Institute of Living/Hartford HealthCare Corporation

Diagnostic Interview for Anxiety, Mood, and OCD and Related Neuropsychiatric Disorders (DIAMOND)

Patient name: _____

Date of birth: _____ **Age:** _____

Interviewer: _____

Date: _____

Version 1.5

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INSTRUCTIONS

Scope of the Interview

The DIAMOND is intended to be used with adults (age 18 and up) with known or suspected Mood, Anxiety, or Obsessive-Compulsive and Related Disorders. The DIAMOND includes diagnostic and other information for all of the diagnoses in those sections of DSM-5. In addition, the DIAMOND 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 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, Sexual Dysfunctions, Gender Dysphoria, Paraphilic Disorders, and Personality Disorders.

Sources of Information

Although the DIAMOND is designed as a semi-structured interview to be used with the patient, 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 will not reliably detect over- or under-reporting of symptoms and assumes a certain level of honesty from interviewees.

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 has an optional screening self-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 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 responded "Yes" (corresponding DIAMOND 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's response to the questionnaire. When the patient 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."

	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

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

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.

Suicide Screen
A screening tool for suicidal ideation and behavior is on p. 126. 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

In published works, please use the following citation:

Tolin, D. F., Gilliam, C., Wootton, B. M., Bowe, W., Bragdon, L. B., Davis, E., Hannan, S. E., Steinman, S. A., Worden, B., & Hallion, L. S. (2018). Psychometric properties of a structured diagnostic interview for DSM-5 anxiety, mood, and obsessive-compulsive and related disorders. *Assessment*, *25*(1), 3-13. https://doi.org/10.1177/1073191116638410

Training

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

www.diamondinterview.org

Questions

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

INITIAL INTERVIEW QUESTIONS

Can you describe what kind of problem or problems you are here to discuss?[2]

_____

_____

How is your physical health? Do you have any significant medical conditions?

_____

_____

What medications do you currently take?

_____

_____

Have you had mental health treatment before? If so, can you describe it? When did it occur? 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 psychiatric reasons before? If so, can you describe 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?[3]

_____

_____

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.

_____

_____

[2] The clinician should begin the interview with the section that pertains to the most likely primary diagnosis.

[3] Complete the suicide screen on p. 125.

ANXIETY DISORDERS

SOCIAL ANXIETY DISORDER (SOCIAL PHOBIA)

- **In the past month, do you feel very afraid or anxious in any social situations, because you are worried that others will judge you negatively, or that you will embarrass yourself?**_____

- **In the past month, do you feel very afraid or anxious in situations where other people might observe you?** _____
  - ⇨ Can you describe that fear or anxiety? _____
  - ⇨ What kind of situations 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 encounter (social situation), or when you anticipate encountering (social situation), what are you afraid will happen?** _____
  - ⇨ Are you afraid that you will act in a way that is humiliating or embarrassing? _____
  - ⇨ Are you afraid that others will see that you're anxious and judge you negatively? _____
  - ⇨ Are you afraid that you will act in a way that is offensive to others? _____
  - ⇨ Are you afraid that you will act in a way that causes others to reject you? _____

1. Does the person report marked fear or anxiety about one or more social situations in which the person 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 encounter (object or situation)?** _____
  - ⇨ Are there times when you can encounter (object or situation) and not 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 make significant efforts to avoid encountering (social situation)?** _____
  - ⇨ In what ways do you avoid it? _____

- **In the past month, if you can't avoid (social situation), do you feel intensely anxious?**

☐ 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. 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 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 get in the way of your ability to function, like at school or work, in your social life, in your family, or in your ability to do things that are important to you? How?**
  - ⇨ Do you avoid any activities or situations because of these problems?
  - ⇨ Do these problems interfere with your ability to focus on necessary tasks?

☐ 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	☐ Financial 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 9 and circle "No"*

- **Do you think your level of fear and avoidance is excessive or unreasonable in some way**? _____
  - ⇨ Would someone else think that this fear and avoidance are excessive or unreasonable? _____

(Note: This item is based on the clinician's opinion, not solely on the patient's self-report. Consider all available information about the actual degree of threat associated with the social situation.)

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 experiencing this fear and avoidance?** _____

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

6. Is the fear or avoidance persistent?	*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 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: 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

- **Have you ever had a panic attack, where you suddenly felt very afraid, or felt a lot of uncomfortable physical sensations?** _____
  - ⇨ Can you describe the attack or attacks? _____

- **Did it feel like a sudden rush of fear or discomfort?** _____
  - ⇨ **How long did it take from the time it started to when it was at its 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")

- **Were these attacks triggered by something, such as a specific situation, or worry? Have you ever had panic attacks out of the blue or that seemed to come on for no reason?**
  - ☐ At least some of the panic attacks have been unexpected (no obvious trigger)

(Note: continue only if the above is checked)

- **What kind of physical symptoms do you experience during a panic attack?**
  - ☐ Heart palpitations, pounding, or increased heart rate
  - ☐ Trembling or shaking
  - ☐ Choking feelings
  - ☐ Dizziness, lightheadedness, or feeling faint
  - ☐ Fear of losing control or going crazy
  - ☐ Abdominal distress (e.g., nausea, upset stomach, feeling of diarrhea)
  - ☐ Derealization (feeling that things are not real) or depersonalization (feeling like you are not yourself or "out of body" feelings)
  - ☐ Sweating
  - ☐ Shortness of breath or a feeling of suffocation
  - ☐ Chest pain or discomfort
  - ☐ Feeling chills or heat flashes
  - ☐ Fear of dying
  - ☐ Paresthesias (numbness or tingling sensations, usually in fingers, toes, or face)

(Note: continue only if at least four or more of the above symptoms are present)

- **How many panic attacks, with at least four of the symptoms we just discussed, have you had in your life?** _____

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

- **After any of these panic attacks, did you worry a lot about having another attack, or worry about when and where the attack was going to happen?** _____
  - ⇨ Did you worry about this for at least a month? _____
  - ⇨ Have you worried about this in the past month? _____

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

- **After any of these attacks, did you worry a lot about what might happen to you because of the panic attacks? For example, did you worry that you were going to have a heart attack or some other medical emergency? Did you worry that you would lose control of yourself or do something embarrassing? Did you worry that you would go crazy or lose your mind?**
  - ⇨ Did you worry about this for at least a month? _____
  - ⇨ Have you worried about this in the past month? _____

- **Did you change your activities in some way after any of these panic attacks? For example, did you do things in order to prevent yourself from having more attacks? Did you stop any activities, like exercising? Did you stop going certain places, like unfamiliar locations? Did you need to bring someone or something with you in order to feel safer, because of the panic attacks?**
  - ⇨ 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 you have any medication changes, use any drugs, or have a medical illness or injury?** _____
  - ⇨ Has there been any reason to believe that this problem is caused by a medical problem, drugs, or medications? _____
  - ⇨ Have you spoken to a medical clinician about these concerns? _____

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*

- **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 get in the way of your ability to function, like at school or work, in your social life, in your family, or in your ability to do things that are important to you? How?**
  - ⇨ Do you avoid any activities or situations because of these problems?
  - ⇨ Do these problems interfere with your ability to focus on necessary tasks?

☐ 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
☐ Financial problems
☐ Problems of health or safety
☐ Other functional impairment _____

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 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: 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

- **In the past month, do you feel very fearful or anxious about any of the following situations?**
  - ☐ Using public transportation, like buses or planes?
  - ☐ Standing in line, or being in a crowded place?
  - ☐ Being in open spaces, like parking lots or bridges?
  - ☐ Being by yourself outside of your home?
  - ☐ Being in enclosed places, like shops or theaters?

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

⇨ Can you describe that fear or anxiety? _____

1. Does the person 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 make significant efforts to avoid encountering (situation)?** _____
  ⇨ In what ways do you avoid it? _____

- **In the past month, do you need to have someone with you if you're going to encounter (feared situation)?** _____

- **In the past month, if you can't avoid (situation), do you feel intensely anxious?** _____
  - ☐ 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 are in one of these situations?**
  - ☐ Do you worry that you will have a lot of anxiety or panic symptoms in that situation? [Fears having panic-like, incapacitating, or embarrassing symptoms]
  - ☐ Do you worry that it would be hard to get out of that situation or to get help if you had these symptoms? [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 person 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 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 get in the way of your ability to function, like at school or work, in your social life, in your family, or in your ability to do things that are important to you? How?** _____
  - ⇨ Do you avoid any activities or situations because of these problems? _____
  - ⇨ Do these problems interfere with your ability to focus on necessary tasks? _____

☐ 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 ☐ Financial 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"*

- **Do you think your level of fear and avoidance is excessive or unreasonable in some way**?
  - ⇨ Would someone else think that this fear and avoidance are excessive or unreasonable?

