social, family life) OR • Some failure to meet role obligations (e.g., poor school performance, missing days of school) OR • Symptoms pose a minor risk of harm to self or others
6. Severe	• Between Marked and Extreme	• Between Marked and Extreme
7. Extreme	• Distress occurs constantly without relief OR • Distress is extremely intense or unbearable	• Impairment is extreme in most or all domains of functioning (e.g., completely unable to perform in school or engage in social interactions) OR • Patient is considered incapacitated OR • Symptoms pose a severe risk of harm to self or others OR • Acutely psychotic OR • In need of hospitalization or residential care

AVOIDANT/RESTRICTIVE FOOD INTAKE DISORDER

Best source: Child with parent

- **In the past month, are you[45] a really picky eater?** _____
  - ⇨ Are there only a few foods that you will eat? _____
  - ⇨ Why do you think you are eating very little? _____
  - ⇨ Do you stay away from certain foods because of the way they look, smell, or feel? Or because of how they feel when you chew them? _____
  - ⇨ Do you not really care about eating? _____
  - ⇨ Are you worried that something bad will happen if you eat these foods? _____

- **Has anyone ever told you that you're not eating enough, or getting enough vitamins?** _____

1. Is there an eating or feeding disturbance manifested by persistent failure to meet nutritional and/or energy needs?	*Yes*	*No* *Skip to item 6 and circle "No"*

- **Because of how you eat …**
  - ☐ Have you lost weight? [Significant weight loss]
  - ☐ Do you have a hard time getting enough vitamins? [Significant nutritional deficiency]
  - ☐ Do you have to eat or drink any supplements because of how you eat?, Have you ever had to go to a hospital and have a tube put in your stomach? [Dependence on enteral feeding or oral nutritional supplements]
  - ☐ Has the way you eat caused problems with your work, your school, your friends, or other activities? [Marked interference in functioning]

2. Does the eating or feeding disturbance cause at least one of the items above?	*Yes*	*No* *Skip to item 6 and circle "No"*

- **Do you eat very little because there's not enough food around?** _____
- **Do you eat very little because of your religion or your family's rules about what you shouldn't eat?** ____
  - ⇨ Do other people from your religion or your family have the same eating habits that you do? _____

3. Are the symptoms better explained by lack of available food or a culturally sanctioned practice?	*No*	*Yes* *Skip to item 6 and circle "No"*

- **In the past month, are you eating this way because you're very worried about gaining weight or about how your body looks?** _____
  - ⇨ How important is it for you to be thin? _____
  - ⇨ How does your weight or body shape affect how you feel about yourself? _____
  - ⇨ Do you spend a lot of time checking your weight or your body shape? _____

[45] Or "your child;" continue as appropriate.

4. Does the eating disturbance occur exclusively during the course of bulimia nervosa (see p. 99) or anorexia nervosa (see p. 96), or is there evidence of concerns about body weight or shape?	*No*	*Yes* *Skip to item 6 and circle "No"*

- **Just before you started having this problem, did your doctor change any medicine you were taking, did you use any drugs, or did you have an illness or injury?** _____
  - ⇨ Do you think this problem was caused by an illness, drugs, or changes in your medicine? _____
  - ⇨ Have you or your parents talked to a medical doctor about this? _____

5. Is the disturbance attributable to another medical condition or mental disorder?	*No*	*Yes* *Skip to item 6 and circle "No"*

6. AVOIDANT/RESTRICTIVE FOOD INTAKE DISORDER[46]	*Yes*	*No*

- **In the past month, how much does this problem bother or upset you?**
  - ⇨ How often do you feel upset?_____
  - ⇨ When you feel upset, how long does it last? _____
  - ⇨ How bad does it feel? _____

- **In the past month, does this problem make things harder for you, like make it hard to do well in school or at work, cause problems with your friends or family, or get in the way of doing fun or important things?**
  - ⇨ Are there things you don't do, or places you won't go, because of this problem? _____
  - ⇨ Does this problem make it hard to focus or concentrate? _____

☐ Problems at school
☐ Problems with family
☐ Legal problems
☐ Other functional impairment _____
☐ Problems with work or role functioning
☐ Problems with home responsibilities
☐ Problems with social life
☐ Problems with leisure activities
☐ Problems of health or safety

[46] If clinically significant restricted food intake is present, regardless of diagnosis, complete the PANS screener on p. 143.

Current Severity of Avoidant/Restrictive Food Intake Disorder (circle number):

	Distress	Impairment
1. Normal	• No distress at all or full remission	• No impairment at all or full remission
2. Borderline	• Between Normal and Mild, or subthreshold	• Between Normal and Mild, or subthreshold
3. Mild	• Fairly infrequent distress OR • Brief duration of distress OR • Distress is slight	• Impairment is slight in 1 domain of functioning (e.g., taking longer to complete school tasks, occasional social avoidance) OR • Still generally able to meet obligations
4. Moderate	• Between Mild and Marked	• Between Mild and Marked
5. Marked	• Very frequent distress OR • Very long-lasting distress OR • Distress is substantial	• Impairment is significant in many domains of functioning (e.g., school, social, family life) OR • Some failure to meet role obligations (e.g., poor school performance, missing days of school) OR • Symptoms pose a minor risk of harm to self or others
6. Severe	• Between Marked and Extreme	• Between Marked and Extreme
7. Extreme	• Distress occurs constantly without relief OR • Distress is extremely intense or unbearable	• Impairment is extreme in most or all domains of functioning (e.g., completely unable to perform in school or engage in social interactions) OR • Patient is considered incapacitated OR • Symptoms pose a severe risk of harm to self or others OR • Acutely psychotic OR • In need of hospitalization or residential care

SUBSTANCE-RELATED AND ADDICTIVE DISORDERS

SUBSTANCE USE DISORDER

Best source: Child with or without parent, depending on age and developmental level. Consider medical records, police records, and school records in addition to self-report.

- **How often do you[47] drink alcohol?[48]** _____
  - ⇨ When was the last time you drank alcohol? _____
  - ⇨ How much alcohol do you drink at one time? What do you drink? _____

- **How often do you use drugs?** _____
  - ⇨ What drugs do you use? _____
  - ⇨ When was the last time you used drugs? _____
  - ⇨ How much do you use at one time? _____

- **How often do you take medications that were not yours? How often do you take more of your medication than your doctor told you to? How often do you take medications in order to get high?**
  - ⇨ Which of these drugs have you used more than a few times in your life? How much of them did you use? _____

☐ Alcohol (highest use) _____

☐ Inhalants (highest use) _____

☐ Marijuana/cannabis (highest use) _____

☐ Opioids (highest use) _____

☐ Phencyclidine/PCP (highest use) _____

☐ Sedatives, hypnotics, or anxiolytics (highest use) _____

☐ Other hallucinogens, including cough medication (highest use) _____

☐ Stimulants (highest use) _____

(Note: continue only if one or more of the above is checked. The following questions should be asked for all substances listed above that have been used more than a few times, or for any substance for which problematic use is suspected.)

- **Do you think you have ever had a problem with (substance) or used too much of it?** _____

- **Did anyone ever suggest that you had a problem with (substance) or used too much of it?** _____

- **Did your use of (substance) ever cause problems for you? For example…**

[47] Or "your child;" continue as appropriate.

[48] The Substance Abuse and Mental Health Services Administration (SAMHSA) defines binge drinking as drinking 5 or more alcoholic drinks on the same occasion on at least 1 day in the past 30 days. SAMHSA defines heavy drinking as drinking 5 or more drinks on the same occasion on each of 5 or more days in the past 30 days. However, the clinician should use his/her judgment about what constitutes problematic alcohol use for any given patient.

Did you often use a lot more (substance), or used for a longer period of time, than you intended to? [Substance often taken in larger amounts, or over a longer period of time, than planned]

If yes, write most recent time this occurred

Substance 1	Substance 2	Substance 3

Did you spend a lot of time trying to get (substance), using (substance), or being hung over? [A great deal of time spent in activities necessary to obtain or use substance, or recover from its effects]

If yes, write most recent time this occurred

Substance 1	Substance 2	Substance 3

Did your use of (substance) ever impact your ability to perform at work or school, or to take care of your family? [Recurrent use resulting in failure to fulfill major role obligations]

If yes, write most recent time this occurred

Substance 1	Substance 2	Substance 3

Did you give up or reduce your time spent at work or school, with other people, or in recreational activities so you could spend more time using (substance)? [Reducing important social, occupational, or recreational activities because of use]

If yes, write most recent time this occurred

Substance 1	Substance 2	Substance 3

Did you ever try unsuccessfully to cut down or control your use of (substance)? [Persistent desire or unsuccessful efforts to cut down or control use]

If yes, write most recent time this occurred

Substance 1	Substance 2	Substance 3

When you weren't using (substance), did you think about it a lot and really want to use it? [Craving, or a strong desire to use substance]

If yes, write most recent time this occurred

Substance 1	Substance 2	Substance 3

Did you keep using (substance) even though it was causing problems between you and other people? [Continued use despite persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance]

If yes, write most recent time this occurred

Substance 1	Substance 2	Substance 3

On more than one occasion, did you use (substance) when it was physically dangerous to do so, such as driving or using heavy machinery while intoxicated? [Recurrent use in situations in which it is physically hazardous]

If yes, write most recent time this occurred

Substance 1	Substance 2	Substance 3

Did you keep using (substance) even though it was causing or worsening a medical problem or a psychological problem? [Continued use despite knowledge of a persistent and recurrent physical or psychological problem that is likely caused or exacerbated by substance use]

If yes, write most recent time this occurred

Substance 1	Substance 2	Substance 3

When you didn't have (substance) or stopped using it, did you ever feel sick, shaky, anxious, depressed, or have a serious medical symptom, or did you need to use (substance) or something else in order to make sure you didn't have those problems? [Withdrawal (either of the following):

- Feeling, sick, shaky, anxious, depressed, or having serious medical symptoms shortly following cessation/reduction
- Need to take the substance or a closely related substance to relieve or avoid withdrawal symptoms]

If yes, write most recent time this occurred

Substance 1	Substance 2	Substance 3

Over time, did you need to use more and more of (substance) in order to get the same feeling? [Tolerance (either of the following):

- Need for markedly greater amounts of the substance to achieve the desired effect
- Markedly diminished effect with continued use of the same amount of the substance]

If yes, write most recent time this occurred

Substance 1	Substance 2	Substance 3

(Note: this criterion is met if at least 2 of the above are checked for a specific substance within the same 12-month period.)

