K-SADS-PL DSM-5

November 2016

Includes:

A. Screen Interview

B. Supplements

- **I. Depressive and Bipolar Related Disorders Supplement**
- **II. Schizophrenia Spectrum and Other Psychotic Disorders Supplement**
- **III. Anxiety, Obsessive-Compulsive, and Trauma-Related Disorders Supplement**
- **IV. Neurodevelopmental, Disruptive, and Conduct Disorders Supplement**
- **V. Eating Disorders and Substance-Related Disorders Supplement**

Advanced Center for Intervention and Services Research (ACISR)

for Early Onset Mood and Anxiety Disorders

Western Psychiatric Institute and Clinic

Child and Adolescent Research and Education (CARE)

Program, Yale University

Subject | | | | | | | |

Date | | | / | | | / | 2 | 0 | | |

Interviewer | | | |

Draft

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PL-2009 Working Draft developed by David Axelson, MD, Boris Birmaher, MD, Jamie Zelazny, RN, MPH, Joan Kaufman, PhD, and MaryKay Gill, MSN, with support provided by the Advanced Center for Intervention and Services Research (ACISR, MH 66371) PI: David Brent, MD. The current instrument is also greatly indebted to several other existing structured and semi-structured psychiatric instruments including the SADS-L (Spitzer and Endicott), the SCID (Spitzer, Williams, Gibbon, and First), the DIS (Robins and Helzer), the ISC (Kovacs), the DICA (Reich, Shayka, and Taibleson) and the DUSI (Tarter, Laird, Bukstein, and Kaminer). Guidelines for the introductory interview at the beginning of this instrument were initially provided by Michael Rutter, MD, and Phillip Graham, MD, and refined with subsequent renditions of the KSADS.

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Screen Interview

Kiddie-SADS - Lifetime Version (K-SADS-PL DSM-5 November 2016)

The K-SADS-PL DSM-5 November 2016 combines dimensional and categorical assessment approaches to diagnose current and past episodes of psychopathology in children and adolescents according to DSM-5 criteria. Prior to administering the interview portion of the K-SADS-PL, parents and children are to complete the DSM-5 cross-cutting 25-item symptom rating scales. Responses on these dimensional rating scales are then taken into account in completing the interview portion of the assessment. The primary diagnoses assessed with the K-SADS-PL DSM-5 November 2016 include: Major Depression, Persistent Depression, Mania, Hypomania, Cyclothymia, Bipolar Disorders, Disruptive Mood Dysregulation Disorder, Schizoaffective Disorders, Schizophrenia, Schizophreniform Disorder, Brief Psychotic Disorder, Panic Disorder, Agoraphobia, Separation Anxiety Disorder, Simple Phobia, Social Anxiety Disorder, Selective Mutism, Generalized Anxiety Disorder, Obsessive-Compulsive Disorder, Attention Deficit Hyperactivity Disorder, Conduct Disorder, Oppositional Defiant Disorder, Enuresis, Encopresis, Anorexia Nervosa, Bulimia, Binge Eating Disorder,Transient Tic Disorder, Tourette's Disorder, Chronic Motor or Vocal Tic Disorder, Alcohol Use Disorder, Substance Use Disorder, Post-Traumatic Stress Disorder, Adjustment Disorders, and Autism Spectrum Disorder.

The K-SADS-PL DSM-5 November 2016 is a semi-structured interview. The probes that are included in the interview do not have to be, and should not be, recited verbatim. Rather, they are provided to illustrate ways to elicit the information necessary to score each item. The interviewer should feel free to adjust the probes to the developmental level of the child, and use language supplied by the parent and child when querying about specific symptoms.

After reviewing parent and child responses on the DSM-5 cross-cutting rating scales, the K-SADS-PL DSM-5 November 2016 is administered by interviewing the parent(s), the child, and finally achieving summary ratings which include all sources of information (parent, child, school, chart, and other). In general, when administering the instrument to pre-adolescents, conduct the parent interview first. In general, when working with adolescents, begin with them. There may be clinical reasons to alter the order of administration.

When there are discrepancies between different sources of information, the rater will have to use his/ her best clinical judgment. In the case of discrepancies between parents' and child's reports, the most frequent disagreements occur in the items dealing with subjective phenomena where the parent does not know, but the child is very definite about the presence or absence of certain symptoms. This is particularly true for items like guilt, hopelessness, interrupted sleep, hallucinations, and suicidal ideation. If the disagreements relate to observable behavior (e.g., truancy, fire setting, or a compulsive ritual), as appropriate, the examiner should query the parent(s) and child about the discrepant information. Ultimately the interviewer will have to use his/her best clinical judgment in assigning the summary ratings.

The following guidelines should be used in coding symptoms:

1) *Current Diagnoses*: In coding current episodes (CE) of disorders, symptoms should be rated for the time period when they were the most severe during the episode. *Note in the margins if and when particular symptoms (e.g., insomnia) improved or resolved*. Patients typically present when symptoms are at the worst. In follow-up research assessments, symptoms may be in partial remission.
2) *Disorders Targeted with Medication*: In coding disorders treated with medication (e.g., ADHD) use the ratings to describe the most intense severity of symptoms experienced prior to initiation of medication, when medications wear off, or during 'drug holidays'. *Note in margins symptoms targeted effectively with medication*.
3) *Past Diagnoses*: In order for an episode to be considered 'resolved' or 'past', the child should have had a minimum of *two months* free from the symptoms associated with the disorder. Episodes rated in the past disorders section should represent the most severe past (MSP) episode experienced of that given disorder.
4) *Time Line*: For children with a history of recurrent or episodic disorders, it is recommended that a time line be generated to chart lifetime course of disorder and facilitate scoring of symptoms associated with each episode of illness.

In the process of completing the full interview, diagnoses initially believed to be 'past' may turn out to be current diagnoses in partial remission. Corrections in the coding of current and past severity ratings can be made after completion of the interview.

Administration of the K-SADS-PL DSM-5 November 2016 requires the completion of: 1) the parent and child DSM-5 cross-cutting symptoms measures (DSM-5 CC-SM); 2) an Unstructured Introductory Interview; 3) a Diagnostic Screening Interview; 4) the Supplement Completion Checklist; 5) the appropriate Diagnostic Supplements; and 6) the Summary Lifetime Diagnostic Checklist. The K-SADS-PL is initially completed with each informant separately. If there is no suggestion of current or past psychopathology, no assessments beyond the Screen Interview will be necessary. The Summary Lifetime Diagnostic Checklist is completed after synthesizing all the data and resolving discrepancies in informants' reports. Each of the phases of the K-SADS-PL Interview is discussed briefly below.