(Note: This item is based on the clinician's opinion, not solely on the patient's self-report. Consider all available information about the actual degree of danger associated with the feared situation.)

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 encounter (feared situation)?**
  - ⇨ Are there times when you can encounter (feared situation) and not feel scared?

- **In the past month, when (feared situation) scares you, does the fear almost always come on 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 have you been experiencing this fear and avoidance?** _____

(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 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: 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 person 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

- **In the past month, do you feel excessively anxious or worried about a lot of things?** _____
  - ⇨ Can you describe your worries? _____

☐ Responsibilities at work or school?
☐ Your health?
☐ The health of people in your family?
☐ Financial concerns?
☐ Something bad happening to people you care about?
☐ Things that most people would consider to be minor, like doing chores or being on time for things?
☐ Other worries? _____

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

- **Do you think that your worry is excessive, or out of proportion to the actual threat?** _____

- **In the past month, do you worry more days than not about these things?** _____

- **Have you worried about these things more days than not 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 person 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"*

- **In the past month, is it hard for you to control the worry?** _____
  - ⇨ Do your worries come to mind even though you don't want them to? _____
  - ⇨ Do your worries come to mind even when you're trying to focus on something else? _____
  - ⇨ Do you find it hard to stop worrying once you have started? _____

2. Does the person 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 physical symptoms?**

☐ Restlessness or feeling "keyed up" or "on edge?"
☐ Getting tired or fatigued easily?
☐ Having difficulty concentrating on other things, or your mind going blank?
☐ Feeling irritable or cranky?
☐ Tension in your muscles?
☐ Trouble sleeping, like difficulty falling asleep, difficulty staying asleep, or restless sleep?

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

- **In the past month, do you feel (physical symptoms) more days than not?** _____

- **Have you felt (physical symptoms) more days than not 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.)

3. Is the anxiety and worry associated with at least three 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 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 get in the way of your ability to function, like at school or work, in your social life, in your family, or in your ability to do things that are important to you? How?**
  - ⇨ Do you avoid any activities or situations because of these problems?
  - ⇨ Do these problems interfere with your ability to focus on necessary tasks?

☐ 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

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 you have any medication changes, use any drugs, or have a medical illness or injury? _____**
  - ⇨ Has there been any reason to believe that this problem is caused by a medical problem, drugs, or medications? _____
  - ⇨ Have you spoken to a medical clinician about these concerns? _____

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 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: 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

- **In the past month, are there certain objects, situations, or activities that you are very afraid of?**
  - ⇨ Can you describe that fear? _____
  - ⇨ What are you afraid of? _____
    - ☐ Animals (e.g., spiders, insects, dogs, snakes)
    - ☐ Natural environment (e.g., heights, storms, water)
    - ☐ Blood, injections, or injuries
    - ☐ Situations (e.g., flying, elevators, enclosed spaces)
    - ☐ Other (e.g., choking or vomiting, loud sounds, costumed characters) _____

1. Does the person 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 make significant efforts to avoid encountering (object or situation)?** _____
  - ⇨ In what ways do you avoid it? _____

- **In the past month, if you can't avoid (object or situation), do you feel intensely anxious?** _____
  - ☐ 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 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 get in the way of your ability to function, like at school or work, in your social life, in your family, or in your ability to do things that are important to you? How?**
  - ⇨ Do you avoid any activities or situations because of these problems?
  - ⇨ Do these problems interfere with your ability to focus on necessary tasks?

☐ 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
☐ Financial 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 8 and circle "No"*

- **Do you think your level of fear and avoidance is excessive or unreasonable in some way**?
  - ⇨ Would someone else think that this fear and avoidance are excessive or unreasonable?

(Note: This item is based on the clinician's opinion, not solely on the patient's self-report. Consider all available information about the actual degree of danger associated with the object or situation.)

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

- **In the past month, when (object or situation) scares you, does the fear almost always 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 have you been experiencing this fear and avoidance?** _____

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

6. Is the fear or avoidance persistent?	*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 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: 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

- **In the past month, do you feel very afraid to be away from a certain person or people?** _____
  - ⇨ Can you describe that fear? _____
  - ⇨ Who do you find it hard to be away from? _____
  - ⇨ What specifically do you fear will happen if you are separated from that person or people?_____
  - ⇨ Because you are afraid of being away from (person)…

- ☐ Do you often become very distressed 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 separates you 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 being separated from (person)? [Repeated nightmares about separation]
- ☐ Do you feel sick a lot, like have headaches or stomachaches, when you're separated 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 person 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 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 get in the way of your ability to function, like at school or work, in your social life, in your family, or in your ability to do things that are important to you? How?**
  - ⇨ Do you avoid any activities or situations because of these problems? _____
  - ⇨ Do these problems interfere with your ability to focus on necessary tasks? _____

☐ 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

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"*

- **Have you been experiencing this fear or avoidance for 6 months or more?** _____

4. Has the fear or avoidance lasted 6 months 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 person 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

- **Have you ever had a period of time, lasting at least four days, when your mood was so good or elevated, like you were on top of the world, that it caused problems for you, or people thought you weren't your usual self?** _____
  - ⇨ Have you felt that way in the past month (current episode)? _____

- **What about a period of time, lasting at least four days, when you felt so good about yourself, or you felt so powerful or capable of taking on new projects, that it caused problems for you, or people thought you weren't your usual self?** _____
  - ⇨ Have you felt that way in the past month (current episode)? _____

- **What about a period of time, lasting at least four days, when your mood was so irritable or cranky that it caused problems for you, or people thought you weren't your usual self?** _____
  - ⇨ Have you felt that way in the past month (current episode)? _____
  - ⇨ Can you describe that period or periods? _____
  - ⇨ When did (it/they) start and end? _____
  - ⇨ Was that very different from how you usually are? _____
  - ⇨ Did you feel that way continuously from the time the episode(s) started to the time (it/they) ended?
  - ☐ 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 periods, did you find that you had a lot more energy than you usually do?** _____

- **During any of those periods, did you find that you did 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 continuously from the time the episode(s) started to the time (it/they) ended?
  - ☐ 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 person 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)

- **(Does/Did) this problem get in the way of your ability to function, like at school or work, in your social life, in your family, or in your ability to do things that are important to you? How?**
  - ☐ 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
  - ☐ Financial 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 episode or episodes? _____**
  - ⇨ Was that hospitalization done in order to prevent harm to yourself, or harm to others? _____

- **During the episode or episodes, did you have any unusual 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 get you? _____**

- **During the episode or episodes, 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 consecutive days?

- ☐ 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 episode or episodes, did you or others notice any of the following changes in you?

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

- ☐ Did you feel really great about yourself, like you had special abilities or powers, or were especially important? [grandiose sense of self]
- ☐ Did you need a lot less sleep than usual—like feeling just fine even with very little sleep? [Decreased need for sleep]
- ☐ Were you more talkative than usual, 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 agitated, like you couldn't be still? [Increase in goal-directed activity or psychomotor agitation]
- ☐ Did you get excessively involved in activities that could turn out badly for you, like going on buying sprees, unwise sexual behavior, or unwise investments? [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 comment on the changes in you? Would someone else notice 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 person 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 you have any medication changes, use any drugs, or have a medical illness or injury?** _____
  - ⇨ Has there been any reason to believe that this problem is caused by a medical problem, drugs, or medications? _____
  - ⇨ Have you spoken to a medical clinician about these concerns? _____

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)

(Note: if there has ever been a non-substance/medication-induced manic or hypomanic episode, do not administer this module. The presence of major depressive episodes does not preclude use of this module.)

(Note: Query a past episode of persistent depressive disorder only if criteria are not met for a current episode.)