1. *Is there a problematic pattern of substance use, as evidenced by two or more of the above symptoms within a 12-month period?*	*Current*	*Yes*	*No* *Skip to item 2 and circle "No"*
	Past	*Yes*	*No* *Skip to item 2 and circle "No"*

2. **SUBSTANCE USE DISORDER *(present or past)***	*Yes*	*No*

- **In the past month, how much does this problem bother or distress you?**
  - ⇨ How often do you feel distressed?_____
  - ⇨ When you feel distressed, how long does it last? _____
  - ⇨ How intense is the distress when you experience it? _____

- **In the past month, does this problem make things harder for you, like make it hard to do well in school or at work, cause problems with your friends or family, or get in the way of doing fun or important things?**
  - ⇨ Are there things you don't do, or places you won't go, because of this problem? _____
  - ⇨ Does this problem make it hard to focus or concentrate? _____

☐ Problems at school
☐ Problems with family
☐ Legal problems
☐ Other functional impairment _____
☐ Problems with work or role functioning
☐ Problems with home responsibilities
☐ Financial problems
☐ Problems with social life
☐ Problems with leisure activities
☐ Problems of health or safety

For diagnostic coding:

Substance 1 _____	Substance 2 _____	Substance 3 _____
☐ Mild (2-3 symptoms)	☐ Mild (2-3 symptoms)	☐ Mild (2-3 symptoms)
☐ Moderate (4-5 symptoms)	☐ Moderate (4-5 symptoms)	☐ Moderate (4-5 symptoms)
☐ Severe (6 or more symptoms)	☐ Severe (6 or more symptoms)	☐ Severe (6 or more symptoms)

Current Severity of Substance Use Disorder (circle number):[49]

	Distress	Impairment
1. Normal	• No distress at all or full remission	• No impairment at all or full remission
2. Borderline	• Between Normal and Mild, or subthreshold	• Between Normal and Mild, or subthreshold
3. Mild	• Fairly infrequent distress OR • Brief duration of distress OR • Distress is slight	• Impairment is slight in 1 domain of functioning (e.g., taking longer to complete school tasks, occasional social avoidance) OR • Still generally able to meet obligations
4. Moderate	• Between Mild and Marked	• Between Mild and Marked
5. Marked	• Very frequent distress OR • Very long-lasting distress OR • Distress is substantial	• Impairment is significant in many domains of functioning (e.g., school, social, family life) OR • Some failure to meet role obligations (e.g., poor school performance, missing days of school) OR • Symptoms pose a minor risk of harm to self or others
6. Severe	• Between Marked and Extreme	• Between Marked and Extreme
7. Extreme	• Distress occurs constantly without relief OR • Distress is extremely intense or unbearable	• Impairment is extreme in most or all domains of functioning (e.g., completely unable to perform in school or engage in social interactions) OR • Patient is considered incapacitated OR • Symptoms pose a severe risk of harm to self or others OR • Acutely psychotic OR • In need of hospitalization or residential care

[49] Severity rating should be based on current distress and impairment related to this disorder, not the severity of previous episodes.

NEURODEVELOPMENTAL DISORDERS

ATTENTION-DEFICIT/HYPERACTIVITY DISORDER

Best source: Child with parent. Consider school records and teacher report in addition to self-report.

- **In the past month, does it often seem that you[50] have a lot of trouble paying attention or concentrating when you need to?** _____
  - ⇨ How does this cause you problems? _____

- ☐ Do you miss a lot of details or make a lot of mistakes in your work? [Often fails to pay attention to details, or makes careless mistakes in work]
- ☐ Do you have a hard time keeping your attention on things, like listening during a class lesson or reading? [Often has difficulty sustaining attention in tasks]
- ☐ Do people tell you that you're not listening to them, like you're thinking about something else? [Often doesn't seem to listen when people are speaking to them]
- ☐ Do you forget to finish work or chores, or have trouble following instructions because you get distracted? [Often doesn't follow through on instructions and fails to finish work or chores]
- ☐ Is it hard for you to organize your schoolwork and activities? For example, is it hard to keep your schoolwork neat and in order? Do you have a hard time finishing things on time? [Often has difficulty organizing tasks and activities]
- ☐ Do you try not to do things that need a lot of focus, like studying or doing homework? [Often avoids or dislikes tasks that require sustained mental effort]
- ☐ Do you often lose important things you need, like schoolbooks, notebooks, money, your keys, or your cell phone? [Often loses necessary things]
- ☐ Are you easily distracted by things like noises, movements, or thoughts in your head? [Often gets easily distracted by stimuli such as noises, movements, or unrelated thoughts]
- ☐ Do you often forget to do things like chores or homework? [Often forgetful in daily activities]

(Note: continue if 6 or more of the above are checked for children under age 17; continue if 5 or more of the above are checked for age 17 and above.)

- **In the past month, have these things caused problems with friends, family, school, or work?** _____

- **Have you had these problems for at least 6 months?** _____
  - ⇨ Did these problems start before you were 12 years old?
  - ☐ The 6 or more symptoms (5 or more for age 17 and above) checked above have negatively impacted social, academic, or occupational activities
  - ☐ The 6 or more symptoms (5 or more for age 17 and above) checked above have persisted for at least 6 months
  - ☐ Several of the symptoms were present prior to age 12

(Note: this criterion is met if all three of the above are checked.)

1. Is there a persistent pattern of inattention lasting at least 6 months, and dating back to before age 12?	*Yes*	*No*

[50] Or "your child;" continue as appropriate.

- **In the past month, does it often seem that you have trouble sitting still or waiting for things?**
  - ⇨ How does this problem with sitting still or waiting make things difficult for you?

- ☐ Are you very fidgety and move a lot? [Often fidgets with hands, taps hands, or squirms in seat]
- ☐ Do you have trouble staying in your seat? Like do you have to get up from a chair at school or other places where you're supposed to be sitting down? [Often leaves seat inappropriately]
- ☐ Do you often feel restless? [Often feels restless]
- ☐ Is it hard for you to do quiet things by yourself? [Often unable to engage in quiet leisure activities]
- ☐ Is it hard for you to stay still in places like restaurants or school? Do other people keep telling you that you need to slow down or stop moving? [Often "on the go, as if driven by a motor"]
- ☐ Do you talk too much? [Often talks excessively]
- ☐ Do you have a hard time waiting your turn when talking to people? Do you answer questions before someone has finished asking it? [Often blurts out an answer before a question has been completed, completes others' sentences, or cannot wait for turn in conversation]
- ☐ Is it hard for you do things like wait your turn or stand in a line? [Often has difficulty waiting his/her turn]
- ☐ Do you butt into other people's activities? Do you butt in when other people are talking? [Often intrudes into what others are doing or butts into conversations]

(Note: continue if 6 or more of the above are checked for children under age 17; continue if 5 or more of the above are checked for age 17 and above.)

- **In the past month, does this problem make things harder for you, like make it hard to do well in school or at work, cause problems with your friends or family, or get in the way of doing fun or important things?**
  - ⇨ Are there things you don't do, or places you won't go, because of this problem? _____
  - ⇨ Does this problem make it hard to focus or concentrate? _____

- ☐ Problems at school
- ☐ Problems with family
- ☐ Legal problems
- ☐ Other functional impairment _____
- ☐ Problems with work or role functioning
- ☐ Problems with home responsibilities
- ☐ Problems with social life
- ☐ Problems with leisure activities
- ☐ Problems of health or safety

- **Have you had these problems for at least 6 months?**
  - ⇨ Did these problems start before you were 12 years old?

- ☐ The 6 or more symptoms (5 or more for age 17 and above) checked above have negatively impacted social, academic, or occupational activities
- ☐ The 6 or more symptoms (5 or more for age 17 and above) checked above have persisted for at least 6 months
- ☐ Several of the symptoms were present prior to age 12

(Note: this criterion is met if all three of the above are checked.)

2. Is there a persistent pattern of hyperactivity or impulsivity lasting at least 6 months, and dating back to before age 12?	*Yes*	*No*

3. Are criteria 1 or 2 marked yes?	*Yes*	*No* *Skip to item 7 and circle "No"*

4. Do the symptoms cause impairment in social, academic, or occupational functioning?	*Yes*	*No* *Skip to item 7 and circle "No"*

💎 **In the past month, when and where do (inattention or hyperactivity-impulsivity symptoms) happen?**

☐ Several symptoms are reported at home ☐ Several symptoms are present with friends or relatives
☐ Several symptoms are reported at school or work ☐ Several symptoms are present in other settings

(Note: this criterion is met if at least 2 of the above are checked.)

5. Are several of the symptoms in criterion 1 or 2 present in two or more settings?	*Yes*	*No* *Skip to item 7 and circle "No"*

6. Do the symptoms occur only during the course of a psychotic disorder, or are better explained by another mental disorder?	*No*	*Yes* *Skip to item 7 and circle "No"*

7. ATTENTION-DEFICIT/HYPERACTIVITY DISORDER	Yes	No

💎 **In the past month, how much does this problem bother or upset you?**

⇨ How often do you feel upset? _____
⇨ When you feel upset, how long does it last? _____
⇨ How bad does it feel? _____

Current Severity of Attention-Deficit/Hyperactivity Disorder (circle number):

	Distress	Impairment
1. Normal	• No distress at all or full remission	• No impairment at all or full remission
2. Borderline	• Between Normal and Mild, or subthreshold	• Between Normal and Mild, or subthreshold
3. Mild	• Fairly infrequent distress OR • Brief duration of distress OR • Distress is slight	• Impairment is slight in 1 domain of functioning (e.g., taking longer to complete school tasks, occasional social avoidance) OR • Still generally able to meet obligations
4. Moderate	• Between Mild and Marked	• Between Mild and Marked
5. Marked	• Very frequent distress OR • Very long-lasting distress OR • Distress is substantial	• Impairment is significant in many domains of functioning (e.g., school, social, family life) OR • Some failure to meet role obligations (e.g., poor school performance, missing days of school) OR • Symptoms pose a minor risk of harm to self or others
6. Severe	• Between Marked and Extreme	• Between Marked and Extreme
7. Extreme	• Distress occurs constantly without relief OR • Distress is extremely intense or unbearable	• Impairment is extreme in most or all domains of functioning (e.g., completely unable to perform in school or engage in social interactions) OR • Patient is considered incapacitated OR • Symptoms pose a severe risk of harm to self or others OR • Acutely psychotic OR • In need of hospitalization or residential care

TIC DISORDERS

Best source: Child with or without parent, depending on age and developmental level. Consider behavioral observations in addition to self-report.

- **In the past month, do you[51] make a lot of sudden repeated movements or sounds that you feel you can't control?** _____
  - ⇨ What kind of movements or sounds do you make? _____

Motor tics:

- ☐ Simple motor tics (e.g., eye blinking, shoulder shrugging, extension of extremities, usually lasting only milliseconds) _____
- ☐ Complex motor tics (e.g., multiple simple motor tics occurring simultaneously, or a behavior that seems purposeful such as making an obscene gesture, or copying someone else's movements, usually lasting for a few seconds) _____

Vocal tics:

- ☐ Simple vocal tics (e.g., throat clearing, sniffing, or grunting) _____
- ☐ Complex vocal tics (e.g., repeating one's own sounds or words, repeating the last-heard word or phrase, or abruptly "grunting" or "barking" inappropriate words or phrases) _____

(Note: this criterion is met if either of the above are checked.)

1. *Are motor or vocal tics present?*	*Yes* ☐ *Both motor and vocal tics are present (Circle "No" for item 5 and continue)* ☐ *Only motor tics present (Circle "No" for item 4 and continue)* ☐ *Only vocal tics present (Circle "No" for item 4 and continue)*	*No* *Skip to Items 4, 5, and 6 and circle "No"*

- **How long have you had these problems?** _____
  - ⇨ Have you had these problems for at least 1 year? _____

2. *Have tics persisted for more than 1 year (frequency may wax and wane)?*	*Yes* *Circle "No" for item 6 and continue*	*No* *Circle "No" for items 4 and 5 and continue*

- **Just before you started having this problem, did your doctor change any medicine you were taking, did you use any drugs, or did you have an illness or injury?** _____
  - ⇨ Do you think this problem was caused by an illness, drugs, or changes in your medicine? _____
  - ⇨ Have you or your parents talked to a medical doctor about this? _____

3. *Are tics due to the physiological effects of a substance or another medical condition?*	*No*	*Yes* *Skip to items 4, 5, and 6 and circle "No"*

4. TOURETTE'S DISORDER[52]	*Yes*	*No*

[51] Or "your child;" continue as appropriate.

[52] If clinically significant tics are present, regardless of diagnosis, complete the PANS screener on p. 144.