1) The DSM-5 Cross-Cutting Symptoms Measures (DSM-5 CC-SM). The DSM-5 CC-SM are designed to be self-report measures completed independently by the parent and child before beginning the KSADS Interview. Scores on these self-report scales should be reviewed and recorded in the space provided before beginning the interview portion of the KSADS. The DSM-5 CC-SM include 25-items that assess symptom severity over the past two weeks. The parent and child DSM-5 CC-SM are included at the end of the KSADS. The American Psychiatric Association recommends specific follow-up measures that can be completed if threshold scores are obtained on the 25-item DSM-5 CC-SM and several disorder-specific severity scales. These additional scales can be accessed at: http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures#Level1, but do not need to be completed as part of the KSADS diagnostic assessment.

2) The Unstructured Introductory Interview. This section of the K-SADS-PL DSM-5 November 2016 takes approximately 10 to 15 minutes to complete. In this section, the parent provides information about health, presenting complaint and prior psychiatric treatment data, and both the parent and the child are surveyed about the child's school functioning, hobbies, and peer and family relations. Discussion of these latter topics is extremely important, as it provides a context for eliciting mood symptoms (depression and irritability), and obtaining information to evaluate functional impairment. This section of the K-SADS-PL should be used to establish rapport with the parent(s) and the child, and should never be omitted.

3) The Screen Interview. The Screen Interview surveys the primary symptoms of the different diagnoses assessed in the K-SADS-PL DSM-5 November 2016. Specific probes and scoring criteria are provided to assess each symptom. *The rater is not obliged to recite the probes verbatim, or use all the probes provided, just as many as is necessary to score each item.* Probing should be as neutral as possible, and leading questions should be avoided (e.g., "You don't feel sad, do you?"). Symptoms rated in the screen interview are surveyed for *current* (CE) and *most severe past* (MSP) episodes simultaneously. Begin by asking if the child has *ever* experienced the symptom. If the answer is no, rate the symptom negative for current and past episodes and proceed to the next question. If the answer is yes, find out when the symptom was present. If the symptom is endorsed for one time frame (e.g., currently), inquire if it was ever present at another time (e.g., past).

The diagnoses assessed with the screen interview do not have to be surveyed in order. The interviewer may begin inquiring about relevant diagnoses suggested by the presenting complaint information obtained during the unstructured interview. All sections of the Screen Interview must be completed, however, and most people find it easiest to proceed from start to finish.

Skip Out Criteria. After the primary symptoms associated with each diagnosis are surveyed in the Screen Interview, skip out criteria are delineated for current and past episodes of the disorder. A space is provided to indicate if the child met the skip out criteria, or if the child has clinical manifestations of the primary symptoms associated with the specific diagnosis. If the child failed to meet the skip out criteria for some diagnoses, the appropriate supplements should be administered after the Screen Interview is completed in its entirety.

Scoring. While interviewers are free to utilize latitude in the manner in which symptoms are queried, the scoring criteria are to be applied rigidly. The majority of the items in the K-SADS-PL DSM-5 November 2016 are scored using a 0–3 point rating scale. Scores of 0 indicate no information is available, scores of 1 suggest the symptom is not present, scores of 2 indicate subthreshold levels of symptomatology, and scores of 3 represent threshold criteria. The remaining items are rated on a 0-2 point rating scale on which 0 implies no information, 1 implies the symptom is not present, and 2 implies the symptom is present. When determining whether a symptom meets threshold vs subthreshold level criteria, it is important to assess the severity, frequency, and duration of the symptom, as well as impairment from the symptom. It is often helpful to ask for examples of specific behaviors or symptoms. To attain a threshold score of 3, the child must meet or exceed the threshold scoring criteria. If his symptom severity falls between the threshold and subthreshold criteria, the symptom would be rated subthreshold; a score of 2.

Subthreshold Symptoms While subthreshold manifestations of symptoms are not sufficient to count toward the diagnosis of a disorder, further inquiry may be warranted in certain cases. Subthreshold scores of psychotic symptoms or clusters of other symptoms associated with a given diagnosis should be brought to the attention of the attending physician or research supervisor. If subthreshold scores are attained on multiple items within a given diagnostic section of the Screen Interview, the supplement for that section can be completed to further assess relevant clinical symptomatology.

4) Supplement Completion Checklist. The Supplement Completion Checklist is on the last page of this Screen Interview. It should be torn off before starting the interview. Supplements requiring completion should be noted in the spaces provided, together with the dates of possible current and past episodes of disorder.

5) Diagnostic Supplements. There are five Diagnostic Supplements included with the K-SADS-PL: Supplement #1: Depressive and Bipolar Related Disorders; Supplement #2: Schizophrenia Spectrum and Other Psychotic Disorders; Supplement #3: Anxiety, Obsessive Compulsive, and Trauma-Related Disorders; Supplement #4: Neurodevelopmental, Disruptive, and Conduct Disorders; Supplement #5: Eating Disorders and Substance-Related Disorders. The format of the KSADS with its Screen Interview and five Diagnostic Supplements is designed to facilitate differential diagnoses, with the Screen Interview providing a good overview of potentially relevant diagnostic categories before surveying symptoms associated with the different disorders in detail.

The diagnoses surveyed in each of these supplements are outlined in the Supplement Completion Checklist, and in the Table of Contents at the beginning of each supplement. The skip out criteria in the Screening Interview specify which supplements, if any, should be completed. Like in the Screen Interview, each supplement has a list of symptoms, probes, and criteria to assess current (CE) and most severe past (MSP) episodes of disorder.