- **Have you ever had a period of two years or more when you felt really sad, blue, down, or depressed?**
  - ⇨ Can you describe that depression? _____
- **Did you feel that way most of the day, more days than not, for at least 2 years?** _____
  - ⇨ When did these feelings start? _____
  - ⇨ Are you currently feeling that way? If not, when did these feelings end? _____

1. *Does the person report depressed mood for most of the day, more days than not, for at least 2 years?*	*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 two years…**
- ***(If querying a past episode)*** **During the worst two years of your depressed mood…**

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

- ☐ Did you have very little appetite? 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 or fatigued? [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 distress you?**
  - ⇨ How often (do/did) you feel distressed?_____
  - ⇨ When you (feel/felt) distressed, how long (does/did) it last? _____
  - ⇨ How intense (is/was) the distress when you experience(d) it? _____

- **(Does/did) this problem get in the way of your ability to function, like at school or work, in your social life, in your family, or in your ability to do things that are important to you? How?** _____
  - ⇨ (Do/did) you avoid any activities or situations because of these problems? _____
  - ⇨ (Do/did) these problems interfere with your ability to focus on necessary tasks? _____

☐ 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 ☐ Financial problems ☐ Problems of health or safety
☐ Other functional impairment _____

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 two years, was there ever an extended period in which you didn't feel depressed, and didn't experience (symptoms from item 2)?** _____
  - ⇨ In the last two years, what's the longest you have gone without feeling depressed and experiencing (symptoms from item 2)? _____
  - ⇨ Did that period when you felt ok last at least 2 months?
- ***(If querying a past episode)*** **During the worst two years of your depressed mood, was there ever an extended period in which you didn't feel depressed, and didn't experience (symptoms from item 2)?**
  - ⇨ During the worst two years of your depressed mood, what was the longest you went without feeling depressed and experiencing (symptoms from item 2)? _____
  - ⇨ Did that period when you felt ok last at least 2 months? _____

4. *During the 2-year period, has there been any period of 2 months or longer during which the person 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. 108)?*	*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 you have any medication changes, use any drugs, or have a medical illness or injury?** _____
  - ⇨ Has there been any reason to believe that this problem is caused by a medical problem, drugs, or medications? _____
  - ⇨ Have you spoken to a medical clinician about these concerns? _____

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*[5]	*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 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

[5] 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 disorder 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

- **Have you ever had a time when you felt very sad, blue, down, or depressed, 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 your usual depression? _____

- **What about a time when you lost interest in all or almost all of your usual activities, or you lost the ability to feel any sense of pleasure or fun from all or almost all of your usual activities?**
  - ⇨ Have you felt that way in the past month (current episode)? _____
  - ⇨ Can you describe that period or periods? _____
  - ⇨ When did (it/they) start and end? _____
  - ⇨ Was that very different from how you usually are? _____
  - ⇨ Did you feel that way continuously 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 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 person report a 2-week-long or longer period of persistently depressed 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 of these periods of persistently depressed mood or loss of interest have you had? _____

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

💎 **During the worst two-week period of depressed mood or loss of interest or pleasure, did you also experience any of the following concerns?**

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

- ☐ Did you have a significant change in your weight or appetite? Was the change in appetite present nearly every day? [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), or decrease or increase in appetite nearly every day]
- ☐ Did you have difficulty falling asleep or staying asleep? Did you sleep too much during the day? Was that nearly every day? [Unable to fall asleep or stay asleep, of sleeping too much during the day, nearly every day]
- ☐ Were you restless or agitated, like you couldn't keep still? Were your movements slowed down? Was that something that others would notice? Was that nearly every day? [Being behaviorally restless or agitated, or slowed down, in a way that others could notice, nearly every day]
- ☐ Did you feel fatigued? Did you have low energy? Was that nearly every day? [Fatigue or loss of energy nearly every day]
- ☐ Did you feel worthless? Did you feel very guilty? What did you feel guilty about? Was that nearly every day? [Feeling worthless or guilty nearly every day, not just feeling bad about being depressed]
- ☐ Did you have difficulty thinking or concentrating? Was it hard to make decisions? Was that nearly every day? [Decreased ability to think, concentrate, or make decisions, nearly every day]
- ☐ Did you think about death a lot? Did you think about suicide? 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[6]]

⇨ 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 person 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 distress you?**

⇨ How often (do/did) you feel distressed?_____

⇨ When you (feel/felt) distressed, how long (does/did) it last? _____

⇨ How intense (is/was) the distress when you experience(d) it? _____

💎 **(Does/did) this problem get in the way of your ability to function, like at school or work, in your social life, in your family, or in your ability to do things that are important to you? How?** _____

⇨ (Do/did) you avoid any activities or situations because of these problems? _____

⇨ (Do/did) these problems interfere with your ability to focus on necessary tasks? _____

[6] Complete the suicide screen on p. 125.

☐ 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

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 you have any medication changes, use any drugs, or have a medical illness or injury?** _____
  - ⇨ Has there been any reason to believe that this problem is caused by a medical problem, drugs, or medications?[7] _____
  - ⇨ Have you spoken to a medical clinician about these concerns? _____

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*

[7] 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

1. *Is at least one current or past manic episode (see p. 33) 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. 108)?*	*No*	*Yes* *Skip to item 3 and circle "No"*

3. **BIPOLAR I 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 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 get in the way of your ability to function, like at school or work, in your social life, in your family, or in your ability to do things that are important to you? How?**
  - ⇨ Do you avoid any activities or situations because of these problems?
  - ⇨ Do you concentrate on necessary tasks?

☐ 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	☐ Financial problems	☐ Problems of health or safety
☐ Other functional impairment _____		

Current Severity of Bipolar I Disorder (circle number):[8]

	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

[8] 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 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

(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. 33) endorsed?*	*Yes*	*No* *Skip to item 3 and circle "No"*

2. *Is at least one current or past major depressive episode (see p. 40) 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 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 get in the way of your ability to function, like at school or work, in your social life, in your family, or in your ability to do things that are important to you? How?**
  - ⇨ Do you avoid any activities or situations because of these problems? _____
  - ⇨ Do you have these problems interfere with your ability to focus on necessary tasks? _____

☐ 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

Current Severity of Bipolar II Disorder (circle number):[9]

	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

[9] 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 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

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

1. *Is at least one current or past major depressive episode (see p. 40) 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. 108)?*	*No*	*Yes* *Skip to item 4 and circle "No"*

3. *Has there ever been a manic or hypomanic episode (see p. 33)?*[10]	*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 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 get in the way of your ability to function, like at school or work, in your social life, in your family, or in your ability to do things that are important to you? How?**
  - ⇨ Do you avoid any activities or situations because of these problems?
  - ⇨ Do these problems interfere with your ability to focus on necessary tasks?

☐ 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

[10] 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):[11]

	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

[11] 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

(Note: administer this module only if significant depressive and manic/hypomanic symptoms are reported. If lifetime criteria for a major depressive, manic, or hypomanic episode are met, do not administer this module.)

- **Over the past 2 years, how many episodes have you had in which you experienced (manic/hypomanic symptoms)? _____**
- **How many episodes have you had in which you experienced (depressive symptoms)? _____**

1. *Does the person 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 2 years or more?*	*Yes*	*No* *Skip to item 5 and circle "No"*

- **Over the past 2 years, have you experienced (manic/hypomanic symptoms) at least half of the time?**
- **Over the past 2 years, have you experienced (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 2 years, have you had any periods in which you did not experience 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 2 years

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

2. *Does the person report over the past 2 years 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. 108)?*	*No*	*Yes* *Skip to item 5 and circle "No"*

- **Just before you started having this problem, did you have any medication changes, use any drugs, or have a medical illness or injury? _____**
  - ⇨ Has there been any reason to believe that this problem is caused by a medical problem, drugs, or medications? _____
  - ⇨ Have you spoken to a medical clinician about these concerns? _____

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*

(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 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 get in the way of your ability to function, like at school or work, in your social life, in your family, or in your ability to do things that are important to you? How?**
  - ⇨ Do you avoid any activities or situations because of these problems?
  - ⇨ Do these problems interfere with your ability to focus on necessary tasks?

☐ 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
☐ Financial problems
☐ Problems of health or safety
☐ Other functional impairment _____

Current Severity of Cyclothymic Disorder (circle number):[12]

	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

[12] 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)

PREMENSTRUAL DYSPHORIC DISORDER

(Note: administer as applicable. The diagnosis of PMDD can only be made provisionally based on a single interview. 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.)

- **Do you 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 person 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)

- ☐ 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 person 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 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 get in the way of your ability to function, like at school or work, in your social life, in your family, or in your ability to do things that are important to you? How?**
  - ⇨ Do you avoid any activities or situations because of these problems?
  - ⇨ Do these problems interfere with your ability to focus on necessary tasks?