5. **PERSISTENT (CHRONIC) MOTOR OR VOCAL TIC DISORDER[52]**	*Yes*	*No*

6. **PROVISIONAL TIC DISORDER[52]**	*Yes*	*No*

- **In the past month, how much does this problem bother or upset you?**
  - ⇨ How often do you feel upset?_____
  - ⇨ When you feel upset, how long does it last? _____
  - ⇨ How bad does it feel? _____

- **In the past month, does this problem make things harder for you, like make it hard to do well in school or at work, cause problems with your friends or family, or get in the way of doing fun or important things?**
  - ⇨ Are there things you don't do, or places you won't go, because of this problem? _____
  - ⇨ Does this problem make it hard to focus or concentrate? _____

☐ Problems at school
☐ Problems with work or role functioning
☐ Problems with social life
☐ Problems with family
☐ Problems with home responsibilities
☐ Problems with leisure activities
☐ Legal problems
☐ Problems of health or safety
☐ Other functional impairment _____

Current Severity of Tourette's Disorder, Persistent (Chronic) Motor or Vocal Tic Disorder, or Provisional Tic Disorder (circle number):

	Distress	Impairment
1. Normal	• No distress at all or full remission	• No impairment at all or full remission
2. Borderline	• Between Normal and Mild, or subthreshold	• Between Normal and Mild, or subthreshold
3. Mild	• Fairly infrequent distress OR • Brief duration of distress OR • Distress is slight	• Impairment is slight in 1 domain of functioning (e.g., taking longer to complete school tasks, occasional social avoidance) OR • Still generally able to meet obligations
4. Moderate	• Between Mild and Marked	• Between Mild and Marked
5. Marked	• Very frequent distress OR • Very long-lasting distress OR • Distress is substantial	• Impairment is significant in many domains of functioning (e.g., school, social, family life) OR • Some failure to meet role obligations (e.g., poor school performance, missing days of school) OR • Symptoms pose a minor risk of harm to self or others
6. Severe	• Between Marked and Extreme	• Between Marked and Extreme
7. Extreme	• Distress occurs constantly without relief OR • Distress is extremely intense or unbearable	• Impairment is extreme in most or all domains of functioning (e.g., completely unable to perform in school or engage in social interactions) OR • Patient is considered incapacitated OR • Symptoms pose a severe risk of harm to self or others OR • Acutely psychotic OR • In need of hospitalization or residential care

DISRUPTIVE, IMPULSE-CONTROL, AND CONDUCT DISORDERS

INTERMITTENT EXPLOSIVE DISORDER

Best source: Parent with child to the extent possible

- **In the past month, has your child had a lot of aggressive outbursts?** _____
  - ⇨ Has your child had temper tantrums or verbal tirades, or gotten into verbal fights? _____
    - o Has this been happening at least twice per week on average over the past three months? _____
  - ⇨ Has your child been physically aggressive toward people, animals, or property? _____
    - o Has this been happening at least twice per week on average over the past three months? _____
  - ⇨ Has your child's physical aggression resulted in people or animals being injured, or in property being destroyed? _____
    - o Has this happened at least three times in the past year? _____

- ☐ Verbal aggression occurring at least twice per week for at least 3 months
- ☐ Physical aggression that does not result in injury to people or animals, or destruction of property, occurring at least twice per week for at least 3 months
- ☐ Physical aggression that results in injury to people or animals, or destruction of property, occurring at least 3 times in the past year

(Note: continue if 1 or more of the above are checked.)

1. Are there recurrent aggressive outbursts?	*Yes*	*No* *Skip to item 7 and circle "No"*

- **Are your child's aggressive outbursts out of proportion to the situation?** _____

2. Are the aggressive outbursts markedly out of proportion to external stressors or provocations?	*Yes*	*No* *Skip to item 7 and circle "No"*

- **Does your child plan these aggressive outbursts in advance?** _____

3. Are the aggressive outbursts premeditated?	*No*	*Yes* *Skip to item 7 and circle "No"*

- **Does your child engage in these aggressive behaviors in order to get or achieve something, like to get money, or exert power over another person, or to intimidate other people?** _____

4. Are the aggressive outbursts done in order to achieve a tangible objective?	*No*	*Yes* *Skip to item 7 and circle "No"*

- **In the past month, how much does this problem bother or upset your child?**
  - ⇨ How often does your child feel upset? _____
  - ⇨ When your child feels upset, how long does it last? _____
  - ⇨ How bad does it feel? _____

- **In the past month, does this problem make things harder for you, like make it hard to do well in school or at work, cause problems with your friends or family, or get in the way of doing fun or important things?**
  - ⇨ Are there things you don't do, or places you won't go, because of this problem? _____
  - ⇨ Does this problem make it hard to focus or concentrate? _____

☐ Problems at school
☐ Problems with work or role functioning
☐ Problems with social life
☐ Problems with family
☐ Problems with home responsibilities
☐ Problems with leisure activities
☐ Legal problems
☐ Problems of health or safety
☐ Other functional impairment _____

5. Do the symptoms cause marked distress to the child, significant functional impairment, or financial or legal consequences?	*Yes*	*No* *Skip to item 7 and circle "No"*

- **Just before you started having this problem, did your doctor change any medicine you were taking, did you use any drugs, or did you have an illness or injury?** _____
  - ⇨ Do you think this problem was caused by an illness, drugs, or changes in your medicine? _____
  - ⇨ Have you or your parents talked to a medical doctor about this? _____

6. Are the symptoms attributable to drug effects, a medical condition, or another mental disorder? (See Optional Information; If yes, complete applicable substance-induced or general medical condition module)	*No*	*Yes* *Skip to item 7 and circle "No"*

7. INTERMITTENT EXPLOSIVE DISORDER	Yes	No

Current Severity of Intermittent Explosive Disorder (circle number):

	Distress	Impairment
1. Normal	• No distress at all or full remission	• No impairment at all or full remission
2. Borderline	• Between Normal and Mild, or subthreshold	• Between Normal and Mild, or subthreshold
3. Mild	• Fairly infrequent distress OR • Brief duration of distress OR • Distress is slight	• Impairment is slight in 1 domain of functioning (e.g., taking longer to complete school tasks, occasional social avoidance) OR • Still generally able to meet obligations
4. Moderate	• Between Mild and Marked	• Between Mild and Marked
5. Marked	• Very frequent distress OR • Very long-lasting distress OR • Distress is substantial	• Impairment is significant in many domains of functioning (e.g., school, social, family life) OR • Some failure to meet role obligations (e.g., poor school performance, missing days of school) OR • Symptoms pose a minor risk of harm to self or others
6. Severe	• Between Marked and Extreme	• Between Marked and Extreme
7. Extreme	• Distress occurs constantly without relief OR • Distress is extremely intense or unbearable	• Impairment is extreme in most or all domains of functioning (e.g., completely unable to perform in school or engage in social interactions) OR • Patient is considered incapacitated OR • Symptoms pose a severe risk of harm to self or others OR • Acutely psychotic OR • In need of hospitalization or residential care

OPPOSITIONAL DEFIANT DISORDER

Best source: Parent with child to the extent possible
Administer if: the child does not meet diagnostic criteria for Disruptive Mood Dysregulation Disorder

- **Has your child been angry or irritable? Has he/she argued a lot? Has he/she been spiteful or vindictive toward others? Has he/she not listened to what authority figures were telling him/her to do?** _____
  - ⇨ Under what circumstances do these behaviors occur? _____
  - ⇨ Do these behaviors occur only toward your child's siblings, or do they occur toward other people as well? ____
- **How long have these problems been going on?** _____
  - ⇨ Have these problems been present for at least 6 months? _____

1. Does the child have a pattern of angry/irritable mood, argumentative/defiant behavior, or vindictiveness, occurring toward individuals other than siblings, lasting at least 6 months?	*Yes*	*No* *Skip to item 5 and circle "No"*

- **Does your child…**

☐ Lose his/her temper easily, at least once per week?
☐ Seem touchy or easily annoyed, at least once per week?
☐ Often appear angry and resentful, at least once per week?
☐ Argue with authority figures or adults, at least once per week?
☐ Deliberately annoy others, at least once per week?
☐ Blame others for his/her mistakes or behaviors, at least once per week?
☐ Act spiteful or vindictive at least twice in the past 6 months?
Defy or refuse to cooperate with rules or requests from authority figures, at least once per week?

2. Are least 4 of the above symptoms endorsed?	*Yes*	*No* *Skip to item 5 and circle "No"*

- **In the past month, how much does this problem bother or upset your child or other people?**
  - ⇨ How often do (you/your child) feel upset? _____
  - ⇨ When (you/your child) feel upset, how long does it last? _____
  - ⇨ How bad does it feel? _____

- **In the past month, does this problem make things harder for you, like make it hard to do well in school or at work, cause problems with your friends or family, or get in the way of doing fun or important things?**
  - ⇨ Are there things you don't do, or places you won't go, because of this problem? _____
  - ⇨ Does this problem make it hard to focus or concentrate? _____

☐ Problems at school
☐ Problems with family
☐ Legal problems
☐ Other functional impairment _____
☐ Problems with work or role functioning
☐ Problems with home responsibilities
☐ Problems with social life
☐ Problems with leisure activities
☐ Problems of health or safety

☐ The symptoms cause distress to the child.
☐ The symptoms cause distress to others within the child's social context (e.g., family, peers, or colleagues).
☐ The symptoms negatively impact the child's social, educational, occupational, or other areas of functioning.

Note: This criterion is met if at least one of the above is checked.

3. Do the symptoms cause distress to the child or other people, or impair social, educational, occupational, or other areas of functioning?	*Yes*	*No* *Skip to item 5 and circle "No"*

4. Do the symptoms only occur during the course of psychosis, depression, mania, or substance abuse?	*No*	*Yes* *Skip to item 5 and circle "No"*

5. OPPOSITIONAL DEFIANT DISORDER	Yes	No

Current severity of Oppositional Defiant Disorder (circle number):

	Distress	**Impairment**
1. Normal	• No distress at all or full remission	• No impairment at all or full remission
2. Borderline	• Between Normal and Mild, or subthreshold	• Between Normal and Mild, or subthreshold
3. Mild	• Fairly infrequent distress OR • Brief duration of distress OR • Distress is slight	• Impairment is slight in 1 domain of functioning (e.g., taking longer to complete school tasks, occasional social avoidance) OR • Still generally able to meet obligations
4. Moderate	• Between Mild and Marked	• Between Mild and Marked
5. Marked	• Very frequent distress OR • Very long-lasting distress OR • Distress is substantial	• Impairment is significant in many domains of functioning (e.g., school, social, family life) OR • Some failure to meet role obligations (e.g., poor school performance, missing days of school) OR • Symptoms pose a minor risk of harm to self or others
6. Severe	• Between Marked and Extreme	• Between Marked and Extreme
7. Extreme	• Distress occurs constantly without relief OR • Distress is extremely intense or unbearable	• Impairment is extreme in most or all domains of functioning (e.g., completely unable to perform in school or engage in social interactions) OR • Patient is considered incapacitated OR • Symptoms pose a severe risk of harm to self or others OR • Acutely psychotic OR • In need of hospitalization or residential care

CONDUCT DISORDER

Best source: Parent with child to the extent possible

- **In the past year, has your child frequently misbehaved in a way that harmed other people or could have harmed other people?** _____
- **In the past year, has your child broken the law or seriously violated rules?** _____
  - ⇨ What kind of things does your child do? _____

- **In the past year….**

- ☐ Does your child often bully or threaten people? [Frequently bullies, threatens, or intimidates others]
- ☐ Does your child start physical fights often? [Frequently starts physical fights]
- ☐ Has your child used dangerous weapons against people? [Use of a weapon that can seriously harm others]
- ☐ Has your child been physically cruel to people? [Physically cruel to others]
- ☐ Has your child been physically cruel to animals? [Physically cruel to animals]
- ☐ Has your child ever mugged or robbed someone? [Stealing with confrontation of the victim]
- ☐ Has your child ever stolen things without directly confronting someone, like shoplifting or forgery? [Stealing items of nontrivial value without confronting a victim]
- ☐ Has your child ever forced someone to have sexual activity? [Forcing others into sexual activity]
- ☐ Has your child ever set a fire on purpose in order to cause damage? [Deliberate fire setting with the intention of causing damage]
- ☐ Has your child destroyed someone else's property on purpose? [Deliberate property destruction, other than by fire setting]
- ☐ Has your child ever broken into someone else's house or car? [Breaking into others' home, property, or car]
- ☐ Does your child often lie or "con" people in order to get things, or in order to get out of things? [Frequently lies to obtain benefits or avoid responsibilities]
- ☐ Does your child often stay out at night without your permission? When did that behavior start? [Frequently stays out at night against parents' wishes, beginning before age 13]
- ☐ Has your child run away from home overnight? How many times has that happened? How long was he/she gone? [Running away from home overnight at least twice, or once for a lengthy period]
- ☐ Does your child often skip school? When did that behavior start? [Frequent truancy, beginning before age 13]

(Note: continue if 3 or more of the above are checked.)