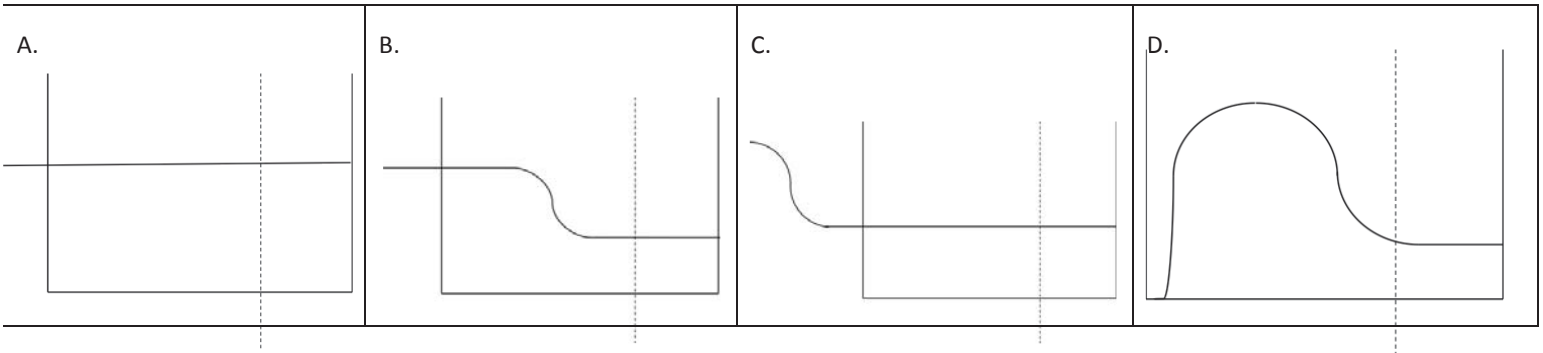
Supplements should be administered in the order that symptoms for the different diagnoses appeared. For example, if the child had evidence of Attention Deficit Hyperactivity Disorder (ADHD) beginning at age 5, and possible Major Depression (MDD) beginning at age 9, the Supplement for ADHD should be completed before the supplement for MDD. If the child had a history of attention difficulties associated with ADHD, when inquiring about concentration difficulties in assessing MDD, it is important to find out if the onset of depressive symptoms was associated with a worsening of the long standing concentration difficulties. If there was no change in attention problems with the onset of the depressive symptoms, the symptom 'Difficulty Concentrating' should not be rated positively in the MDD supplement.

When the time course of disorders overlap, supplements for disorders that may influence the course of other disorders should be completed first. For example, if there is evidence of substance use and possible Mania or Psychosis, the substance abuse supplement should be completed first, and care should be taken to assess the relationship between substance use and possible manic and/or psychotic symptoms.

6) The Summary Lifetime Diagnostic Checklist is a template that was designed to record basic lifetime and current diagnostic information. Clinicians / Investigators may wish to record additional, more specific information (e.g., dates of onset/offset or duration of additional episodes). The Follow-up Summary Diagnostic Checklist is a template designed to record longitudinal course of illness. These template checklists are included at the end of the supplements of the KSADS.

Using the K-SADS in Longitudinal Studies. When the KSADS is used to monitor subjects longitudinally, it is important to be sure that the symptoms and diagnoses are being scored since the last interview. The timeframe for the Current ratings needs to be defined, based on the aims of the study. For example, the Current period could be the month prior to the interview (or 2 weeks, or 2 months, etc.). Then symptoms and diagnoses are rated for the most symptomatic time during the current period. Past symptoms and diagnoses are rated based on the most severe symptomatology between the last interview and whatever time is defined as the Current rating period. These rules are more relevant for episodic disorders such as depression and mania/hypomania. It is recommended that each study define *a priori* the timeframes to be used in administering the KSADS for longitudinal assessments. Results from the follow-up interviews can then be recorded on the Longitudinal Summary Diagnostic Checklist. The longitudinal summary diagnostic checklist may require some modifications by Investigators to accommodate the aims, methodology, and outcome definitions (e.g., remission, recovery, remission, recurrence) utilized in each study.

As depicted below, the KSADS can be used to characterize the subject's longitudinal course of illness. The space between the first two lines on the left side of each diagram below depicts the course of illness since the last assessment up to the "current episode" timeframe, and the space on the right side of each diagram depicts the characterization of the current (e.g., last two months) symptomatology.



Legend. A) Figure A depicts a child with a chronic course of illness from the last interview; B) Figure B depicts a child who met full criteria during the last interview and continued to meet criteria during his most severe past episode during the follow-up interval, then met partial remission criteria during the "current" time frame assessed at follow-up; C) Figure C depicts a child who was in partial remission but never went into full remission during the "past" or "current" follow-up intervals, and is currently in partial remission: D) Figure D depicts a child who had no diagnosis at the initial interview, and then had an onset of a full diagnosis during the follow-up, but met for partial remission during the "current" follow-up interval.

Guidelines for the Administration of the Introductory Unstructured Interview

The unstructured interview should take at least 15 minutes to administer. The aim of the unstructured interview is to establish rapport and obtain information about presenting complaints, prior psychiatric problems, and the child's global functioning. It is helpful to spend a few minutes in general conversation in order to make the child and parent feel at ease.

The interview opens with questions about basic demographics. This is a very easy thing for most people to talk about, and the information helps to orient the interviewer to the child's life circumstances. Health and developmental history data should also be obtained from the parent, as this information may be helpful in making differential diagnoses. The child does not need to be queried about these things.

In discussing onset and course of symptoms, many children will be unable to provide reliable time data. This is developmentally normal. If the child does not provide such data in the first questioning, s/he will probably not provide it at all.

In interviewing the parent, modify the questions to refer to the child.

In the introductory interview and throughout the K-SADS, interviewers are encouraged to use language generated by the child and/or parent when asking about symptoms (e.g., "For how long did you feel bummed?").

After surveying the reason for referral, obtain information about treatment history. Then ask about the child's school adaptation and social relations.

In interviewing children, it is not necessary --- and usually not productive to try to complete all of the introductory interview. Review basic demographics (e.g., age, grade, family constitution, siblings' names and ages), presenting complaints (likely in less detail than with the parent), and family, school adaptation, and peer relations information. The discussion of these latter topics are extremely *important*, as it provides a context for eliciting mood symptoms (depression and irritability) from children, generate hypotheses about possible relevant diagonstic areas, and obtain preliminary information to evaluate functional impairment.