☐ 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
☐ Financial problems
☐ Problems of health or safety
☐ Other functional impairment _____

4. *Do the mood and associated 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 you have any medication changes, use any drugs, or have a medical illness or injury?** _____
  - ⇨ Has there been any reason to believe that this problem is caused by a medical problem, drugs, or medications? _____
  - ⇨ Have you spoken to a medical clinician about these concerns? _____

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*	*No*	*Provisional*

Current Severity of Premenstrual Dysphoric Disorder (circle number):[13]

	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

[13] 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

- **In the past month, have you often experienced thoughts, urges, doubts, or images that you don't want to have? Some examples are thoughts that you are contaminated, thoughts that you might hurt someone or make a terrible mistake, or being very uncomfortable if things aren't arranged in a certain way.**
  - ⇨ Can you describe these thoughts? _____
  - ⇨ 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 have…**

☐ Thoughts about contamination or cleanliness?
☐ Thoughts about harming yourself or others accidentally?
☐ Thoughts about harm coming to people or animals you care about?
☐ A need for things to be ordered in a certain way or a need for symmetry?
☐ Concerns or doubts about making mistakes or errors?
☐ Concerns about making religious or moral mistakes?
☐ Forbidden or taboo thoughts such as about sex or sexuality, religion, or violence?
☐ Good or bad numbers, words, colors, etc.?
☐ Unpleasant, scary, or repulsive mental images?
☐ An urge to do something uncontrolled, shocking, embarrassing or harmful?
☐ The feeling that something bad is going to happen in the future if you do not perform a ritual?
☐ Other intrusive thoughts?
_____

1. Does the person 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 about them?**
  - ⇨ Do you try to ignore them, push them out of your mind, or "fix" or neutralize them with an action or thought? _____

2. Does the person 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, have you done any repetitive behaviors in response to obsessive thoughts, or according to very specific rules? Some examples are hand washing or cleaning, ordering or arranging, checking things, or repeating behaviors over and over.**
  - ⇨ Can you describe these behaviors? _____

- **In the past month, are there any mental acts that you have done over and over in response to obsessive thoughts, or according to very specific rules? Some examples are words or pictures that you have to bring to mind over and over, counting, or replacing a bad thought with a more positive image.**
  - ⇨ Can you describe these mental acts? _____

- **Do these behaviors or mental acts include…**

☐ Washing or cleaning yourself or things?
☐ Checking and rechecking things?
☐ Arranging or lining up things?
☐ Saying or thinking certain words, phrases, prayers, or numbers?
☐ Counting?
☐ Repeating an action over and over?
☐ Trying to have "good" thoughts or images?
☐ Seeking reassurance from others, or reassuring yourself over and over?
☐ Insisting others engage in ritualized behavior?
☐ Trying to do or think things in a "just right" way?
☐ Touching or tapping 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 person 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 perform 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 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 get in the way of your ability to function, like at school or work, in your social life, in your family, or in your ability to do things that are important to you? How?**
  - ⇨ Do you avoid any activities or situations because of these thoughts? _____
  - ⇨ Do the thoughts interfere with your ability to focus on necessary tasks? _____

☐ 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
☐ Financial problems
☐ Problems of health or safety
☐ Other functional impairment _____

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"*

- **About how old were you when you started having this problem?** _____

- **Just before you started having this problem, did you have any medication changes, use any drugs, or have a medical illness or injury?** _____
  - ⇨ Has there been any reason to believe that this problem is caused by a medical problem, drugs, or medications? _____
  - ⇨ Have you spoken to a medical clinician about these concerns? _____

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	*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 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: 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 person 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 person thinks that the obsessive beliefs are probably true and thinks that their behaviors are probably reasonable
- ☐ Absent insight/delusional beliefs: The person is completely convinced that the obsessive beliefs are true and does not consider their behaviors to be excessive or unreasonable.
- ☐ Tic-related: The person has a current or past tic disorder (see p. 106).

BODY DYSMORPHIC DISORDER

- **In the past month, have you spent a lot of time feeling concerned about, or worrying about, your physical appearance?**
  - ⇨ Can you describe your concerns or worries about your appearance? _____
  - ⇨ What do you think is wrong with your appearance? What parts of your body do you worry most about?

☐ Eyes	☐ Ears	☐ Breasts
☐ Nose	☐ Mouth	☐ Buttocks
☐ Skin	☐ Body fat[14]	☐ Genitalia
☐ Hair	☐ Muscle mass or tone	☐ Other _____

(Note: compare self-reported defect or flaw with observable appearance, if possible)

- ⇨ If you added up all of the time per day you spent worrying about your appearance, 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 your physical appearance? _____

1. Does the person 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"*

- **Have these concerns about your physical appearance ever caused you to do any repetitive behaviors, like looking in the mirror, getting reassurance from other people, picking at your skin, or things like that?**
  - ⇨ What kinds of repetitive behaviors do you do, or have you done? _____
- **Have these concerns about your physical appearance ever caused you to do any mental acts, like comparing your appearance to that of other people, over and over?**
  - ⇨ What kinds of repetitive mental acts do you do, or have you done? _____

- **Do these behaviors or mental acts include…**

☐ Repetitive mirror checking or checking your appearance in other reflective surfaces?	☐ Picking at your skin in order to correct a defect?
☐ Physically examining, measuring or inspecting your appearance?	☐ Seeking or obtaining cosmetic surgery or other alteration of your appearance?
☐ Seeking reassurance from others?	☐ Mentally comparing your appearance with that of others?
☐ Wearing excessive makeup or special clothing to hide or camouflage your appearance?	☐ Mentally reassuring yourself?
☐ Spending excessive time with grooming, dressing or changing clothes, or applying makeup?	☐ Other _____

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

[14] Note: if concern is limited to body fat or weight *and* the person meets diagnostic criteria for an eating disorder (see p. 92), Body Dysmorphic Disorder cannot be diagnosed.

- **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 get in the way of your ability to function, like at school or work, in your social life, in your family, or in your ability to do things that are important to you? How?**
  - ⇨ Do you avoid any activities or situations because of these problems?
  - ⇨ Do these problems interfere with your ability to focus on necessary tasks?

☐ 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 ☐ Financial 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 person has an eating disorder (see p. 87), 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 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: 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 person 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 person thinks that their appearance related beliefs are probably true and thinks that their behaviors are probably reasonable
- ☐ Absent insight/delusional beliefs: The person 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 person believes that their body build is too small or not muscular enough.

HOARDING DISORDER

- **In the past month, is there a lot of clutter in your home, so much that it can be hard to use areas of the home?**
  - ⇨ Can you describe the condition of your home? _____
  - ⇨ How does the clutter affect your ability to walk around the living spaces? How does the clutter affect your ability to use the furniture and appliances? _____
  - ⇨ Can you describe what your [living area: kitchen, bedroom, etc.] looks like? _____
  - ⇨ *(If clutter is not reported but hoarding is suspected)* Are the living spaces only uncluttered because someone else is cleaning them up? _____

Cluttered Active Living Areas

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

Cluttered Non-Active Living Areas[15]

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

(Note: compare self-reported clutter with observations or photographs of the home, if possible)

1. Does the person 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, do you often find it very hard to discard or part with things, even things that other people might throw away more easily?** _____
  - ⇨ Is it hard to part even with things that other people might not consider to be valuable? _____

2. Does the person 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 find it very hard to discard or part with possessions because you feel like it's important to save them?** _____
  - ⇨ **Why is that?** _____

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

- ☐ Do you feel like you need to save them for future use?
- ☐ Do you feel like you need to save them for someone else?
- ☐ Do you feel responsible to make sure it is used or disposed of correctly?
- ☐ Do you feel emotionally attached to possessions?
- ☐ Do you feel like you need to save them so that you don't forget something or someone?
- ☐ Do you feel like it's important to make sure nothing is wasted?
- ☐ Do you feel like you need to save them as part of your identity?
- ☐ Do you feel like you need to save them in order to maintain control of your life?
- ☐ Do you feel like you need to save them in order to avoid making mistakes?
- ☐ Other reason _____

💎 **In the past month, do you find it very hard to discard or part with possessions because it would feel emotionally uncomfortable to let go of them?** _____

3. *Is the person'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, 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 get in the way of your ability to function, like at school or work, in your social life, in your family, or in your ability to do things that are important to you? How?**
- ⇨ Are there things that you avoid doing or people you avoid seeing because of the condition of your home, or your saving behavior? _____
- ⇨ Has anyone else told you that the saving and clutter are causing a problem? _____
- ⇨ Does the condition of your home cause any health or safety problems for you, or for anyone else? ____

- ☐ 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
- ☐ Financial 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 you have any medication changes, use any drugs, or have a medical illness or injury?** _____
- ⇨ Has there been any reason to believe that this problem is caused by a medical problem, drugs, or medications? _____
- ⇨ Have you spoken to a medical clinician about these concerns? _____

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*

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 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: 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).
- ☐ Neurocognitive disorders: HD is not diagnosed if the saving behaviors are the direct result of a degenerative disorder such as Alzheimer's disease.