- **Which of these behaviors have been present within the past 6 months?** _____

1. Is there a repetitive and persistent pattern of violating the basic rights of others or age-appropriate social norms, with at least one criterion present in the past 6 months?	*Yes*	*No*

- **In the past month, does this problem make things harder for you, like make it hard to do well in school or at work, cause problems with your friends or family, or get in the way of doing fun or important things?**
  - ⇨ Are there things you don't do, or places you won't go, because of this problem? _____
  - ⇨ Does this problem make it hard to focus or concentrate? _____

☐ Problems at school
☐ Problems with work or role functioning
☐ Problems with social life
☐ Problems with family
☐ Problems with home responsibilities
☐ Problems with leisure activities
☐ Legal problems
☐ Problems of health or safety
☐ Other functional impairment _____

2. Do the symptoms cause impairment in social, academic, or occupational functioning?	*Yes*	*No* *Skip to item 3 and circle "No"*

3. CONDUCT DISORDER	Yes	No

- **How old was your child when these problems started? _____**
  - ☐ Childhood onset (at least one criterion prior to age 10)
  - ☐ Adolescent onset (no criteria prior to age 10)

- **In the past month, how much does this problem bother or upset your child?**
  - ⇨ How often does your child feel upset? _____
  - ⇨ When your child feels upset, how long does it last? _____
  - ⇨ How bad does it feel? _____

Current Severity of Conduct Disorder (circle number):

	Distress	Impairment
1. Normal	• No distress at all or full remission	• No impairment at all or full remission
2. Borderline	• Between Normal and Mild, or subthreshold	• Between Normal and Mild, or subthreshold
3. Mild	• Fairly infrequent distress OR • Brief duration of distress OR • Distress is slight	• Impairment is slight in 1 domain of functioning (e.g., taking longer to complete school tasks, occasional social avoidance) OR • Still generally able to meet obligations
4. Moderate	• Between Mild and Marked	• Between Mild and Marked
5. Marked	• Very frequent distress OR • Very long-lasting distress OR • Distress is substantial	• Impairment is significant in many domains of functioning (e.g., school, social, family life) OR • Some failure to meet role obligations (e.g., poor school performance, missing days of school) OR • Symptoms pose a minor risk of harm to self or others
6. Severe	• Between Marked and Extreme	• Between Marked and Extreme
7. Extreme	• Distress occurs constantly without relief OR • Distress is extremely intense or unbearable	• Impairment is extreme in most or all domains of functioning (e.g., completely unable to perform in school or engage in social interactions) OR • Patient is considered incapacitated OR • Symptoms pose a severe risk of harm to self or others OR • Acutely psychotic OR • In need of hospitalization or residential care

SCHIZOPHRENIA SPECTRUM AND OTHER PSYCHOTIC DISORDERS

DELUSIONS

Best source: Child with parent. Consider behavioral observations, police records, medical records, school records, or physical examination in addition to self-report.

- **Now I'm going to ask you about some thoughts or beliefs that some people have. At any time in your life, did you[53] strongly believe things that other people didn't?** _____
  - ⇨ Have you ever believed any of these next things:

- ☐ That people were out to get or hurt you, were watching you, poisoning you, or trying to bother you?
- ☐ That the government or some other group was watching you or trying to bother you?
- ☐ That you had a very special talent or powers that other people didn't know about, or that you had made an important discovery that only you knew about?
- ☐ That you were famous?
- ☐ That a celebrity, or someone that you didn't know, was in love with you?
- ☐ That there was something very strange going on with your body, like it was giving off a very bad smell, or that you had bugs inside you, or that a part of your body was not working right?
- ☐ That someone you were dating was cheating on you?
- ☐ That someone or something had taken thoughts out of your mind?
- ☐ That someone else could read your mind?
- ☐ That someone or something had put thoughts into your mind, like using a machine or a spell of some kind?
- ☐ That someone or something was controlling what you did?
- ☐ That someone or something was sending you special messages meant only for you, like through your TV, radio, computer, or books?
- ☐ That you were to blame for a disaster, such as a hurricane, or that you were to blame for a serious crime?

(Note: continue if at least 1 of the above items is checked.)

- ***(For any belief endorsed)* What made you think this?** _____
- ***(For any belief endorsed)* Did anyone ever tell you that this belief was not true? How did you answer them?** _____
  - ⇨ *(For any belief endorsed)* What if I told to you that this thought was not true and that there was another way of thinking about it *(give examples of alternative interpretations if possible)*? What would you say or do? _____

- ☐ It is reasonable to assume that the belief is not based on reality, or is clearly exaggerated
- ☐ The belief is firmly held and resistant to change, even in light of conflicting evidence

(Note: this criterion is met if both of the above are checked.)

1. *Does the child report a fixed and irrational belief that is not amenable to change with conflicting evidence?*	*Yes*	*No* *Skip to item 3 and circle "No"*

[53] Or "your child;" continue as appropriate.

- **Just before you started having this problem, did your doctor change any medicine you were taking, did you use any drugs, or did you have an illness or injury?** _____
  - ⇨ Do you think this problem was caused by an illness, drugs, or changes in your medicine?[54] _____
  - ⇨ Have you or your parents talked to a medical doctor about this? _____

2. *Is the delusion attributable to the physiological effects of a substance or another medical condition? (If yes, complete applicable substance-induced or general medical condition module)*	*No*	*Yes* *Skip to item 3 and circle "No"*

3. **DELUSIONS**	*Yes*	*No*

[54] A depressive episode that begins during or shortly after pregnancy does not rule out the diagnosis but does warrant a peripartum onset specifier.

HALLUCINATIONS

Best source: Child with parent. Consider behavioral observations, police records, medical records, school records, or physical examination in addition to self-report.

- **Now I'm going to ask you about some strange experiences that some people have. At any time in your life, have you[55] ever experienced any of these things?**
  - ☐ Hearing things that others couldn't hear, such as voices or music?
  - ☐ Feeling strange feelings on your skin or in your body, like insects or electric shocks?
  - ☐ Other strange experiences in or on your body? _____
  - ☐ Seeing things that others couldn't see, such as people, animals, colors, or spirits?
  - ☐ Smelling things that others could not smell, such as vomit, urine, feces, something rotting, or smoke?

(Note: continue if at least 1 of the above items is checked.)

Is this happening right now? _____

- ***(For any hallucination endorsed)* Were you fully awake at the time? Were you falling asleep or waking up from sleep?** _____
  - ☐ Hallucination occurs when fully awake, and not falling asleep or waking from sleep

(Note: continue if the above item is checked.)

- ***(For any hallucination endorsed)* Did you have (hallucination) on purpose? For example, was it part of a meditation or religious ceremony?** _____
  - ☐ Hallucination is not under voluntary control and is not a normal part of a religious experience

(Note: this criterion is met if the above is checked.)

1. *Does the child report perceptual experiences that occur without an external stimulus?*	*Yes*	*No* *Skip to item 5 and circle "No"*

- **Just before you started having this problem, did your doctor change any medicine you were taking, did you use any drugs, or did you have an illness or injury?** _____
  - ⇨ Do you think this problem was caused by an illness, drugs, or changes in your medicine? _____
  - ⇨ Have you or your parents talked to a medical doctor about this? _____

2. *Are the hallucinations attributable to the physiological effects of a substance or another medical condition? (If yes, complete applicable substance-induced or general medical condition module)*	*No*	*Yes* *Skip to item 5 and circle "No"*

3. **HALLUCINATIONS**	*Yes*	*No*

[55] Or "your child;" continue as appropriate.

SCHIZOAFFECTIVE DISORDER

Best source: Child with parent

1. *Has there been one uninterrupted period in which both criterion 2 of schizophrenia (see p. 128) and either a manic episode (see p. 37) or a major depressive episode (see p. 44) were present?*	*Yes*	*No* *Skip to item 5 and circle "No"*

- **When did you[56] have [delusions or hallucinations]?**
- **When did you have [major depressive or manic symptoms]?**
  - ⇨ **Did you ever notice [delusions or hallucinations] when your mood felt fine, like you weren't feeling [major depressive or manic symptoms]? _____**

2. *Has there been some point when delusions (see p. 124) or hallucinations (see p. 125) have been present for 2 or more weeks in the absence of a manic episode (see p. 37) or a major depressive episode (see p. 44)? (if no, consider Major Depressive Disorder or Bipolar I Disorder with Psychotic Features)*	*Yes*	*No* *Skip to item 5 and circle "No"*

3. *Have symptoms of a manic episode (see p. 37) or a major depressive episode (see p. 44) been present for most of the active and residual portions of the illness?*	*Yes*	*No* *Skip to item 5 and circle "No"*

- **Just before you started having this problem, did your doctor change any medicine you were taking, did you use any drugs, or did you have an illness or injury?** _____
  - ⇨ Do you think this problem was caused by an illness, drugs, or changes in your medicine? _____
  - ⇨ Have you or your parents talked to a medical doctor about this? _____

(Note: consider collateral reports and medical records in addition to interview responses)

4. *Are the symptoms attributable to the physiological effects of a substance or another medical condition? (If yes, complete applicable substance-induced or general medical condition module)*	*No*	*Yes* *Skip to item 5 and circle "No"*

5. **SCHIZOAFFECTIVE DISORDER[57]**	Yes	No

- **In the past month, how much does this problem bother or upset you?**
  - ⇨ How often do you feel upset?_____
  - ⇨ When you feel upset, how long does it last? _____
  - ⇨ How bad does it feel? _____

[56] Or "your child;" continue as appropriate.

[57] If schizoaffective disorder is diagnosed, major depression and bipolar disorder should not be diagnosed.