SUBJECT INFORMATION

First Name: **Last Name:**

Date of Birth: / /

Gender: ○ Male ○ Female

Ethnicity: ○ Hispanic or Latino ○ Not Hispanic or Latino

Race *(Mark all that apply):* ○ Black or African American ○ Native Hawaiian or Pacific Islander ○ Asian ○ Native American or Alaskan Native ○ White or Caucasian ○ Other Specify:

With whom is subject currently living (choose one)?

○ Both biological parents	○ Biological father only	○ Group home
○ Both biological parents, but joint custody	○ Stepmother only	○ Residential institution
○ Biological mother and stepfather	○ Stepfather only	○ Boarding home
○ Biological father and stepmother	○ Grandparent	○ Runaway
○ Biological mother and boyfriend/girlfriend	○ Adoptive parent	○ College student
○ Biological father and boyfriend/girlfriend	○ Other relative/friend	○ Lives independently
○ Biological mother only	○ Foster home	○ Other

PARENTAL PARTICIPATION:

Who is the informant/reporter for this interview?

- ○ Both biological parents
- ○ Biological mother
- ○ Biological father
- ○ Both adoptive parents
- ○ Adoptive mother
- ○ Adoptive father
- ○ Step-mother
- ○ Step-father
- ○ Grandparent
- ○ Other relative
- ○ Other

If Other, please specify:

SUBJECT'S PRIMARY CAREGIVER's

First Name: **(lives with subject, if applicable)** **Last Name:**

This is Subject's: ○ Biological Mother ○ Bio Father ○ Foster Mother ○ Foster Father ○ None ○ Stepmother ○ Stepfather ○ Aunt ○ Uncle ○ Other Specify: ○ Adopted Mother ○ Adopted Father ○ Grandmother ○ Grandfather

SUBJECT'S SECONDARY CAREGIVER's

First Name: **(lives with subject, if applicable)** **Last Name:**

This is Subject's: ○ Biological Mother ○ Bio Father ○ Foster Mother ○ Foster Father ○ None ○ Stepmother ○ Stepfather ○ Aunt ○ Uncle ○ Other Specify: ○ Adopted Mother ○ Adopted Father ○ Grandmother ○ Grandfather

BIOLOGICAL MOTHER

First Name: **Last Name:**

Does child live with biological mother: ○ Yes ○ No

If no, describe nature of contact/relationship:

- ○ Mother deceased
- ○ Mother alive, regular visitation
- ○ Mother alive, sporadic contact
- ○ Mother alive but no contact

Quality of Relationship:

○ Excellent ○ Good ○ Fair ○ Poor

BIOLOGICAL FATHER

First Name: | | | | | | | | | | | | | |

Last Name: | | | | | | | | | | | | | | | |

Does child live with biological father: ○ Yes ○ No

If no, describe nature of contact/relationship:

- ○ Father deceased
- ○ Father alive, regular visitation
- ○ Father alive, sporadic contact
- ○ Father alive but no contact

Quality of Relationship:

○ Excellent ○ Good ○ Fair ○ Poor

SUBJECT'S SIBLINGS

First Name:

Last Name:

Age:

○ Half sibling ○ Full sibling

Quality of Relationship between Sibling and Subject:

○ Excellent ○ Good ○ Fair ○ Poor

First Name:

Last Name:

Age:

○ Half sibling ○ Full sibling

Quality of Relationship between Sibling and Subject:

○ Excellent ○ Good ○ Fair ○ Poor

First Name:

Last Name:

Age:

○ Half sibling ○ Full sibling

Quality of Relationship between Sibling and Subject:

○ Excellent ○ Good ○ Fair ○ Poor

Of the people in your family, or among the people you live with, who would you say you are closest to? ____________________

____

____

CHILD AND ADOLESCENT HEALTH SCREEN

PREGNANCY AND BIRTH:

1. Mother's age at birth of child ☐☐

2. Did mother have any illness or injury during pregnancy? ○ Yes ○ No ☐☐☐☐☐☐☐☐☐☐☐☐

3. Did she take any medications other than vitamins and iron? ○ Yes ○ No ☐☐☐☐☐☐☐☐☐☐☐☐

4. Did mother drink or use elicit drugs during pregnancy? ○ Yes ○ No ☐☐☐☐☐☐☐☐☐☐☐☐

5. Did mother smoke during pregnancy? ○ Yes ○ No ☐☐☐☐☐☐☐☐☐☐☐☐

6. Was the baby premature? (record # wks: _____) ○ Yes ○ No ☐☐☐☐☐☐☐☐☐☐☐☐

7. What was the birth weight? ☐☐☐ lbs.

8. Did the baby have any trouble at birth? ○ Yes ○ No ☐☐☐☐☐☐☐☐☐☐☐☐

9. Did the baby have any other trouble? (Jaundice, infections, other?) ○ Yes ○ No ☐☐☐☐☐☐☐☐☐☐☐☐

10. How many days did the baby stay in the hospital after birth? ☐☐☐ days

MEDICAL AND SURGICAL HISTORY:

11. Current height: ☐ feet ☐☐ inches Weight: ☐☐☐.☐ lbs

12. Where does your child go for medical care? ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

13. Date of last medical exam: ☐☐ / ☐☐ / ☐☐☐☐

14. Has your child had allergic reactions to any medications? If ***YES***, please specify: ○ Yes ○ No ☐☐☐☐☐☐☐☐☐☐☐☐

Allergic reactions to foods? ○ Yes ○ No ☐☐☐☐☐☐☐☐☐☐☐☐

Allergic reactions to insect bites? ○ Yes ○ No ☐☐☐☐☐☐☐☐☐☐☐☐

15. Has your child had all immunizations? ○ Yes ○ No

16. Any bad reactions to immunizations? ○ Yes ○ No ☐☐☐☐☐☐☐☐☐☐☐☐

MEDICAL AND SURGICAL HISTORY cont:

17. Any hospitalizations? If ***YES***, for what? ○ Yes ○ No

18. Any serious injuries? If ***YES***, what kind? ○ Yes ○ No

19. Any head injuries? (Indicate if your child lost consciousness): ○ Yes ○ No

20. Any other current or past significant medical health problems? If ***YES***, please specify: ○ Yes ○ No

DEVELOPMENTAL HISTORY:

1. Problems with social relatedness during infancy and early childhood: ○ Yes ○ No

If yes, please explain:

2. Developmental milestones within normal limits: ○ Yes ○ No

If no, please explain:

Clinician

Supervising Physician/Supervising Researcher

☐☐ / ☐☐ / ☐☐☐☐

Date

Presenting Complaint:

Probe: Have you or anyone else in your family had psychiatric treatment before? For what sorts of problems?