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

TRICHOTILLOMANIA AND EXCORIATION (SKIN-PICKING) DISORDER

- **In the past month, do you frequently pull out hair from your scalp or your body for reasons other than cosmetic purposes?** _____
  - ⇨ Has your pulling resulted in visible hair loss? _____

- **In the past month, do you frequently pick at your skin?** _____
  - ⇨ Has your picking resulted in sores or scars? _____

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 describe the process of your (hair pulling/skin picking)? How do you do it? Are you aware of it when it's happening? _____
- ⇨ Where do you (pull/pick) from? _____

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

(Note: compare self-reported hair loss or skin lesions with observable appearance, if possible)

1. ***Trichotillomania:*** *Does the person 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 person 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 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 get in the way of your ability to function, like at school or work, in your social life, in your family, or in your ability to do things that are important to you? How?**
  - ⇨ Do you avoid any activities or situations because of these problems?
  - ⇨ Do these problems interfere with your ability to focus on necessary tasks?

- ☐ 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

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 cut down on (pulling/picking), or stop altogether?** _____
  - ⇨ Have you tried more than once? _____
  - ⇨ What was the result of your attempts? _____

☐ 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 person made repeated attempts to decrease or stop pulling?*	*Yes*	*No* *Skip to item 5 and circle "No"*
***Excoriation (Skin Picking) Disorder**: Has the person 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 you have any medication changes, use any drugs, or have a medical illness or injury?** _____
  - ⇨ Has there been any reason to believe that this problem is caused by a medical problem, drugs, or medications? _____
  - ⇨ Have you spoken to a medical clinician about these concerns? _____

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

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

- **In the past month, do you have any medical or health problems? Do any of your physical symptoms bother you greatly?** _____
  - ⇨ Do you have any physical symptoms, such as pain or fatigue? _____
- ☐ 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 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 get in the way of your ability to function, like at school or work, in your social life, in your family, or in your ability to do things that are important to you? How?**
  - ⇨ Do you avoid any activities or situations because of these problems?
  - ⇨ Do these problems interfere with your ability to focus on necessary tasks?

☐ 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	☐ Financial 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 the symptom(s)? [Excessive thoughts about the symptom(s)]
  - ☐ Do you feel very anxious or distressed about the symptom(s)? [Excessive feelings about the symptom(s)]
  - ☐ Do you have to see a lot of health care professionals because of the symptom(s)? [Excessive behaviors related to the symptom(s)]

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

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 experiencing this symptom(s) and these thoughts, feelings, or behaviors?**
(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 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

ILLNESS ANXIETY DISORDER

- **In the past month, do you often worry that you have a serious medical illness, or that you are going to develop a serious medical illness?**
  - ⇨ How much of your day is spent thinking about medical illness? _____

(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 illness?

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 symptoms, such as pain or fatigue? _____
  - ⇨ *(If symptoms are present)* How severe are these physical symptoms? _____

☐ 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.)

- **Do you have a known medical condition that you are worried about?** _____
  - ⇨ Do you have a known risk of developing a medical condition that you are worried about? _____

(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 think or worry a lot about illness?** _____
- **In the past month, do you easily get alarmed or distressed if you get some bad news about your health, or if you notice a physical sensation or symptom?** _____

☐ 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 person easily alarmed about personal health status?	*Yes*	*No* *Skip to item 7 and circle "No"*

- **In the past month, do you have to do a lot in order to make sure you don't have an illness, to make sure you don't get an illness, or to make sure you'll detect an illness?**
  - ⇨ Do you have to see a lot of health care professionals because of these concerns?
  - ⇨ Do you check yourself a lot for signs of illness?
  - ⇨ Do you do a lot of research about illness, like on the internet?
  - ⇨ Do you often seek reassurance from other people, like friends, family members, or doctors?

- **In the past month, are there things that you avoid doing or people you avoid seeing because of your concerns about illness?**
  - ⇨ Do you avoid being near sick people?
  - ⇨ Do you avoid going to doctors or hospitals?
  - ⇨ Do you avoid hearing or seeing information about illness?

☐ Excessive health-related behaviors
☐ Maladaptive avoidance

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

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

- **Have you been experiencing this worry about illness, or other worries about illness, 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 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 get in the way of your ability to function, like at school or work, in your social life, in your family, or in your ability to do things that are important to you? How?**
  - ⇨ Do you avoid any activities or situations because of these problems?
  - ⇨ Do these problems interfere with your ability to focus on necessary tasks?

☐ 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
☐ Financial 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

- **Have you ever experienced a really bad event, in which you thought you might die or be seriously harmed, such as a serious accident, being physically or sexually assaulted, or being in a war zone?**

- **Have you ever witnessed events like these happening to another person, or heard of something violent happening to a close family member or close friend?**

- **Have you ever been exposed over and over to extremely horrific details of a really bad violent or accidental event?**[16]
  - ⇨ What did you experience/witness/learn of/receive repeated or extreme details of?

    _____

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 person report exposure to actual or threatened death, serious injury, or sexual violence?*	*Yes*	*No*

- **When did (event/events) occur?** _____
  - ☐ Less than 1 month ago: administer the module for Acute Stress Disorder (p. 78)
  - ☐ More than 1 month ago: administer the module for Posttraumatic Stress Disorder (p. 81)

[16] 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

1. *Does the person report a significant potentially traumatic event within the past month (see p. 77)?*	*Yes*	*No* *Skip to item 6 and circle "No"*

- **Sometimes when someone has a really upsetting experience, they have some concerns that can last even when the experience is over. I'd like to ask you about some of them.**
- **Since the (event), do you find that you have recurrent, intrusive thoughts or dreams about it, or get very anxious or have a strong physical reaction when something reminds you of what happened?**

- Are you bothered by memories of (the event) that pop into your mind even when you don't want them to? [Recurrent, involuntary, intrusive, and distressing memories of the event]
- Do you have bad dreams related to (the event)? [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 notice a lot of changes in your body? [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, in the present? [Dissociative flashbacks in which it feels as if the event is happening again]

- **Since the (event), do you avoid activities or situations that remind you of what happened or try to avoid thinking about it?**

- Do you try to avoid thinking about (the event) or having feelings about it? 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 had a head injury or were under the influence of alcohol or drugs? [Inability to remember an important aspect of the event, not due to head injury, alcohol, or drugs]
- Do you try to avoid 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]

- **Since the (event), have your emotions changed significantly?**

- 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 having an out of body experience, or that you're in a daze, or that time slows down? [Altered sense of reality (e.g., "out of body experience," being in a daze, time slowing down)]

- **Since the (event), have you been more irritable or jumpy, or have you had increased problems with things like sleep or concentration?**

☐ Do you find you are very jumpy or get startled easily? [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 problems falling asleep or staying asleep? Does your sleep feel restless? [Sleep disturbance (difficulty falling asleep, difficulty staying asleep, restless sleep)]
☐ Do you get really irritable or aggressive in response to minor things? [Irritable behavior and angry or aggressive outbursts, with little or no provocation]
☐ Is it hard for you to concentrate? [Difficulty concentrating]

2. *Does the person 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 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 get in the way of your ability to function, like at school or work, in your social life, in your family, or in your ability to do things that are important to you? How?**
  - ⇨ Do you avoid any activities or situations because of these problems?
  - ⇨ Do these problems interfere with your ability to focus on necessary tasks?

☐ 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

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 have you been experiencing these problems?**

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 you have any medication changes, use any drugs, or have a medical illness or injury?** _____
  - ⇨ Has there been any reason to believe that this problem is caused by a medical problem, drugs, or medications? _____
  - ⇨ Have you spoken to a medical clinician about these concerns? _____

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 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

POSTTRAUMATIC STRESS DISORDER

1. *Does the person report a significant potentially traumatic event more than 1 month ago (see p. 77)?*	*Yes*	*No* *Skip to item 9 and circle "No"*

- **Since (event) and in the past month, do you find that you have recurrent, intrusive thoughts or dreams about (event), or get very anxious or have a strong physical reaction when something reminds you of what happened?**

- ☐ Are you bothered by memories of (the event) that pop into your mind even when you don't want them to? [Recurrent, involuntary, intrusive, and distressing memories of the event]
- ☐ Do you have bad dreams related to (the event)? [Recurrent, distressing dreams that are related to the event in content or affect]
- ☐ Do you sometimes feel like (the event) is happening again, in the present? [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 notice a lot of changes in your body? [Strong physiological reactions to internal or external cues that resemble the event]

2. *Does the person 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"*

- **Since (event) and in the past month, do you avoid activities or situations that remind you of what happened or try to avoid thinking about it?**

- ☐ Do you try to avoid thinking about (the event) or having feelings about it? How do you try? [Efforts to avoid unpleasant memories thoughts, or feelings related to the event]
- ☐ Do you try to avoid 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 person 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"*

Since (event) and in the past month, have your emotions been significantly different? 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 had a head injury or were under the influence of alcohol or drugs? [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 view others as threatening? Do you view the world as dangerous? [Persistent and exaggerated negative beliefs about one's self, others, or the world]
- Do you spend a lot of time thinking about who is to blame for (the event)? Whom do you blame for (the event)? [Persistent, distorted cognitions about the cause or consequences of the event, leading the person to blame self or others]
- Do you feel unhappy most of the time? [Persistent negative emotional state]
- Have you lost interest in all or almost all of your usual activities, or participate much less in all or almost all of your usual activities? [Marked decrease in interest or participation in significant activities]
- Do you feel disconnected from other people, or like no one understands you? [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 person 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"*

Since (event) and in the past month, have you been more irritable or jumpy, acted recklessly or dangerously, or have you had increased problems with things like sleep or concentration?