- **In the past month, does this problem make things harder for you, like make it hard to do well in school or at work, cause problems with your friends or family, or get in the way of doing fun or important things?**
  - ⇨ Are there things you don't do, or places you won't go, because of this problem? _____
  - ⇨ Does this problem make it hard to focus or concentrate? _____

☐ Problems at school
☐ Problems with work or role functioning
☐ Problems with social life
☐ Problems with family
☐ Problems with home responsibilities
☐ Problems with leisure activities
☐ Legal problems
☐ Problems of health or safety
☐ Other functional impairment _____

Current Severity of Schizoaffective Disorder (circle number):

	Distress	Impairment
1. Normal	• No distress at all or full remission	• No impairment at all or full remission
2. Borderline	• Between Normal and Mild, or subthreshold	• Between Normal and Mild, or subthreshold
3. Mild	• Fairly infrequent distress OR • Brief duration of distress OR • Distress is slight	• Impairment is slight in 1 domain of functioning (e.g., taking longer to complete school tasks, occasional social avoidance) OR • Still generally able to meet obligations
4. Moderate	• Between Mild and Marked	• Between Mild and Marked
5. Marked	• Very frequent distress OR • Very long-lasting distress OR • Distress is substantial	• Impairment is significant in many domains of functioning (e.g., school, social, family life) OR • Some failure to meet role obligations (e.g., poor school performance, missing days of school) OR • Symptoms pose a minor risk of harm to self or others
6. Severe	• Between Marked and Extreme	• Between Marked and Extreme
7. Extreme	• Distress occurs constantly without relief OR • Distress is extremely intense or unbearable	• Impairment is extreme in most or all domains of functioning (e.g., completely unable to perform in school or engage in social interactions) OR • Patient is considered incapacitated OR • Symptoms pose a severe risk of harm to self or others OR • Acutely psychotic OR • In need of hospitalization or residential care

SCHIZOPHRENIA AND SCHIZOPHRENIFORM DISORDER

Best source: Child with parent. Consider behavioral observations, police records, medical records, school records, or physical examination in addition to self-report.

Administer if: The child does not meet criteria for schizoaffective disorder

- ☐ Lifetime presence of delusions (see p. 123)
- ☐ Lifetime presence of hallucinations (see p. 125)
- ☐ Lifetime presence of disorganized speech (e.g., frequent derailment or incoherence)

1. *Have one or more of the above symptoms been present a significant portion of the time, for 1 month or longer, at any time in the child's life?*	*Yes*	*No* *Skip to items 6 and 7 and circle "No"*

- ☐ Grossly disorganized (e.g., confronting others without logical reason, wearing many layers of clothing on a warm day, very messy appearance, engaging in sexual behavior in public) or catatonic (e.g., stupor/inactivity, purposeless and excessive motor activity, and either rigidity or extreme flexibility of the limbs) behavior
- ☐ Negative symptoms (diminished emotional expression or lack of drive or motivation to pursue goals)

(Note: the presence of grossly disorganized or catatonic behavior, or negative symptoms, should be determined by behavioral observations, collateral reports, and other data.)

2. *Have there been at least 2 psychotic symptoms present (including at least one from item 1) for a significant portion of the time, for 1 month or longer, at any time in the child's life?*	*Yes*	*No* *Skip to items 6 and 7 and circle "No"*

♦ **In the past month, does this problem make things harder for you, like make it hard to do well in school or at work, cause problems with your friends or family, or get in the way of doing fun or important things?**

⇨ Are there things you don't do, or places you won't go, because of this problem? _____

⇨ Does this problem make it hard to focus or concentrate? _____

- ☐ Problems at school
- ☐ Problems with work or role functioning
- ☐ Problems with social life
- ☐ Problems with family
- ☐ Problems with home responsibilities
- ☐ Problems with leisure activities
- ☐ Legal problems
- ☐ Problems of health or safety
- ☐ Other functional impairment _____

(Note: the presence of functional impairment should be determined by interview, behavioral observations, collateral reports, and other data.)

3. *Is or was level of functioning in at least 1 major area markedly below the level achieved prior to onset? Or, if onset was in childhood, has there been a failure to achieve expected level of functioning?*	*Yes*	*No* *Skip to items 6 and 7 and circle "No"*

- ☐ No major depressive or manic episodes have occurred concurrently with the psychotic symptoms
- ☐ Major depressive or manic episodes have occurred concurrently with the psychotic symptoms, but they have been present for a minority of the total duration of the active and residual psychotic symptoms

(Note: this criterion is met if either of the above are checked.)

💎 **How long have you had these problems?**
- ⇨ For at least 1 month? _____
- ⇨ For at least 6 months? _____

4. *Were least some of the symptoms continuously present for at least 1 month at any time in the child's life?*	*Yes*	*No* *Skip to items 6 and 7 and circle "No"*

5. *Were least some of the symptoms continuously present for 6 months or more at any time in the child's life?*	*Yes* *Circle "No" for item 6 and "Yes" for item 7*	*No* *Circle "Yes" for item 6 and "No" for item 7*

6. **SCHIZOPHRENIFORM DISORDER**	Yes	No

7. **SCHIZOPHRENIA**	Yes	No

Schizophrenia Specifiers:

- ☐ First episode, currently in acute episode
- ☐ First episode, currently in partial remission
- ☐ First episode, currently in full remission
- ☐ Multiple episodes, currently in acute episode
- ☐ Multiple episodes, currently in partial remission
- ☐ Multiple episodes, currently in full remission
- ☐ Continuous
- ☐ Unspecified

💎 **In the past month, how much does this problem bother or upset you?**
- ⇨ How often do you feel upset? _____
- ⇨ When you feel upset, how long does it last? _____
- ⇨ How bad does it feel? _____

Current Severity of Schizophreniform Disorder or Schizophrenia (circle number):

	Distress	Impairment
1. Normal	• No distress at all or full remission	• No impairment at all or full remission
2. Borderline	• Between Normal and Mild, or subthreshold	• Between Normal and Mild, or subthreshold
3. Mild	• Fairly infrequent distress OR • Brief duration of distress OR • Distress is slight	• Impairment is slight in 1 domain of functioning (e.g., taking longer to complete school tasks, occasional social avoidance) OR • Still generally able to meet obligations
4. Moderate	• Between Mild and Marked	• Between Mild and Marked
5. Marked	• Very frequent distress OR • Very long-lasting distress OR • Distress is substantial	• Impairment is significant in many domains of functioning (e.g., school, social, family life) OR • Some failure to meet role obligations (e.g., poor school performance, missing days of school) OR • Symptoms pose a minor risk of harm to self or others
6. Severe	• Between Marked and Extreme	• Between Marked and Extreme
7. Extreme	• Distress occurs constantly without relief OR • Distress is extremely intense or unbearable	• Impairment is extreme in most or all domains of functioning (e.g., completely unable to perform in school or engage in social interactions) OR • Patient is considered incapacitated OR • Symptoms pose a severe risk of harm to self or others OR • Acutely psychotic OR • In need of hospitalization or residential care

DELUSIONAL DISORDER

Best source: Child with parent

Administer if: The child does not meet criteria for schizoaffective disorder or schizophrenia, and criterion 2 of schizophrenia (see p. 128) has never been met

1. *Have delusion(s) been present for 1 month or longer?*	*Yes*	*No* *Skip to item 6 and circle "No"*

- **In the past month, does this problem make things harder for you, like make it hard to do well in school or at work, cause problems with your friends or family, or get in the way of doing fun or important things?**
  - ⇨ Are there things you don't do, or places you won't go, because of this problem? _____
  - ⇨ Does this problem make it hard to focus or concentrate? _____

☐ Problems at school
☐ Problems with work or role functioning
☐ Problems with social life
☐ Problems with family
☐ Problems with home responsibilities
☐ Problems with leisure activities
☐ Legal problems
☐ Problems of health or safety
☐ Other functional impairment _____

(Note: the presence of functional impairment should be determined by interview, behavioral observations, collateral reports, and other data.)

☐ Functioning is not markedly impaired other than the impact of the delusion and its ramifications
☐ Behavior is not obviously bizarre or odd (determined by behavioral observations, collateral reports, and other data)

(Note: this criterion is met if both of the above are checked.)

2. *Apart from the impact of the delusion(s) and its ramifications, is functioning markedly impaired and is behavior bizarre or odd?*	*No*	*Yes* *Skip to item 6 and circle "No"*

3. *If manic or major depressive episodes have occurred, have they been brief relative to the duration of the delusional periods?*	*Yes*	*No* *Skip to item 6 and circle "No"*

- **Just before you started having this problem, did your doctor change any medicine you were taking, did you use any drugs, or did you have an illness or injury?** _____
  - ⇨ Do you think this problem was caused by an illness, drugs, or changes in your medicine? _____
  - ⇨ Have you or your parents talked to a medical doctor about this? _____

(Note: consider collateral reports and medical records in addition to interview responses)

4. *Are the symptoms attributable to the effects of a substance or a medical condition? (If yes, complete applicable substance-induced or general medical condition module)*	*No*	*Yes* *Skip to item 6 and circle "No"*

5. *Are the symptoms attributable to another mental disorder?*	*No*	*Yes* *Skip to item 6 and circle "No"*

6. **DELUSIONAL DISORDER**	Yes	No

- **In the past month, how much does this problem bother or upset you?**
  - ⇨ How often do you feel upset?_____
  - ⇨ When you feel upset, how long does it last? _____
  - ⇨ How bad does it feel? _____

Current Severity of Delusional Disorder (circle number):

	Distress	Impairment
1. Normal	• No distress at all or full remission	• No impairment at all or full remission
2. Borderline	• Between Normal and Mild, or subthreshold	• Between Normal and Mild, or subthreshold
3. Mild	• Fairly infrequent distress OR • Brief duration of distress OR • Distress is slight	• Impairment is slight in 1 domain of functioning (e.g., taking longer to complete school tasks, occasional social avoidance) OR • Still generally able to meet obligations
4. Moderate	• Between Mild and Marked	• Between Mild and Marked
5. Marked	• Very frequent distress OR • Very long-lasting distress OR • Distress is substantial	• Impairment is significant in many domains of functioning (e.g., school, social, family life) OR • Some failure to meet role obligations (e.g., poor school performance, missing days of school) OR • Symptoms pose a minor risk of harm to self or others
6. Severe	• Between Marked and Extreme	• Between Marked and Extreme
7. Extreme	• Distress occurs constantly without relief OR • Distress is extremely intense or unbearable	• Impairment is extreme in most or all domains of functioning (e.g., completely unable to perform in school or engage in social interactions) OR • Patient is considered incapacitated OR • Symptoms pose a severe risk of harm to self or others OR • Acutely psychotic OR • In need of hospitalization or residential care

SUBSTANCE/MEDICATION-INDUCED DISORDER, DISORDER DUE TO ANOTHER MEDICAL CONDITION, OTHER SPECIFIED DISORDER, AND UNSPECIFIED DISORDER

SUBSTANCE/MEDICATION-INDUCED DISORDER

Best source: Child with parent. Consider medical records in addition to self-report.
Administer if: There is reason to suspect that symptoms are substance/medication-induced.

1. *Is the clinical picture dominated by symptoms characteristic of obsessive-compulsive and related disorders, anxiety disorders, mood disorders, trauma- and stressor-related disorders, schizophrenia spectrum and other psychotic disorders, feeding and eating disorders, or neurodevelopmental disorders?*	*Yes*	*No* *Skip to item 7 and circle "No"*

- **In the past month, how much does this problem bother or upset you?**
  - ⇨ How often do you feel upset?_____
  - ⇨ When you feel upset, how long does it last? _____
  - ⇨ How bad does it feel? _____

- **In the past month, does this problem make things harder for you, like make it hard to do well in school or at work, cause problems with your friends or family, or get in the way of doing fun or important things?**
  - ⇨ Are there things you don't do, or places you won't go, because of this problem? _____
  - ⇨ Does this problem make it hard to focus or concentrate? _____

☐ Problems at school
☐ Problems with work or role functioning
☐ Problems with social life
☐ Problems with family
☐ Problems with home responsibilities
☐ Problems with leisure activities
☐ Legal problems
☐ Problems of health or safety
☐ Other functional impairment _____

2. *Do the symptoms cause significant distress, or cause impairment in important areas of functioning?*	*Yes*	*No* *Skip to item 7 and circle "No"*

- **Just before (symptoms) started, were you taking any medications or using any drugs?**
  - ⇨ Are you still using these medications or drugs?
  - ⇨ Did (symptoms) start after being exposed to the medication or drug?
  - ⇨ Did (symptoms) start when you were intoxicated, or shortly after intoxication?
  - ⇨ Did (symptoms) start when you stopped using the medication or drug, or shortly after stopping?