Criteria: **0 = No Information**
1 = Not Present
2 = Probable
3 = Definite

	Mother	Father	Sibling	Half-Sibling	Grandparent	Aunt/Uncle	Other
Psychiatric Tx	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
Depression	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
Mania	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
ADHD	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
Conduct/Antisocial	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
Schizophrenia	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
Other Psychosis	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
Alcohol Use Disorder	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
Substance Use Dis.	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
Autism Spectrum	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
Suicide Attempt	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
Suicide Completion	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
Other	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3

LIFETIME TREATMENT HISTORY

		Age of first tx (in YEARS)	Age of first tx (in MONTHS)
Outpatient Treatment	○ No info ○ No ○ Yes		
Psychiatric Hospitalization	○ No info ○ No ○ Yes		
Partial Hospitalization	○ No info ○ No ○ Yes		
Residential Treatment Facility	○ No info ○ No ○ Yes		
In-Home Services Tx (e.g., Wrap Around/Family Based)	○ No info ○ No ○ Yes		

Number of Psychiatric Hospitalizations

OVERALL RELIABILITY OF INFORMATION:

☐ Good ☐ Fair ☐ Poor

Medication listing

		Past/ Current				Past/ Current
1		○	○	7		○ ○
2		○	○	8		○ ○
3		○	○	9		○ ○
4		○	○	10		○ ○
5		○	○	11		○ ○
6		○	○	12		○ ○

School Information

Current Grade (or highest grade completed): ☐☐ Any Repeated Grades? List: ☐☐ ☐☐ ☐☐

Current School Setting:
- ○ Regular Public School
- ○ Regular Private School
- ○ Vocational-Technical School
- ○ Not in School
- ○ Specialized School for Youth with Emotional/Behavioral Problems
- ○ Cyber School
- ○ Home School
- ○ Other, specify: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Specialized Services:
- ○ Full-time Emotional Support Classroom
- ○ Full-time Learning Support Classroom
- ○ Full-time Aide
- ○ Tutoring Support
- ○ Other, specify: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
- ○ Special Education for specific subjects (partially mainstreamed)
- ○ Part-time Aide
- ○ Resource Room
- ○ Gifted Program

Recent Grades - Academic Classes:

Best: ○ A ○ B ○ C ○ D ○ F

Average: ○ A ○ B ○ C ○ D ○ F

Worst: ○ A ○ B ○ C ○ D ○ F

Subject Strengths:

Subject Weaknesses:

Concerns from teachers about behavior:

Detentions (past year): ☐☐☐

Suspensions (past year): ☐☐

Reasons for Disciplinary Action (check all that apply):
- _____ Fights in school
- _____ Talking back to teachers
- _____ Pulling fire alarm
- _____ Threats of violence
- _____ Other (specify)

Expulsions (ever): ○ yes ○ no If yes, how many? ☐☐

Peer Relations

Best friend(s)? ○ yes ○ no

Relations with peers at school: ○ Excellent ○ Good ○ Fair ○ Poor

Relations with peers in the neighborhood: ○ Excellent ○ Good ○ Fair ○ Poor

Bullied by others? ○ Never/Rarely - not a problem ○ Sometimes- can be a problem ○ Often - definite problem ○ Very Often- major problem

Other Activities / Interests

(Mark those that apply and specify)

○ Hobbies 1 2

○ Preferred Activies during free-time 1 2 3 4

○ Sports 1 2 3 4

○ Organizations 1 2

1. Depressed Mood

DSM-5 DR# 6: Felt down, depressed:

Parent Rating: _____ Child Rating: _____

Have you ever felt sad, blue, down, or empty?
Did you feel like crying? When was that?
Do you feel _____ now?
Was there ever another time you felt _____?
Did you have any other bad feelings?
Did you have a bad feeling all the time that you couldn't get rid of?
Did you cry or were you tearful? Did you feel (_____) all the time, some of the time? (Percent of awake time: summation of % of all labels if they do not occur simultaneously).
(Assessment of diurnal variation can secondarily clarify daily duration of depressive mood)
Did it come and go?
How often? Everyd ay?
How long did it last?
What do you think brought it on?
Could other people tell that you were sad?

	P	C	S
0 - No information.	( )	( )	( )
1 - Not present. Not at all or less than once a week.	( )	( )	( )
2 - Subthreshold: Depressed mood at least 2-3 days/ week, for much of the day.	( )	( )	( )
3 - Threshold: Depressed mood, more days than not (4-7 days/week), most of the day (at least 50% of awake time.).	( )	( )	( )

PAST: ☐ P ☐ C ☐ S

Duration of Depressed Mood: (current) ☐☐☐

Duration of Depressed Mood: (most severe past) ☐☐☐

NOTE: SOMETIMES THE CHILD WILL INITIALLY GIVE A NEGATIVE ANSWER AT THE START OF THE INTERVIEW BUT WILL BECOME OBVIOUSLY SAD AS THE INTERVIEW GOES ON. THEN THESE QUESTIONS SHOULD BE REPEATED ELICITING THE PRESENT MOOD AND USING IT AS AN EXAMPLE TO DETERMINE ITS FREQUENCY. SIMILARLY, IF THE MOTHER'S REPORT IS THAT THE CHILD IS SAD MOST OF THE TIME AND THE CHILD DENIES IT, THE CHILD SHOULD BE CONFRONTED WITH THE MOTHER'S OPINION AND THEN ASKED WHY HE THINKS HIS MOTHER BELIEVES HE FEELS SAD SO OFTEN.

NOTE: WHEN A CHILD OR PARENT REPORTS FREQUENT SHORT PERIODS OF SADNESS THROUGHOUT THE DAY, IT IS LIKELY THAT THIS CHILD IS ALWAYS SAD AND ONLY REPORTS THE EXACERBATIONS, IN WHICH CASE THE RATING OF DEPRESSIVE MOOD WILL BE 4. THUS, IT IS ALWAYS ESSENTIAL TO ASK ABOUT THE REST OF THE TIME: "Besides these times when you felt (_____), during the rest of the time, did you feel happy or were you more sad than your friends?"