- Do you get really irritable or aggressive in response to minor things? [Irritable behavior and angry or aggressive outbursts, with little or no provocation]
- Do you act recklessly or 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]
- Do you find you are very jumpy or get startled easily? [Exaggerated startle response]
- Is it hard for you to concentrate? [Difficulty concentrating]
- Do you have problems falling asleep or staying asleep? Does your sleep feel restless? [Sleep disturbance (difficulty falling asleep, difficulty staying asleep, restless sleep)]

5. *Does the person 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 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 get in the way of your ability to function, like at school or work, in your social life, in your family, or in your ability to do things that are important to you? How?**
  - ⇨ Do you avoid any activities or situations because of these problems?
  - ⇨ Do these problems interfere with your ability to focus on necessary tasks?

☐ 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 ☐ Financial 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 have you been experiencing these problems?**

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 you have any medication changes, use any drugs, or have a medical illness or injury?** _____
  - ⇨ Has there been any reason to believe that this problem is caused by a medical problem, drugs, or medications? _____
  - ⇨ Have you spoken to a medical clinician about these concerns? _____

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*

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 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

ADJUSTMENT DISORDER

(Note: if criteria for Posttraumatic Stress Disorder or Acute Stress Disorder are met, do not administer this module.)

- **Have you had anything particularly stressful or unpleasant happen, or had any major changes in your life, within the past 6 months?**
  - ⇨ What kind of stressful or unpleasant things have you experienced?

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

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

- **Since (event) and in the past month, have you noticed a significant change 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 person 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, in relation to (event), 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"*

- **Do you think your emotional or behavioral reaction is excessive or unreasonable in some way**?
  - ⇨ Would someone else think that this emotional or behavioral reaction is excessive or unreasonable?

(Note: This item is based on the clinician's opinion, not solely on the patient's self-report. Consider all available information about the actual severity of the stressor.)

- **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 get in the way of your ability to function, like at school or work, in your social life, in your family, or in your ability to do things that are important to you? How?**
  - ⇨ Do you avoid any activities or situations because of these problems?
  - ⇨ Do these problems interfere with your ability to focus on necessary tasks?

☐ 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

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 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

FEEDING AND EATING DISORDERS

ANOREXIA NERVOSA

- **In the past month, what are your current eating habits like in a typical day?** _____
  - ⇨ Do you eat 3 meals a day? _____
  - ⇨ Has anyone ever told you that you were too thin, or that you didn't eat enough? _____
  - ⇨ Do you watch your calorie intake carefully? How many calories do you eat per day? _____
  - ⇨ What is your height? _____ What is your weight? _____

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

(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

(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 in order to not gain weight?** _____

☐ Vomiting
☐ Misuse of laxatives or diuretics
☐ Fasting
☐ Excessive exercise
☐ 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 there are any problems or dangers associated with your current eating habits or weight? _____

☐ 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**	*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 get in the way of your ability to function, like at school or work, in your social life, in your family, or in your ability to do things that are important to you? How?**
  - ⇨ Do you avoid any activities or situations because of these problems?
  - ⇨ Do these problems interfere with your ability to focus on necessary tasks?

☐ 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
☐ Financial 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 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

BINGE EATING

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

- **In the past month, do you often have eating "binges," in which you eat a lot of food or it feels like your eating is out of control?** _____
  - ⇨ How often do these binges occur? _____
  - ⇨ How much do you eat during these binges? _____
  - ⇨ During these binges, does it feel like you can't stop eating, or that you can't control how much you are eating? _____
  - ⇨ How long do these binges 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*

BULIMIA NERVOSA

1. *Are there recurrent episodes of binge eating? (see p. 90)*	*Yes*	*No* *Skip to item 6 and circle "No"*

- **In the past month, are there any things that you do, perhaps after an eating binge, in order to prevent weight gain?** _____

☐ Vomiting
☐ Misuse of laxatives or diuretics
☐ Fasting
☐ Excessive exercise
☐ Ritualized eating pattern
☐ Other compensatory behavior _____

(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, in an average week, have you had these eating "binges" 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. 87)?*	*No*	*Yes* *Skip to item 6 and circle "No"*

6. **BULIMIA NERVOSA**	*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 get in the way of your ability to function, like at school or work, in your social life, in your family, or in your ability to do things that are important to you? How?**
  - ⇨ Do you avoid any activities or situations because of these problems?
  - ⇨ Do these problems interfere with your ability to focus on necessary tasks?

☐ 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
☐ Financial 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 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

BINGE-EATING DISORDER

(Note: if criteria are met for Bulimia Nervosa, do not administer this module.)

1. Are there recurrent episodes of binge eating? (see p. 90)	*Yes*	*No* *Skip to item 6 and circle "No"*

In the past month, when you have these eating binges…

- ☐ How rapidly do you eat? [Eats much more rapidly than usual]
- ☐ How full do you get? [Eats until uncomfortably full]
- ☐ Do you have these eating binges 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, physically and emotionally? [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 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? _____

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. 91) or anorexia nervosa (see p. 87)?	*No*	*Yes* *Skip to item 6 and circle "No"*

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

- **In the past month, does this problem get in the way of your ability to function, like at school or work, in your social life, in your family, or in your ability to do things that are important to you? How?**
  - ⇨ Do you avoid any activities or situations because of these problems?
  - ⇨ Do these problems interfere with your ability to focus on necessary tasks?

☐ 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 ☐ Financial 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 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

AVOIDANT/RESTRICTIVE FOOD INTAKE DISORDER

- **In the past month, are your eating habits so picky that they cause problems for you?** _____
  - ⇨ What are your current eating habits like in a typical day? _____
  - ⇨ Why do you think you are eating very little? _____
  - ⇨ Are you uninterested in eating or food? _____
  - ⇨ Do you avoid certain foods because of the way they look, the way they smell, their texture, or how they feel when you chew them? _____
  - ⇨ Are you concerned that something bad will happen if you eat these foods? _____

- **Have your eating habits made it hard for you to get enough calories, or get appropriate nutrition?** _____

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 your eating habits…**
  - ☐ Have you lost weight? [Significant weight loss]
  - ☐ Do you have any vitamin, mineral, or other nutritional deficiencies? [Significant nutritional deficiency]
  - ☐ Do you have to take nutritional supplements, or have you ever had to have a feeding tube in your stomach or intestines? [Dependence on enteral feeding or oral nutritional supplements]
  - ☐ Have you had significant problems with your work, your school, your social relationships, 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 it's hard for you to obtain or afford enough food?** _____
- **Do you eat very little because of a religious or cultural practice?** _____
  - ⇨ Do other people from your religion or culture 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 concerned about your body weight or shape?** _____
  - ⇨ 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. *Does the eating disturbance occur exclusively during the course of bulimia nervosa (see p. 91) or anorexia nervosa (see p. 87), 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 you have any medication changes, use any drugs, or have a medical illness or injury?** _____
  - ⇨ Has there been any reason to believe that this problem is caused by a medical problem, drugs, or medications? _____
  - ⇨ Have you spoken to a medical clinician about these concerns? _____

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	*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 get in the way of your ability to function, like at school or work, in your social life, in your family, or in your ability to do things that are important to you? How?**
  - ⇨ Do you avoid any activities or situations because of these problems? _____
  - ⇨ Do these problems interfere with your ability to focus on necessary tasks? _____

☐ 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

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 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

SUBSTANCE-RELATED AND ADDICTIVE DISORDERS

SUBSTANCE USE DISORDER

- **How much alcohol do you drink?**
  - ⇨ How much do you drink on a given occasion?[17]
  - ⇨ What do you drink?
  - ⇨ How often do you drink?[18]_____
- **Have you ever used street or recreational drugs?** _____
- **Have you ever used prescription medications other than how they were prescribed?** _____
  - ⇨ What substances have you used more than a few times in your life? _____
  - ⇨ When was your period of the most use of (substance)? How much were you using (substance) at that time? _____

☐ Alcohol (highest use) _____

☐ Marijuana/cannabis (highest use) _____

☐ Phencyclidine/PCP (highest use) _____

☐ Other hallucinogens (highest use) _____

☐ Inhalants (highest use) _____

☐ Opioids (highest use) _____

☐ Sedatives, hypnotics, or anxiolytics (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…**

[17] One ounce of liquor, one beer, and one glass of wine have roughly equivalent alcohol levels and constitute 1 drink.