☐ The symptoms developed after exposure to a medication or drug
☐ The symptoms developed during or soon after substance intoxication
☐ The symptoms developed during or soon after substance withdrawal

- **Have you spoken to a medical clinician about these concerns?** _____
- **Has there been any reason to believe that the (symptoms) are caused by drugs or medications**? _____

Evidence for association with substance established by:

- ☐ *History* _____
- ☐ *Physical examination* _____
- ☐ *Laboratory findings* _____

3. Is there evidence from history, physical examination, or laboratory findings that the symptoms developed during or soon after substance intoxication or withdrawal or after exposure to a medication?	*Yes*	*No* *Skip to item 7 and circle "No"*

Evidence for that the substance is capable of producing the symptoms established by:

- ☐ *History* _____
- ☐ *Physical examination* _____
- ☐ *Laboratory findings* _____
- ☐ *Known effects of substance* _____

4. Is there evidence from history, physical examination, or laboratory findings that the involved substance or medication is capable of producing the symptoms?	*Yes*	*No* *Skip to item 7 and circle "No"*

5. Are the symptoms better explained by a non-substance induced disorder?	*No*	*Yes* *Skip to item 7 and circle "No"*

6. Do the symptoms occur exclusively during delirium (disturbance in attention and awareness, disturbance in cognition, develops over a short period of time, represents a change from baseline status, and tends to fluctuate over the course of a day)?	*No*	*Yes* *Skip to item 7 and circle "No"*

7. SUBSTANCE/MEDICATION-INDUCED DISORDER	*Yes*	*No*

Current Severity of Substance/ Medication-Induced Disorder (circle number):

	Distress	Impairment
1. Normal	• No distress at all or full remission	• No impairment at all or full remission
2. Borderline	• Between Normal and Mild, or subthreshold	• Between Normal and Mild, or subthreshold
3. Mild	• Fairly infrequent distress OR • Brief duration of distress OR • Distress is slight	• Impairment is slight in 1 domain of functioning (e.g., taking longer to complete school tasks, occasional social avoidance) OR • Still generally able to meet obligations
4. Moderate	• Between Mild and Marked	• Between Mild and Marked
5. Marked	• Very frequent distress OR • Very long-lasting distress OR • Distress is substantial	• Impairment is significant in many domains of functioning (e.g., school, social, family life) OR • Some failure to meet role obligations (e.g., poor school performance, missing days of school) OR • Symptoms pose a minor risk of harm to self or others
6. Severe	• Between Marked and Extreme	• Between Marked and Extreme
7. Extreme	• Distress occurs constantly without relief OR • Distress is extremely intense or unbearable	• Impairment is extreme in most or all domains of functioning (e.g., completely unable to perform in school or engage in social interactions) OR • Patient is considered incapacitated OR • Symptoms pose a severe risk of harm to self or others OR • Acutely psychotic OR • In need of hospitalization or residential care

Specify:

- ☐ Substance/Medication-Induced Anxiety Disorder
- ☐ Substance/Medication-Induced Depressive Disorder
- ☐ Substance/Medication-Induced Bipolar and Related Disorder
- ☐ Substance/Medication-Induced Obsessive-Compulsive and Related Disorder
- ☐ Substance/Medication-Induced Trauma- and Stressor-Related Disorder
- ☐ Substance/Medication-Induced Feeding and Eating Disorder
- ☐ Substance/Medication-Induced Neurodevelopmental Disorder
- ☐ Substance/Medication-Induced Schizophrenia Spectrum and Other Psychotic Disorder

DISORDER DUE TO ANOTHER MEDICAL CONDITION

Best source: Child with parent. Consider medical records in addition to self-report.
Administer if: There is reason to suspect that symptoms are due to another medical condition.

1. *Is the clinical picture dominated by symptoms characteristic of obsessive-compulsive and related disorders, anxiety disorders, mood disorders, trauma- and stressor-related disorders, schizophrenia spectrum and other psychotic disorders, feeding and eating disorders, or neurodevelopmental disorders?*	*Yes*	*No* *Skip to item 6 and circle "No"*

- **In the past month, how much does this problem bother or upset you?**
  - ⇨ How often do you feel upset? _____
  - ⇨ When you feel upset, how long does it last? _____
  - ⇨ How bad does it feel? _____

- **In the past month, does this problem make things harder for you, like make it hard to do well in school or at work, cause problems with your friends or family, or get in the way of doing fun or important things?**
  - ⇨ Are there things you don't do, or places you won't go, because of this problem? _____
  - ⇨ Does this problem make it hard to focus or concentrate? _____

☐ Problems at school
☐ Problems with work or role functioning
☐ Problems with social life
☐ Problems with family
☐ Problems with home responsibilities
☐ Problems with leisure activities
☐ Legal problems
☐ Problems of health or safety
☐ Other functional impairment _____

2. *Do the symptoms cause significant distress, or cause impairment in important areas of functioning?*	*Yes*	*No* *Skip to item 6 and circle "No"*

- **Just before (symptoms) started, did you have any medical illness or injury?** _____
  - ⇨ Do you still have this medical illness or injury? _____
- **Have you spoken to a medical clinician about these concerns?** _____
- **Has there been any reason to believe that the (symptoms) are caused by a medical illness or injury**?

Evidence for association with a medical condition established by:

☐ *History* _____
☐ *Physical examination* _____
☐ *Laboratory findings* _____

3. *Is there evidence from history, physical examination, or laboratory findings that the symptoms are a direct pathophysiological consequence of another medical condition? (If yes, complete applicable substance-induced or general medical condition module)*	*Yes*	*No* *Skip to item 6 and circle "No"*

4. *Are the symptoms better explained by another mental disorder?*	*No*	*Yes* *Skip to item 6 and circle "No"*

5. *Do the symptoms occur exclusively during delirium (disturbance in attention and awareness, disturbance in cognition, develops over a short period of time, represents a change from baseline status, and tends to fluctuate over the course of a day)?*	*No*	*Yes* *Skip to item 6 and circle "No"*

6. DISORDER DUE TO ANOTHER MEDICAL CONDITION	*Yes*	*No*

Current Severity of Disorder Due To Another Medical Condition (circle number):

	Distress	**Impairment**
1. Normal	• No distress at all or full remission	• No impairment at all or full remission
2. Borderline	• Between Normal and Mild, or subthreshold	• Between Normal and Mild, or subthreshold
3. Mild	• Fairly infrequent distress OR • Brief duration of distress OR • Distress is slight	• Impairment is slight in 1 domain of functioning (e.g., taking longer to complete school tasks, occasional social avoidance) OR • Still generally able to meet obligations
4. Moderate	• Between Mild and Marked	• Between Mild and Marked
5. Marked	• Very frequent distress OR • Very long-lasting distress OR • Distress is substantial	• Impairment is significant in many domains of functioning (e.g., school, social, family life) OR • Some failure to meet role obligations (e.g., poor school performance, missing days of school) OR • Symptoms pose a minor risk of harm to self or others
6. Severe	• Between Marked and Extreme	• Between Marked and Extreme
7. Extreme	• Distress occurs constantly without relief OR • Distress is extremely intense or unbearable	• Impairment is extreme in most or all domains of functioning (e.g., completely unable to perform in school or engage in social interactions) OR • Patient is considered incapacitated OR • Symptoms pose a severe risk of harm to self or others OR • Acutely psychotic OR • In need of hospitalization or residential care

Specify:

- ☐ Anxiety Disorder due to Another Medical Condition
- ☐ Depressive Disorder due to Another Medical Condition
- ☐ Bipolar and Related Disorder due to Another Medical Condition
- ☐ Obsessive-Compulsive and Related Disorder due to Another Medical Condition
- ☐ Trauma- and Stressor-Related Disorder due to Another Medical Condition
- ☐ Feeding and Eating Disorder due to Another Medical Condition
- ☐ Neurodevelopmental Disorder due to Another Medical Condition
- ☐ Schizophrenia Spectrum and Other Psychotic Disorder due to Another Medical Condition

OTHER SPECIFIED/UNSPECIFIED DISORDER

Child with or without parent, depending on age and developmental level
Administer if: Criteria are not met for another disorder

1. Does the child report symptoms characteristic of obsessive-compulsive and related disorders, anxiety disorders, mood disorders, trauma- and stressor-related disorders, schizophrenia spectrum and other psychotic disorders, feeding and eating disorders, or neurodevelopmental disorders that do not meet full diagnostic criteria?	*Yes*	*No* *Skip to items 4 and 5 and circle "No"*

- **In the past month, how much does this problem bother or upset you?**
  - ⇨ How often do you feel upset?_____
  - ⇨ When you feel upset, how long does it last? _____
  - ⇨ How bad does it feel? _____

- **In the past month, does this problem make things harder for you, like make it hard to do well in school or at work, cause problems with your friends or family, or get in the way of doing fun or important things?**
  - ⇨ Are there things you don't do, or places you won't go, because of this problem? _____
  - ⇨ Does this problem make it hard to focus or concentrate? _____

☐ Problems at school
☐ Problems with family
☐ Legal problems
☐ Other functional impairment _____
☐ Problems with work or role functioning
☐ Problems with home responsibilities
☐ Problems with social life
☐ Problems with leisure activities
☐ Problems of health or safety

2. Do the symptoms cause significant distress, or cause impairment in important areas of functioning?	*Yes*	*No* *Skip to items 4 and 5 and circle "No"*

3. Does the clinician choose not to specify the reason criteria are not met, or is there insufficient information to make a more specific diagnosis?	*Yes* *Circle "No" for item 4 and "Yes" for item 5*	*No* *Circle "Yes" for item 4 and "No" for item 5*

4. OTHER SPECIFIED DISORDER	*Yes*	*No*

5. UNSPECIFIED DISORDER	*Yes*	*No*

Current Severity of Other Specified or Unspecified Disorder (circle number):

	Distress	Impairment
1. Normal	• No distress at all or full remission	• No impairment at all or full remission
2. Borderline	• Between Normal and Mild, or subthreshold	• Between Normal and Mild, or subthreshold
3. Mild	• Fairly infrequent distress OR • Brief duration of distress OR • Distress is slight	• Impairment is slight in 1 domain of functioning (e.g., taking longer to complete school tasks, occasional social avoidance) OR • Still generally able to meet obligations
4. Moderate	• Between Mild and Marked	• Between Mild and Marked
5. Marked	• Very frequent distress OR • Very long-lasting distress OR • Distress is substantial	• Impairment is significant in many domains of functioning (e.g., school, social, family life) OR • Some failure to meet role obligations (e.g., poor school performance, missing days of school) OR • Symptoms pose a minor risk of harm to self or others
6. Severe	• Between Marked and Extreme	• Between Marked and Extreme
7. Extreme	• Distress occurs constantly without relief OR • Distress is extremely intense or unbearable	• Impairment is extreme in most or all domains of functioning (e.g., completely unable to perform in school or engage in social interactions) OR • Patient is considered incapacitated OR • Symptoms pose a severe risk of harm to self or others OR • Acutely psychotic OR • In need of hospitalization or residential care

Specify:

☐ Other Specified Anxiety Disorder

_____

☐ Other Specified Depressive Disorder

_____

☐ Other Specified Bipolar and Related Disorder

_____

☐ Other Specified Obsessive-Compulsive and Related Disorder

_____

☐ Other Specified Trauma- and Stressor-Related Disorder

_____

☐ Other Specified Feeding and Eating Disorder

_____

☐ Other Specified Disruptive, Impulse-Control, and Conduct Disorder

_____

☐ Other Specified Neurodevelopmental Disorder

_____

☐ Other Specified Schizophrenia Spectrum and Other Psychotic Disorder

_____

☐ Unspecified Anxiety Disorder
☐ Unspecified Depressive Disorder
☐ Unspecified Bipolar and Related Disorder
☐ Unspecified Obsessive-Compulsive and Related Disorder
☐ Unspecified Trauma- and Stressor-Related Disorder
☐ Unspecified Feeding and Eating Disorder
☐ Unspecified Disruptive, Impulse-Control, and Conduct Disorder

☐ Unspecified Neurodevelopmental Disorder
☐ Unspecified Schizophrenia Spectrum and Other Psychotic Disorder

SCHOOL REFUSAL SCREEN

Best source: Parent with child to the extent possible. Consider school records and teacher report in addition to self-report.