2. Irritability and Anger

DSM-5 DR# 7: Felt more irritated than usual:

Parent Rating: _____ Child Rating: _____

Was there ever a time when you got annoyed, irritated, or cranky at little things?
Did you ever have a time when you lost your temper a lot? When was that?
Are you like that now? Was there ever another time you felt _____? What kinds of things made you _____?
Were you feeling mad or angry also (even if you didn't show it)?
How angry?
More than before?
What kinds of things made you feel angry?
Did you sometimes feel angry and/or irritable and/or cranky and didn't know why?
Did this happen often?
Did you lose your temper?
With your family?
Your friends?
Who else?
At school?
What did you do?
Did anybody say anything about it?
How much of the time did you feel angry, irritable, and/or cranky?
All of the time?
Lots of the time?
Just now and then?
None of the time?

When you got mad, what did you think about?
Did you think about killing others or hurting yourself? Or about hurting them or torturing them? Whom? Did you have a plan? How?

NOTE: IRRITABILITY MAY BE DUE TO OTHER DISORDERS (e.g., BIPOLAR DISORDER, ADHD, ODD, CD, SUBSTANCE ABUSE, AUTISM SPRECTRUM DISORDER).

P	C	S
( )	( )	( )
( )	( )	( )
( )	( )	( )
( )	( )	( )

0 - No information

1 - Not present. Not at all or less than once a week.

2 - Subthreshold: Feels definitely more angry or irritable than called for by the situation at least (2-3 days/week), for much of the day.

3 - Threshold: Feels irritable/angry, more days than not, (4-7 days/week), most of the day (at least 50% of awake time.).

PAST: ☐ P ☐ C ☐ S

Duration of Irritable Mood (current)

☐☐☐

Duration of Irritable Mood (most severe past)

☐☐☐

	P	C	S
3. Anhedonia, Lack of interest, Apathy, Low Motivation, or Boredom	( )	( )	( )
DSM-5 DR# 5: Has less fun doing things:	( )	( )	( )
Parent Rating: _____ Child Rating: _____	( )	( )	( )

0 - No information.

1 - Not present.

2 - Subthreshold: Several activities definitely less pleasurable or interesting. Or bored or apathetic at least 3 times a week during activities.

3 - Threshold: Most activities much less pleasurable or interesting. Or bored or apathetic daily, or almost daily, at least 50% of the time.

PAST: ☐ P ☐ C ☐ S

Boredom is a term all children understand and which frequently refers to loss of ability to enjoy (anhedonia) or to loss of interest or both. Loss of pleasure and loss of interest are not mutually exclusive and may coexist.

What are the things you do for fun? Enjoy?
(Get examples: nintendo, sports, friends, favorite games, school subjects, outings, family activities, favorite TV programs, computer or video games, music, dancing, playing alone, reading, going out, etc.).

Has there ever been a time you felt bored a lot of the time? When?
Do you feel bored a lot now?
Was there another time you felt bored a lot?
Did you feel bored when you thought about doing the things you usually like to do for fun? (Give examples mentioned above).
Did this stop you from doing those things?
Did you (also) feel bored while you were doing things you used to enjoy?

Anhedonia refers to partial or complete (pervasive) loss of ability to get pleasure, enjoy, have fun during participation in activities which have been attractive to the child like the ones listed above. It also refers to basic pleasures like those resulting from eating favorite foods and, in adolescents, sexual activities.

Did you look forward to doing the things you used to enjoy? (Give examples)
Did you try to get into them?
Did you have to push yourself to do your favorite activities?
Did they interest you?
Did you get excited or enthusiastic about doing them? Why not?
Did you have as much fun doing them as you used to before you began feeling (sad, etc.)?
If less fun, did you enjoy them a little less? Much less? Not at all?
Did you have as much fun as your friends?
How many things are less fun now than they used to be (use concrete examples provided earlier by child)?
How many were as much fun? More fun?
Did you do _____ less than you used to? How much less?

In adolescents: (if sexually active) *Do you enjoy sex as much as you used to? Are you less sexually active than you used to be?*

This item does not refer to inability to engage in activities (loss of ability to concentrate on reading, games, TV, or school subjects).

Two comparisons should be made in each assessment: Enjoyment as compared to that of peers and/or enjoyment as compared to that of child when not depressed. The second is not possible in episodes of long duration because normally children's preferences change with age. Severity is determined by the number of activities which are less enjoyable to the child, and by the degree of loss of ability to enjoy.

Do not confuse with lack of opportunity to do things which may be due to excessive parental restrictions.

Duration of Anhedonia: (current)

☐☐☐

Duration of Anhedonia: (past)

☐☐☐

4a. Recurrent Thoughts of Death

Sometimes children who get upset or feel bad, wish they were dead or feel they'd be better off dead.
Have you ever had these type of thoughts? When?
Do you feel that way now?
Was there ever another time you felt that way?

	P	C	S
0 - No information.	( )	( )	( )
1 - Not present.	( )	( )	( )
2 - Subthreshold: Infrequent thoughts of death (e.g., less than once per month, vague, non-specific).	( )	( )	( )
3 - Threshold: Recurrent thoughts of death, "I would be better off dead" or "I wish I were dead."	( )	( )	( )

PAST: ☐ P ☐ C ☐ S

4b. Suicidal Ideation

DSM-5 DR# 24: Thoughts of committing suicide

Parent Rating: _____ Child Rating: _____

Sometimes children who get upset or feel bad think about dying or even killing themselves.
Have you ever had such thoughts?
How would you do it?
Did you have a plan?

	P	C	S
0 - No information.	( )	( )	( )
1 - Not at all.	( )	( )	( )
2 - Subthreshold: Infrequent or vague thoughts of suicide (e.g., less than once per month).	( )	( )	( )
3 - Threshold: Recurrent thoughts of suicide.	( )	( )	( )

PAST: ☐ P ☐ C ☐ S

4c. Suicidal Acts - Intent

DSM-5 DR# 25: Ever tried to kill self

Parent Rating: _____ Child Rating: _____

Have you actually tried to kill yourself? When?
What did you do?
Any other things?
How close did you come to doing it?
Was anybody in the room? In the apartment?
Did you tell them in advance?
How were you found? Did you really want to die?
Did you ask for any help after you did it?