[18] 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 get in the way of your ability to function, like at school or work, in your social life, in your family, or in your ability to do things that are important to you? How?**
  - ⇨ Do you avoid any activities or situations because of these problems? _____
  - ⇨ Do these problems interfere with your ability to focus on necessary tasks? _____

☐ 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	☐ Financial problems	☐ Problems of health or safety
☐ Other functional impairment _____		

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):[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 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

[19] 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

- **In the past month, does it often seem that you have a great deal of difficulty paying attention or concentrating when you need to?** _____
  - ⇨ In what ways does this problem of paying attention or concentrating make things difficult for you?

- ☐ 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]
- ☐ Is it often hard for you to keep your attention focused on something, like a conversation, a lecture, or a book? [Often has difficulty sustaining attention in tasks]
- ☐ Do people often think you're not listening to them, like your mind is somewhere 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 work and activities? For example, is it hard to keep your materials in order, or to work neatly? Do you have a hard time managing your time? Do you miss deadlines? [Often has difficulty organizing tasks and activities]
- ☐ Do you try to avoid tasks that require a lot of focus, like preparing reports, completing forms, or reviewing papers? [Often avoids or dislikes tasks that require sustained mental effort]
- ☐ Do you often lose important things, like tools, your wallet, 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 things like chores, errands, appointments, returning calls, or paying bills? [Often forgetful in daily activities]

(Note: continue if 5 or more of the above are checked.)

- **In the past month, have these problems had a negative effect on your social life, school, or work?** _____

- **Have these problems been present for at least 6 months?** _____
  - ⇨ Have several of these problems been present since you were younger than 12 years old?
  - ☐ The 5 or more symptoms checked above have negatively impacted social, academic, or occupational activities
  - ☐ The 5 or more symptoms 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*

- **In the past month, does it often seem that you have difficulty sitting still or waiting for things?**
  - ⇨ In what ways 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]
- ☐ Are you often unable to stay in a seat? Like do you have to get up from a chair at work 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 often 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 meetings? Do other people see you as restless, or have a hard time keeping up with you? [Often "on the go, as if driven by a motor"]
- ☐ Do you often talk too much? [Often talks excessively]
- ☐ Do you often have a hard time waiting your turn in a conversation, like answering a question before the person 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 often hard for you do things like wait your turn or stand in a line? [Often has difficulty waiting his/her turn]
- ☐ Do you often butt into other people's activities or conversations? [Often intrudes into what others are doing or butts into conversations]

(Note: continue if 5 or more of the above are checked.)

- **In the past month, have these problems had a negative effect on your social life, school, or work?**
- **Have these problems been present for at least 6 months?**
  - ⇨ Have several of these problems been present since you were younger than 12 years old?

- ☐ The 5 or more symptoms checked above have negatively impacted social, academic, or occupational activities
- ☐ The 5 or more symptoms 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"*

- **In the past month, do these problems impair your ability to function, like at school or work, or in your social life? How?**

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

☐ Problems at school ☐ Problems with work or role ☐ Problems with social life ☐ Problems with family

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

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, in what situations do (inattention or hyperactivity-impulsivity symptoms) occur?**

☐ 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, does this problem get in the way of your ability to function, like at school or work, in your social life, in your family, or in your ability to do things that are important to you? How?**

⇨ Do you avoid any activities or situations because of these problems?
⇨ Do these problems interfere with your ability to focus on necessary tasks?

☐ 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 ☐ Financial problems ☐ Problems of health or safety
☐ Other functional impairment _____

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 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

TIC DISORDERS

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

- **In the past month, do you find that you have a lot of sudden repeated movements or make repeated sounds that you feel unable to 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 6 and continue)* *☐ Only motor tics present (Circle "No" for item 5 and continue)* *☐ Only vocal tics present (Circle "No" for item 5 and continue)*	*No* *Skip to Items 5, 6, and 7 and circle "No"*

- **How long have these problems been present?** _____
  - ⇨ Have they been present for at least 1 year? _____
  - ⇨ Have they been present since before you were 18 years old? _____

2. Have tics persisted for more than 1 year (frequency may wax and wane)?	*Yes* *Circle "No" for item 7 and continue*	*No* *Circle "No" for items 5 and 6 and continue*

3. Did tics begin before age 18?	*Yes*	*No* *Skip to items 5, 6, and 7 and circle "No"*

- **Just before you started having this problem, did you have any medication changes, use any drugs, or have a medical illness or injury?** _____
  - ⇨ Has there been any reason to believe that this problem is caused by a medical problem, drugs, or medications? _____
  - ⇨ Have you spoken to a medical clinician about these concerns? _____

4. Are tics due to the physiological effects of a substance or another medical condition?	*No*	*Yes* *Skip to items 5, 6, and 7 and circle "No"*

5. **TOURETTE'S DISORDER**	*Yes*	*No*

6. **PERSISTENT (CHRONIC) MOTOR OR VOCAL TIC DISORDER**	*Yes*	*No*

7. **PROVISIONAL TIC DISORDER**	*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 get in the way of your ability to function, like at school or work, in your social life, in your family, or in your ability to do things that are important to you? How?**
  - ⇨ Do you avoid any activities or situations because of these problems?
  - ⇨ Do these problems interfere with your ability to focus on necessary tasks?

☐ 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

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 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

SCHIZOPHRENIA SPECTRUM AND OTHER PSYCHOTIC DISORDERS

DELUSIONS

(Note: Some patients with delusions will be guarded, have low insight, or have other factors that affect their self-report. In such cases, other sources of information such as collateral reports, 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.)

- **Now I'm going to ask you about some beliefs that some people have. At any time in your life, did you have a strong belief that other people didn't agree with?**
  - ⇨ Have you ever believed any of the following?

- ☐ That people were conspiring against you, cheating you, spying on you, following you, poisoning or drugging you, or harassing you?
- ☐ That a governmental or religious organization was following you or harassing you?
- ☐ That you had a very special talent or powers that other people didn't know about, that you had made an important discovery that only you knew about, or 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 emitting a very bad odor, or that you had insects or parasites inside you, that a part of your body was misshapen, ugly, or not functioning?
- ☐ That a partner was being unfaithful to you?
- ☐ That someone or something had removed the thoughts from your mind?
- ☐ That someone else could read your mind?
- ☐ That someone or something had placed thoughts into your mind, like using a machine or a spell of some kind?
- ☐ That someone or something was controlling your movements and actions?
- ☐ That someone or something was sending you special messages meant only for you, like through your TV, radio, or books?
- ☐ That you were responsible for a disaster, such as a hurricane, or that you were responsible for a serious crime?

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

- ***(For any belief endorsed)*** **How did you arrive at that belief? What made you decide that it was true?**
- ***(For any belief endorsed)*** **Did anyone ever suggest that this belief was not true? How did you respond?**
  - ⇨ *(For any belief endorsed)* What if I suggested to you that this belief was not true, that perhaps there was another way of thinking about it *(give examples of alternative interpretations if possible)*? How would you respond?

- ☐ 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 person report a fixed and irrational belief that is not amenable to change with conflicting evidence?*	*Yes*	*No* *Skip to item 3 and circle "No"*

- **Just before you started having this problem, did you have any medication changes, use any drugs, or have a medical illness or injury?** _____
  - ⇨ Has there been any reason to believe that this problem is caused by a medical problem, drugs, or medications? _____
  - ⇨ Have you spoken to a medical clinician about these concerns? _____

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*

HALLUCINATIONS

(Note: Some patients with hallucinations will be guarded, have low insight, or have other factors that affect their self-report. In such cases, other sources of information such as collateral reports, 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.)

- **Now I'm going to ask you about some unusual experiences that some people have. At any time in your life, have you ever experienced any of the following?**

☐ Hearing things that others couldn't hear, such as voices or music?

☐ Seeing things that others couldn't see, such as people, animals, colors, or spirits?

☐ Feeling odd sensations on your skin or in your body, like insects or electric shocks?

☐ Smelling odors that others could not smell, such as vomit, urine, feces, something rotting, or smoke?

☐ Other sensory experiences? _____

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

Are you experiencing those things now?