Administer if*: There is a concern related to school attendance, regardless of whether diagnostic criteria for a disorder have been met*

- **Has there ever been a time when your child missed a lot of school or class?** _____
  - ⇨ When did this problem start? _____
  - ⇨ Has this happened in the past month? _____

- **What was your child's school attendance like over the most recent month of school?** _____
  - ⇨ How many full days of school did your child miss? _____
  - ⇨ How many days did your child arrive late for school? _____
  - ⇨ How often did your child leave school earlier than his/her scheduled time to end the day? _____
  - ⇨ How often did your child leave class and go somewhere else, such as the nurse's office or counselor's office? _____

1. *Is there a pattern of school avoidance marked by excessive (e.g., more than 10% of school) absences or an inability to stay in school/class over the most recent month of school?*	*Yes*	*No* *Skip to item 5 and circle "No"*

- **What were the reasons for your child's absences from school or class?**

☐ Does your child avoid school because he/she feels very anxious or depressed at school? [Avoidance of negative affect]

☐ Does your child avoid school because he/she worries that other kids don't like him/her, or will negatively evaluate him/her? [Escape from social evaluation]

☐ Does your child avoid school because he/she finds it preferable to be with caregivers or other adults? [Attention-getting behavior] Does your child avoid school because he/she doesn't feel well physically when it's time to go to school? Is there reason to believe that these symptoms are related to a true medical illness? [Medically unexplained somatic symptoms] [58]

☐ Does your child avoid school because he/she feels too far behind, or unable to learn? [Perceived threat of academic failure][59]

☐ Is your child out of school because of a medical illness? Does the avoidance seem out of proportion to the illness? Does your child's doctor recommend that your child attend school? [If a medical illness is present, absence is out of proportion to the symptoms or is not medically recommended]

☐ Is your child out of school because of a serious stressor in his or her life, such as a death in the family or divorce? Does the avoidance seem out of proportion to the stressor? [If a psychosocial stressor is present, absence is out of proportion to the stressor]

☐ Is your child out of school because someone has been bullying or threatening him/her? Does the avoidance seem out of proportion to the situation? [If bullying is present, absence is out of proportion to the bullying]

☐ Other reasons? _____

(Note: consider all available information, collateral reports, and other data in determining whether the absences are justified. The presence of a diagnosed medical or psychiatric condition or psychosocial stressors does not necessarily rule out the presence of school refusal.)

[58] School refusal behavior that is related to medical issues may suggest the need for consultation with a medical provider to determine if school absence is medically necessary.

[59] School refusal behavior that is related to academic or learning issues may suggest the need for consultation with school personnel or an appropriate specialist.

2. Does the child have difficulty attending school due to emotional or psychological issues that do not warrant absence from school?	*Yes*	*No* *Skip to item 5 and circle "No"*

3. If medical, psychosocial, or academic problems are present, is the degree of absenteeism clearly out of proportion?	*Yes*	*No* *Skip to item 5 and circle "No"*

4. Is the school absence solely explained by conduct disorder or by the fact that the child finds non-school activities more enjoyable than school?	*No*	*Yes* *Skip to item 5 and circle "No"*

5. SCHOOL REFUSAL	***Yes***	***No***

Additional information:

School refusal	**Not school refusal**
☐ With school withdrawal by parents	☐ Truancy ☐ Absenteeism due to conduct disorder

AUTISM SPECTRUM DISORDER SCREEN

Best source: Parent with child to the extent possible. Consider behavioral observations, school records, and teacher report in addition to self-report.

- **Does your child have difficulties with social skills compared to other kids his/her age?** _____
  - ⇨ What kinds of difficulties have you or others noticed? _____

- ☐ Does your child have difficulty with back-and-forth conversations? Does he/she not share his/her interests and emotions with others? Does he/she have difficulty initiating or responding appropriately in social interactions? [Deficits in social-emotional reciprocity]
- ☐ Does your child have difficulty developing and maintaining friendships? Does he/she appear uninterested in having social relationships with his/her peers? [Deficits in developing, maintaining, and understanding relationships]
- ☐ Does your child make too little or too much eye contact with others? Does he/she misunderstand the body language of others, such as when someone is angry or upset? Does he/she make less facial expressions compared to other children his/her age? [Deficits in nonverbal communicative behaviors used for social interactions]

(Note: continue if any of the above are checked.)

- **In what settings does your child have difficulty with social interactions? Are these difficulties present in multiple situations, like at home and at school?** _____

1. *Has there been a persistent deficit in social communication and interaction across multiple contexts?*	*Yes*	*No* *Skip to item 5 and circle "No"*

- **Does your child show any of the following:**

- ☐ Does your child have any repetitive behaviors, such as flapping his/her hands or rocking his/her body? Does he/she often repeat what other people say or repeat the same word or phrase over and over? [Stereotyped or repetitive motor movements or speech]
- ☐ Does your child become distressed at small changes in his/her regular routines? Does he/she insist that his/her routines and activities remain the same? Does he/she have difficulty transitioning from one activity to another? [Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior]
- ☐ Does your child have unusual, specific, intense interests that differ from those of other children his/her age? Does your child spend a lot of time talking about this interest, even when others are not interested? [Highly restricted, fixated interests]
- ☐ Does your child have unusual reactions to certain sights, sounds, textures, or smells? Does he/she get upset or become excited in response to particular sounds or textures? [Hyper- or hyporeactivity to sensory input or unusual sensory interests]

(Note: this criterion is met if at least 2 of the above are checked.)

2. *Does the child display at least 2 restricted, repetitive behaviors, interests, or activities?*	*Yes*	*No*

		Skip to item 5 and circle "No"

- **Were your child's symptoms present when he/she was younger, like when he/she was a toddler?**
  - ⇨ When did his/her symptoms begin? _____

(Note: this criterion is also satisfied if symptoms were present in early development but did not cause difficulties until later childhood or adolescence.)

3. Were symptoms present in the early developmental period?	*Yes*	*No* *Skip to item 5 and circle "No"*

4. Are these symptoms accounted for by another disorder, such as social anxiety disorder or obsessive compulsive disorder?	*No*	*Yes* *Skip to item 5 and circle "No"*

5. ASD REQUIRES FURTHER EVALUATION	*Yes*	*No*

** Further ASD evaluation by specialists is indicated.*

PEDIATRIC ACUTE ONSET NEUROPSYCHIATRIC SYNDROME (PANS) SCREEN

Best source: Parent with child to the extent possible. Consider medical records and physical examination in addition to self-report.

<u>Administer if:</u> There are clinically significant obsessions, compulsions, tics, or restricted food intake, regardless of whether diagnostic criteria for a disorder have been met

- ☐ Clinically significant obsessions
- ☐ Clinically significant compulsions
- ☐ Clinically significant tics
- ☐ Clinically significant restricted food intake

- **When did (obsessions, compulsions, tics, restricted food intake) begin? Did they begin gradually, or all of a sudden?** _____
  - ⇨ Did these problems reach a peak within 48 hours after starting? _____
  - ⇨ If these problems already existed previously, did they suddenly get a lot worse, reaching a peak within 48 hours? _____
  - ⇨ Have there been repeated episodes of these problems starting or worsening suddenly, reaching a peak within 48 hours? _____

- ☐ Abrupt onset of symptoms, peaking within 48 hours
- ☐ Abrupt worsening of existing symptoms, peaking within 48 hours
- ☐ A series of recurrent episodes with abrupt onset, peaking within 48 hours

(Note: this criterion is satisfied if any of the above are checked.)

1. Has there been an abrupt onset, or a pattern of abrupt episodes, of obsessions, compulsions, tics, or severely restricted food intake?	*Yes*	*No* *Skip to item 3 and circle "No"*

- **When these problems started did your child start to show any of the following:**

- ☐ Did your child suddenly become very anxious? For example, did he/she seem terror stricken or panicky? Did he/she suddenly become very fearful of being without a parent? [Abrupt and dramatic onset of anxiety]
- ☐ Did your child suddenly become very depressed or moody? For example, did his/her moods change very rapidly and frequently? {Abrupt and sudden onset of emotional lability and/or depression]
- ☐ Did your child suddenly become very irritable or aggressive? For example, did he/she get into a lot of arguments or fights, break things, or become more disobedient than usual? [Abrupt and sudden onset of irritability, aggression, or oppositional behavior]
- ☐ Did your child begin acting much younger than normal, such as having temper tantrums or talking like he/she was much younger? [Regression of behavior]
- ☐ Did your child become very sensitive to things like lights, touch, smells, tastes, textures, or sound? Did your child's handwriting or drawing seem to get a lot messier? Did he/she become very clumsy? Did he/she have any new problems with vision? Did he/she see or hear things that weren't there? [Sensory sensitivity, motor disturbance, visual disturbance, or hallucinations]
- ☐ Did your child have significant problems with sleep, like difficulty sleeping or nightmares? Did he/she have urinary problems like frequent

- ☐ Did your child's concentration or academic performance get a lot worse? For example, did he/she get significant worse at things like math? Did his/her ability to do things like puzzles or building things get a lot worse? [Problems with concentration, academics, or visuospatial skills]

- ☐ Did your child's urination or bed-wetting get a lot worse? [Sleep or urinary disturbance]

(Note: this criterion is met if at least 2 of the above are checked.)