NOTE: CODE SELF-HARMING BEHAVIOR WITH NO INTENT TO DIE AS NON-SUICIDAL, SELF-INJURIOUS BEHAVIOR - NOT AS SUICIDAL BEHAVIOR.

	P	C	S
0 - No information.	( )	( )	( )
1 - No attempt.	( )	( )	( )
2 - Subthreshold: Preparations with no actual intent to die (e.g., held pills in hand) or planned attempt but did not follow through or engage in self harming behavior.	( )	( )	( )
3 - Threshold: Self injurious behavior with ANY suicidal intent. (If subject endorses even a 1% intent to die, code as threshold here).	( )	( )	( )

PAST: ☐ P ☐ C ☐ S

Ever attempted suicide: ○ Yes ○ No

Number of lifetime attempts meeting threshold of (3): ☐☐☐

	P	C	S
4d. Suicidal Acts - Medical Lethality	( )	( )	( )

Actual medical threat to life or physical condition following the most serious suicidal act. Take into account the method, impaired consciousness at time of being rescued, seriousness of physical injury, toxicity of ingested material, reversibility, amount of time needed for complete recovery and how much medical treatment needed.

How close were you to dying after your (most serious suicidal act)?
What did you do when you tried to kill yourself?
What happened to you after you tried to kill yourself?

NOTE: CODE SELF-HARMING BEHAVIOR WITH NO INTENT TO DIE AS NON-SUICIDAL, SELF-INJURIOUS BEHAVIOR - NOT AS SUICIDAL BEHAVIOR.

0 - No information.

1 - No attempt or engaged in behavior with no intent to die (e.g., held pills in hand). No medical damage.

2 - Subthreshold: superficial cuts, scratch to wrist, took a couple of extra pills.

3 - Threshold: Medical intervention occurred or was indicated; or significant cut with bleeding, or took more than a couple of pills.

PAST: ☐ P ☐ C ☐ S

	P	C	S
4e. Non-suicidal, Self-Injurious Behavior	( )	( )	( )

Refers to intentional self-inflicted damage to the surface of the body, of a sort likely to induce bleeding or pain for purposes that are not socially sanctioned AND done without intent of killing himself, with the expectation that the injury will lead to only minor or moderate physical harm.

Did you ever try to hurt yourself?
Have you ever burned yourself with matches/ candles?
Or scratched yourself with needles/ a knife? Your nails?
Or put hot pennies on your skin?
Anything else?
Why did you do it?
How often?
Do you have many accidents?
What kind?
How often?

Some kids do these types of things because they want to kill themselves, and other kids do them because it makes them feel a little better afterwards. Why do you do these things?

0 - No information.

1 - Not present.

2 - Subthreshold: Once. Has engaged in the behavior on 1-4 occasions. Has never caused serious injury to self.

3 - Threshold: Repetitive. Has engaged in the behavior more than 5 times and/or has engaged in the behavior with significant injury to self (e.g., burn left scar, cut required stitches).

PAST: ☐ P ☐ C ☐ S

— **IF RECEIVED A SCORE OF 3 ON CURRENT RATING OF ANY OF THE PREVIOUS ITEMS, COMPLETE THE DEPRESSIVE/ DYSTHYMIC DISORDERS (CURRENT) SECTION OF THE DEPRESSIVE AND BIPOLAR RELATED DISORDERS SUPPLEMENT, AFTER FINISHING THE SCREEN INTERVIEW.**

— **IF RECEIVED A SCORE OF 3 ON PAST RATING OF ANY OF THE PREVIOUS ITEMS, COMPLETE THE DEPRESSIVE/ DYSTHYMIC DISORDERS (PAST) SECTION OF DEPRESSIVE AND BIPOLAR RELATED DISORDERS SUPPLEMENT, AFTER FINISHING THE SCREEN INTERVIEW.**

— **NO EVIDENCE OF DEPRESSIVE/ DYSTHYMIC DISORDER.**

NOTE: (RECORD DATES OF POSSIBLE CURRENT AND PAST DEPRESSIVE DISORDERS).

P C S

1. Elevated, Elated, or Expansive Mood

( ) ( ) ( ) **0 -** No information.

( ) ( ) ( ) **1 -** Not present.

( ) ( ) ( ) **2 -** Definitely elevated and optimistic outlook that is somewhat out of proportion to the circumstances (above and beyond what is expected in a child of the subject's age). Occurs less than 4 hours in a day and/or for fewer than 3 separate days.

( ) ( ) ( ) **3 -** Mood and outlook are clearly out of proportion to circumstances. Noticeable to others and perceived as odd or exaggerated. Occurs for at least 4 hours out of a day for at least 2 consecutive days or on at least 3 separate days within one week.

PAST: ☐ ☐ ☐
P C S

Elevated mood and/or excessively optimistic attitude which is out of proportion to circumstances and above and beyond what is expected in children of the same age or same developmental level. **Differentiate from normal mood in chronically depressed subjects. Do not rate positive if mild elation is reported in situations like Christmas, birthdays, going to amusement parks, which normally overstimulate and make children very excited.**

NOTE: DO NOT SCORE POSITIVELY IF ELATED MOOD IS EXCLUSIVELY DUE TO DRUGS, MEDICATIONS, OR ANY OTHER PSYCHIATRIC OR MEDICAL CONDITION.

Has there ever been a time when you felt super happy or on top-of-the world? Way more than your normal happy feeling?
Did the super-happy feeling seem to come out of the blue?
Have there been times when you were super silly, much more silly than everyone else around you?
Were you laughing about things that normally you would not find funny?
Did it feel like you couldn't stop laughing?
Did it seem like you were drunk or high, even though you weren't taking drugs or alcohol?
Did other people notice?
Have your friends ever said anything to you about being way too happy, too silly or too high?
Did you feel super-positive, like nothing could go wrong?
Did you have the feeling that everything was terrific and would turn out just the way you wanted?
Did you feel really excited or full of enthusiasm but there really was not a reason to feel this way?
Can you give me some examples?
How long did this feeling usually last?
Would it come and go throughout the day?
Did you ever have problems or get in trouble for being too happy or high?

Ask Parent/Caregiver: *Was this above and beyond what you would see in his/her friends or other kids of the same age or developmental level in the same circumstances?*

P C S

2. Explosive Irritability / Anger

( ) ( ) ( ) **0 -** No information.