- ***(For any hallucination endorsed)*** **Were you fully awake at the time? Were you in the process of 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 experience (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 person report perceptual experiences that occur without an external stimulus?*	*Yes*	*No* *Skip to item 3 and circle "No"*

- **Just before you started having this problem, did you have any medication changes, use any drugs, or have a medical illness or injury?** _____
  - ⇨ Has there been any reason to believe that this problem is caused by a medical problem, drugs, or medications? _____
  - ⇨ Have you spoken to a medical clinician about these concerns? _____

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 3 and circle "No"*

3. **HALLUCINATIONS**	*Yes*	*No*

SCHIZOPHRENIA AND SCHIZOPHRENIFORM DISORDER

- ☐ Lifetime presence of delusions (see p. 108)
- ☐ Lifetime presence of hallucinations (see p. 110)
- ☐ Lifetime presence of disorganized speech (e.g., frequent derailment or incoherence)

(Note: the presence of disorganized speech should be determined by behavioral observations, collateral reports, and other data.)

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 person's life?*	*Yes*	*No* *Skip to items 7 and 8 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 person's life?*	*Yes*	*No* *Skip to items 7 and 8 and circle "No"*

💎 **(Does/did) this problem get in the way of your ability to function, like at school or work, in your social life, in your family, or in your ability to do things that are important to you? How?**

- ⇨ Do you avoid any activities or situations because of these problems?
- ⇨ Do these problems interfere with your ability to focus on necessary tasks?

☐ 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	☐ Financial 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 7 and 8 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.)

4. *Have schizoaffective disorder (see p. 114), Major Depressive Disorder (see p. 47), and Bipolar Disorder (see p. 41) been ruled out?*	*Yes*	*No* *Skip to items 7 and 8 and circle "No"*

- **How long (have/did) you experience(d) these problems?**
  - ⇨ For at least 1 month? _____
  - ⇨ For at least 6 months? _____

5. *Were least some of the symptoms continuously present for at least 1 month at any time in the person's life?*	*Yes*	*No* *Skip to items 7 and 8 and circle "No"*

6. *Were least some of the symptoms continuously present for 6 months or more at any time in the person's life?*	*Yes* *Circle "No" for item 7 and "Yes" for item 8*	*No* *Circle "Yes" for item 7 and "No" for item 8*

7. **SCHIZOPHRENIFORM DISORDER**	Yes	No

8. **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 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 get in the way of your ability to function, like at school or work, in your social life, in your family, or in your ability to do things that are important to you? How?**
  - ⇨ Do you avoid any activities or situations because of these problems?
  - ⇨ Do these problems interfere with your ability to focus on necessary tasks?

- ☐ 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
- ☐ Financial problems
- ☐ Problems of health or safety
- ☐ Other functional impairment _____

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 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

SCHIZOAFFECTIVE DISORDER

1. *Has there been one uninterrupted period in which both criterion 2 of schizophrenia (see p. 111) and either a manic episode (see p. 33) or a major depressive episode (see p. 40) were present?*	*Yes*	*No* *Skip to item 5 and circle "No"*

2. *Has there been some point when delusions (see p. 109) or hallucinations (see p. 110) have been present for 2 or more weeks in the absence of a manic episode (see p. 33) or a major depressive episode (see p. 40)?*	*Yes*	*No* *Skip to item 5 and circle "No"*

3. *Have symptoms of a manic episode (see p. 33) or a major depressive episode (see p. 40) 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 you have any medication changes, use any drugs, or have a medical illness or injury?** _____
  - ⇨ Has there been any reason to believe that this problem is caused by a medical problem, drugs, or medications? _____
  - ⇨ Have you spoken to a medical clinician about these concerns? _____

(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**	Yes	No

- **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 get in the way of your ability to function, like at school or work, in your social life, in your family, or in your ability to do things that are important to you? How?**
  - ⇨ Do you avoid any activities or situations because of these problems?
  - ⇨ Do these problems interfere with your ability to focus on necessary tasks?

☐ 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
☐ Financial 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 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

DELUSIONAL DISORDER

(Note: if criterion 2 of schizophrenia [see p. 111] has ever been met, do not administer this module.)

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 get in the way of your ability to function, like at school or work, in your social life, in your family, or in your ability to do things that are important to you? How?**
  - ⇨ Do you avoid any activities or situations because of these problems?
  - ⇨ Do these problems interfere with your ability to focus on necessary tasks?

☐ 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

(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 you have any medication changes, use any drugs, or have a medical illness or injury?** _____
  - ⇨ Has there been any reason to believe that this problem is caused by a medical problem, drugs, or medications? _____
  - ⇨ Have you spoken to a medical clinician about these concerns? _____

(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 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? _____

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 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

SUBSTANCE/MEDICATION-INDUCED DISORDER, DISORDER DUE TO ANOTHER MEDICAL CONDITION, OTHER SPECIFIED DISORDER, AND UNSPECIFIED DISORDER

SUBSTANCE/MEDICATION-INDUCED DISORDER

(Note: review previous modules for presence of symptoms of disorders; administer this module if there is reason to suspect that these 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 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 get in the way of your ability to function, like at school or work, in your social life, in your family, or in your ability to do things that are important to you? How?**
  - ⇨ Do you avoid any activities or situations because of these problems?
  - ⇨ Do these problems interfere with your ability to focus on necessary tasks?

☐ 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	☐ Financial 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 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

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

(Note: review previous modules for presence of symptoms of disorders; administer this module if there is reason to suspect that these 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 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 get in the way of your ability to function, like at school or work, in your social life, in your family, or in your ability to do things that are important to you? How?**
  - ⇨ Do you avoid any activities or situations because of these problems?
  - ⇨ Do these problems interfere with your ability to focus on necessary tasks?

☐ 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
☐ Financial 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 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

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

(Note: If criteria are met for another disorder, do not administer this module.)

1. Does the person 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 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 get in the way of your ability to function, like at school or work, in your social life, in your family, or in your ability to do things that are important to you? How?**
  - ⇨ Do you avoid any activities or situations because of these problems? _____
  - ⇨ Do these problems interfere with your ability to focus on necessary tasks? _____

☐ 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

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 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

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 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 Neurodevelopmental Disorder
□ Unspecified Schizophrenia Spectrum and Other Psychotic Disorder

SUICIDE SCREEN

- **Have you ever thought about hurting or killing yourself?** _____
  - ⇨ Have you been having these kinds of thoughts recently? _____

1. Does the person report suicidal ideation?	*Current*	*Past*	*None*

- **Do you intend to hurt or kill yourself today or in the future?** _____
  - ⇨ How long have intended to hurt or kill yourself? Do you intend to die? _____

2. Does the person report suicidal intent?	*Current*	*Past*	*None*

- **Have you made a plan for how you would hurt or kill yourself?** _____
  - ⇨ What specifically is your plan to hurt or kill yourself? _____

3. Does the person report a suicidal plan?	*Current*	*Past*	*None*

- **(If a plan is endorsed) Do you have the ability to carry out that plan?** _____
  - ⇨ Do you have access to (planned method: gun, knife, etc.)? Could you easily gain such access? _____

4. Does the person report having the means to commit suicide?	*Current*	*Past*	*None*

- **(If a plan is endorsed) What steps have you taken to carry out that plan?** _____
  - ⇨ Have you made an attempt to hurt or kill yourself, written a suicide note, researched ways to do it, gathered materials for the plan, given away possessions, gotten your affairs in order, etc.? Have you ever attempted to hurt or kill yourself in the past? _____

5. Does the person report present or past behaviors that could lead to suicide?	*Current*	*Past*	*None*

- **(If a plan is endorsed) What would stop you from carrying out that plan?** _____
  - ⇨ Do you have religious beliefs, or a sense that things could get better? Do you have a responsibility to others that would give you a reason for living? _____

6. Does the person have internal or external protective factors that decrease the risk?	*Current*	*Past*	*None*

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)

- ☐ Set up a no-suicide contract
- ☐ Provide emergency/crisis numbers
- ☐ Explore what resources are available (e.g. family support, friends, etc.)
- ☐ 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 _____

DIAGNOSIS CODING SHEET

Anxiety Disorders

- ☐ 309.21/F93.0 Separation Anxiety Disorder

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

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
- ☐ 296.25/F32.4 In partial remission
- ☐ 296.26/F32.5 In full remission

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
- ☐ 296.35/F33.41 In partial remission
- ☐ 296.36/F33.42 In full remission

- ☐ 296.20/F32.9 Unspecified
- ☐ 300.4/F34.1 Persistent Depressive Disorder (Dysthymia)
- ☐ 625.4/F32.81 Premenstrual Dysphoric Disorder
- ☐ 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/F50.8 Avoidant/Restrictive Food Intake Disorder

Somatic Symptom and Related Disorders
- ☐ 300.82/F45.1 Somatic Symptom Disorder
- ☐ 300.7/F45.21 Illness Anxiety 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

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

- ☐ 304.30/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

- ☐ 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