2. Are the symptoms associated with at least 2 neuropsychiatric symptoms?	*Yes*	*No* *Skip to item 3 and circle "No"*

3. PANS REQUIRES FURTHER EVALUATION[60]	*Yes*	*No*

Additional Information

- **Did your child have strep throat or another strep infection shortly before these symptoms began or worsened?** _____
  - ⇨ Has your child's doctor done a throat culture for a streptococcal infection? _____
  - ⇨ Has your child's doctor done a blood test for anti-streptococcal titers? _____

- **Did your child have another kind of infection shortly before these symptoms began or worsened?** _____
  - ⇨ What was the infection? For example, mononucleosis, influenza, pneumonia, or Lyme? _____
  - ⇨ When was your child diagnosed with this infection? _____

- **Has your child been diagnosed with a neurological or medical disorder that can account for these symptoms?**
  - ⇨ What was the disorder? For example, Sydenham's chorea or an autoimmune disorder? _____
  - ⇨ When was your child diagnosed with this disorder? _____

[60] *Potential PANS suggests further evaluation for potential medical (e.g. infectious diseases, autoimmune disorders) causes for symptoms. Further evaluation by specialists may be warranted after initial medical/psychiatric workup.*

SUICIDE SCREEN

Best source: Child with or without parent, depending on age and developmental level

- **Have you[61] ever thought about hurting or killing yourself?** _____
  - ⇨ Have you been having these kinds of thoughts recently? _____

1. Does the child report suicidal ideation?	*Current*	*Past*	*None*

- **Do you want to hurt or kill yourself today or in the future?** _____
  - ⇨ How long have you wanted to hurt or kill yourself? Do you want to die? _____

2. Does the child report suicidal intent?	*Yes*	*No*

- **Have you made a plan for how you would hurt or kill yourself?** _____
  - ⇨ What is your plan to hurt or kill yourself? _____

3. Does the child report a suicidal plan?	*Yes*	*No*

- **(If a plan is endorsed) Do you have the things you need to hurt or kill yourself?** _____
  - ⇨ Do you have (planned method)? Could you easily get (planned method)? _____

4. Does the child report having the means to commit suicide?	*Yes*	*No*

- **(If a plan is endorsed) What have you done to hurt or kill yourself, or get ready to hurt or kill yourself?**
  - ⇨ Have you ever actually tried to hurt or kill yourself, or started to try it? Written a suicide note? Looked up ways to do it on the Internet? Gotten things you need for the plan? Given away your things to family or friends, etc.? _____

5. Does the child report present or past behaviors that could lead to suicide?	*Yes*	*No*

- **(If a plan is endorsed) What would stop you from doing this?** _____
  - ⇨ Do you have religious beliefs? Do you think that things could get better? Do you have people in your life that make you want to stay alive? _____

6. Does the child have internal or external protective factors that decrease the risk?	*No*	*Yes*

Current Risk Level

- ☐ High (Psychiatric diagnoses with severe symptoms, or acute precipitating event; protective factors not relevant; potentially lethal attempt or persistent ideation with strong intent or rehearsal)
- ☐ Moderate (Multiple risk factors, few protective factors; ideation with plan, but no intent or behavior)
- ☐ Low (Modifiable risk factors, strong protective factors; thoughts of death, no plan, intent or behavior)

Intervention(s)

- ☐ Provide emergency/crisis numbers
- ☐ Notify parent or guardian of risk
- ☐ Develop a plan to deal with potential weapons, medications, drugs, etc.
- ☐ Refer for adjunctive treatment
- ☐ Provide information about local crisis teams
- ☐ Hospitalize patient
- ☐ Other intervention _____

[61] Or "your child;" continue as appropriate.

DIAGNOSIS CODING SHEET

Anxiety Disorders

- ☐ 309.21/F93.0 Separation Anxiety Disorder
- ☐ 312.23/F94.0 Selective Mutism

Specific Phobia

- ☐ 300.29/F40.218 Animal
- ☐ 300.29/F40.228 Natural environment
- ☐ 300.29/F40.230 Blood
- ☐ 300.29/F40.231 Injections/transfusions
- ☐ 300.29/F40.232 Other medical care
- ☐ 300.29/F40.233 Injury
- ☐ 300.29/F40.248 Situational (e.g. planes, elevators)
- ☐ 300.29/F40.298 Other (e.g. vomiting, clowns)

- ☐ 300.23/F40.10 Social Anxiety Disorder (Social Phobia)
- ☐ 300.01/F41.0 Panic Disorder
- ☐ 300.22/F40.00 Agoraphobia
- ☐ 300.02/F41.1 Generalized Anxiety Disorder
- ☐ 293.84/F06.4 Anxiety Disorder Due to Another Medical Condition
- ☐ 300.09/F41.8 Other Specified Anxiety Disorder
- ☐ 300.00/F41.9 Unspecified Anxiety Disorder

Bipolar and Related Disorders

Bipolar I Disorder, current or most recent episode manic

- ☐ 296.41/F31.11 Mild
- ☐ 296.42/F31.12 Moderate
- ☐ 296.43/F31.13 Severe
- ☐ 296.44/F31.2 With psychotic features
- ☐ 296.45/F31.73 In partial remission
- ☐ 296.46/F31.74 In full remission
- ☐ 296.40/F31.9 Unspecified

- ☐ 296.40/F31.0 Bipolar I Disorder, current or most recent episode hypomanic
  - ☐ 296.45/F31.73 In partial remission
  - ☐ 296.46/F31.74 In full remission
- ☐ 296.40/F31.9 Unspecified

Bipolar I Disorder, current or most recent episode depressed

- ☐ 296.51/F31.31 Mild
- ☐ 296.52/F31.32 Moderate
- ☐ 296.53/F31.4 Severe
- ☐ 296.54/F31.5 With psychotic features
- ☐ 296.55/F31.75 In partial remission
- ☐ 296.56/F31.76 In full remission
- ☐ 296.50/F31.9 Unspecified

- ☐ 296.7/F31.9 Bipolar I Disorder, current or most recent episode unspecified
- ☐ 296.89/F31.81 Bipolar II Disorder
- ☐ 301.13/F34.0 Cyclothymic Disorder
- ☐ Substance/Medication-Induced Bipolar and Related Disorder

Bipolar and Related Disorder Due to Another Medical Condition

- ☐ 293.83/F06.33With depressive features
- ☐ 293.83/F06.33 With manic-or hypomanic-like episodes
- ☐ 293.83/F06.34 With mixed features

- ☐ 296.89/F31.89 Other Specified Bipolar and Related Disorder
- ☐ 296.80/F31.9 Unspecified Bipolar and Related Disorder

Depressive Disorders

- ☐ 296.99/F34.81 Disruptive Mood Dysregulation Disorder

Major Depressive Disorder, single episode

- ☐ 296.21/F32.0 Mild
- ☐ 296.22/F32.1 Moderate
- ☐ 296.23/F32.2 Severe
- ☐ 296.24/F32.3 With psychotic features

Major Depressive Disorder, recurrent episodes

- ☐ 296.31/F33.0 Mild
- ☐ 296.32/F33.1 Moderate
- ☐ 296.33/F33.2 Severe
- ☐ 296.34/F33.3 With psychotic features

- ☐ 296.25/F32.4 In partial remission
- ☐ 296.26/F32.5 In full remission
- ☐ 296.20/F32.9 Unspecified

☐ 300.4/F34.1 Persistent Depressive Disorder (Dysthymia)

☐ 625.4/F32.81 Premenstrual Dysphoric Disorder

- ☐ 296.35/F33.41 In partial remission
- ☐ 296.36/F33.42 In full remission
- ☐ 296.30/F33.9 Unspecified

☐ Substance/Medication-Induced Depressive Disorder

Depressive Disorder Due to Another Medical Condition

- ☐ 293.83/F06.31 With depressive features
- ☐ 293.83/F06.32 With major depressive-like features
- ☐ 293.83/F06.34 With mixed features

☐ 311/F32.89 Other Specified Depressive Disorder

☐ 311/F32.9 Unspecified Depressive Disorder

Obsessive-Compulsive and Related Disorders

☐ 300.3/F42.2 Obsessive-Compulsive Disorder

☐ 300.7/F45.22 Body Dysmorphic Disorder

☐ 300.3/F42.3 Hoarding Disorder

☐ 312.39/F63.3 Trichotillomania

☐ 698.4/F42.4 Excoriation (Skin-Picking) Disorder

☐ Substance/Medication-Induced Obsessive-Compulsive and Related Disorder

☐ 294.8/F06.8 Obsessive-Compulsive and Related Disorder Due to Another Medical Condition

☐ 300.3/F42.8 Other Specified Obsessive-Compulsive and Related Disorder

☐ 300.3/F42.9 Unspecified Obsessive-Compulsive and Related Disorder

Trauma- and Stressor-Related Disorders

☐ 309.81/F43.10 Posttraumatic Stress Disorder

☐ 308.3/F43.0 Acute Stress Disorder

Adjustment Disorder

- ☐ 309.0/F43.21 With depressed mood
- ☐ 309.24/F43.22 With anxiety
- ☐ 309.28/F43.23 With mixed anxiety and depressed mood
- ☐ 309.3/F43.24 With disturbance of conduct
- ☐ 309.4/F43.25 With mixed disturbance of emotions and conduct
- ☐ 309.9/F43.20 Unspecified

Feeding and Eating Disorders

Anorexia Nervosa

- ☐ 307.1/F50.01 Anorexia Nervosa, Restricting type
- ☐ 307.1/F50.02 Anorexia Nervosa, Binge-eating/purging type

☐ 307.51/F50.2 Bulimia Nervosa

☐ 307.51/F50.81 Binge-Eating Disorder

☐ 307.59/F50.89 Avoidant/Restrictive Food Intake Disorder

Somatic Symptom and Related Disorders

☐ 300.82/F45.1 Somatic Symptom Disorder

☐ 300.7/F45.21 Illness Anxiety Disorder

Disruptive, Impulse-Control, and Conduct Disorders

☐ 313.81/F91.3 Oppositional Defiant Disorder

Conduct Disorder

- ☐ 312.81/F91.1 Childhood-Onset Type
- ☐ 312.32/F92.1 Adolescent-Onset Type

☐ 312.34/F63.81 Intermittent Explosive Disorder

☐ 312.89/F91.8 Other Specified Disruptive, Impulse-Control, and Conduct Disorder

- ☐ 312.89/F91.9 Unspecified Onset
- ☐ 312.89/F91.8 Unspecified Disruptive, Impulse-Control, and Conduct Disorder

Substance-Related and Addictive Disorders

Alcohol Use Disorder
- ☐ 305.00/F10.10 Mild
- ☐ 303.90/F10.20 Moderate
- ☐ 303.90/F10.20 Severe

Cannabis Use Disorder
- ☐ 305.20/F12.10 Mild
- ☐ 304.30/F12.20 Moderate
- ☐ 304.30/F12.20 Severe

Phencyclidine Use Disorder
- ☐ 305.90/F15.929 Mild
- ☐ 304.60/F18.20 Moderate
- ☐ 304.60/F18.20 Severe

Other Hallucinogen Use Disorder
- ☐ 305.30/F18.10 Mild
- ☐ 304.50/F18.20 Moderate
- ☐ 304.5/F18.20 Severe

Inhalant Use Disorder
- ☐ 305.90/F18.10 Mild
- ☐ 304.60/F18.20 Moderate
- ☐ 304.60/F18.20 Severe

Opioid Use Disorder
- ☐ 305.50/F11.10 Mild
- ☐ 304.00/F11.20 Moderate
- ☐ 304.00/F11.20 Severe

Sedative, Hypnotic, or Anxiolytic Use Disorder
- ☐ 305.40/F13.10 Mild
- ☐ 304.10/F13.20 Moderate
- ☐ 304.10/F13.20 Severe

Stimulant Use Disorder
- ☐ Mild
  - ☐ 305.70/F15.10 Amphetamine-type substance
  - ☐ 305.60/F14.10 Cocaine
  - ☐ 305.70/F15.10 Other or unspecified stimulant
- ☐ Moderate
  - ☐ 304.40/F15.20 Amphetamine-type substance
  - ☐ 304.20/F14.20 Cocaine
  - ☐ 304.40/F15.20 Other or unspecified stimulant
- ☐ Severe
  - ☐ 304.40/F15.20 Amphetamine-type substance
  - ☐ 304.20/F14.20 Cocaine
  - ☐ 304.40/F15.20 Other or unspecified stimulant

Neurodevelopmental Disorders

Attention-Deficit/Hyperactivity Disorder
- ☐ 314.01/F90.8 Combined presentation
- ☐ 314.00/F90.0 Predominantly inattentive presentation
- ☐ 314.01/F90.8 Predominantly hyperactive/impulsive presentation

- ☐ 307.23/F95.2 Tourette's Disorder
- ☐ 307.22-F95.1 Persistent (Chronic) Motor or Vocal Tic Disorder
- ☐ 307.21/F95.0 Provisional Tic Disorder

Schizophrenia Spectrum and Other Psychotic Disorders

- ☐ 295.90/F20.9 Schizophrenia
- ☐ 295.70/F25.0 Schizoaffective Disorder
- ☐ 297.1/F22 Delusional Disorder
- ☐ 295.40/F20.81 Schizophreniform Disorder