( ) ( ) ( ) **1 -** Not present.

( ) ( ) ( ) **2 -** Subthreshold: Definite periods of excessively irritable/angry mood. Anger / Irritability is out of proportion for the situation and occurs for much of the day or intensely for a brief period (< 1 hour).

( ) ( ) ( ) **3 -** Threshold: Episodes of explosive irritability / anger that are far out of proportion to any stressor or stimuli - has associated aggressive behavior (e.g. threats, property destruction or physical aggression). Occurs on at least 2 consecutive days or on at least 3 separate days within one week.

PAST: ☐ ☐ ☐
P C S

DSM-5 DR# 8: Felt angry or lost your temper:

Parent Rating: _____ Child Rating: _____

Was there ever a time you were so irritable and angry that you exploded?
When you are feeling really mad, do you throw things or break things?
Tear your room apart?
Have you ever punched a hole in the wall when you were angry?
When you got really angry, did you ever threaten or actually hurt a parent or a teacher? What about other kids or pets?
What was going on at the time when this happened? What set you off?
Have there been times when you got super angry without knowing why or over little things that you normally would not get upset about?

NOTE: **Only rate irritability and explosiveness in this item that occurs during distinct episode(s) and represents a change from baseline. Do not rate chronic irritability of one year duration or longer unless there was a marked change in intensity during a distinct period of time.**

	P	C	S
3. Increased Energy or Activity	( )	( )	( )
DSM-5 DR #9: Starting lots more projects	( )	( )	( )
Parent Rating: _____ Child Rating: _____	( )	( )	( )
	( )	( )	( )

0 - No information.

1 - Not present.

2 - Subthreshold: Brief period(s) of increased energy, or mild intensification from baseline (or) likely caused by environmental stimulus; of questionable clinical significance.

3 - Threshold: Definite episodes of clear increased energy or activity, well beyond baseline or far in excess of same age peers in the same situation.

Has there ever been a time where you had much more energy than usual, so much energy that it felt like too much? What kinds of things were you doing when that happened?
Was there a change in how much you were doing ?
Did it seem like you were doing too many things or were super hyper?
How long did that feeling last? Did other people notice it?
Was it different than other people around you?
Did anything seem to cause that feeling?
Was there anything else different about you during the time of high energy - your speed of talking, thinking, any thing else?

PAST: ☐ P ☐ C ☐ S

NOTE: IF THE CHILD HAS ADHD OR IS VERY ACTIVE AND ENERGETIC AT BASELINE, ONLY RATE POSITIVE IF THIS IS A DISTINCT PERIOD OF SUBSTANTIAL INCREASE IN ENERGY.

NOTE: The (hypo)manic symptom of increased energy should only be rated as positive if it is associated with an abnormal mood (e.g., elation or irritability). If the symptom is only questionably associated with an abnormal mood, then it should be rated as subthreshold.

	P	C	S
4. Decreased Need for Sleep			
DSM-5 DR 3: Problems falling asleep, staying asleep, or waking early:	( )	( )	( )
Parent Rating: _____ Child Rating: _____	( )	( )	( )
DSM-5 DR 10: Sleeping less than usual, still have energy:	( )	( )	( )
Parent Rating: _____ Child Rating: _____			
Less sleep than usual yet still feels rested (average for several days when needs less sleep).	( )	( )	( )

0 - No information.

1 - Not present.

2 - At least 1 1/2 hours less than usual without feeling tired, for at least 2 consecutive days, or at least 3 separate days.

3 - At least 3 hours less than usual because he/she felt energetic or high and did not feel tired. Occurs for at least 2 consecutive days, or on at least 3 separate days within one week.

Have you ever needed less sleep than usual to feel rested?
How much sleep do you ordinarily need?
How much had you been sleeping?
Did you stay up because you felt especially high or energetic? Were you with friends or by yourself? Had you taken any drugs? Were you up busy doing things?
What time did you wake up?
Were you tired the next day, or did you have plenty of energy and did not seem to need the sleep?

PAST: ☐ P ☐ C ☐ S

NOTE: DO NOT SCORE POSITIVELY IF DECREASED NEED FOR SLEEP TRIGGERED BY SOCIAL EVENT OR ACADEMIC COMMITMENTS OR DRUG USE, OR REFLECTIVE OF TYPICAL IRREGULAR ADOLESCENT SLEEP PATTERN.

5. Hypersexuality

[Excessive Involvement in High Risk Pleasurable Activities]

NOTE: HYPERSEXUALITY IN THE ABSENCE OF SEXUAL ABUSE OR INAPPROPRIATE EXPOSURE TO SEXUAL BEHAVIOR OR MEDIA IS A SYMPTOM FAIRLY SPECIFIC TO MANIC/HYPOMANIA. IT IS NOT A SEPARATE DSM-5 DIAGNOSTIC CRITERION, BUT WHEN PRESENT, IT CAN POTENTIALLY FULFILL EITHER BOTH THE INCREASED GOAL-DIRECTED ACTIVITY AND THE RISKY, PLEASURE-SEEKING BEHAVIOR B CRITERION.

For younger children ask parent/caregiver:
Have there been times when your child was excessively focused on sex, nudity, his/ her private parts or touching others' private parts?
Did your child show an unusual increase in touching their privates in public or dressing in an inappropriate or sexual manner?
Would your child kiss or touch you in a sexual way or be way too affectionate instead of their usual way of showing affection?
What was his/ her mood like during these times?
Did anything happen to cause these changes?

For adolescents:
Have there been times when you suddenly got much more interested in sex than usual or that your sex drive seemed to go way up?
Did you do anything differently when this happened (dress in a revealing way, talk about sex a lot or ask other people to be intimate / have sex with you)?
Were there times when you were driven to have sex much more than usual or with many different partners?

NOTE: IF ENDORSED POSITIVE, NEED TO RULE OUT SEXUAL ABUSE OR INAPPROPRIATE EXPOSURE TO SEXUAL MATERIAL OR BEHAVIOR.

P	C	S	
( )	( )	( )	**0 -** No information.
( )	( )	( )	**1 -** Not present.
( )	( )	( )	**2 -** Isolated, brief incidents of mildly inappropriate sexual behavior, of questionable clinical significance.
( )	( )	( )	**3 -** Definite episodes of clearly inappropriate sexual behavior.

PAST: ☐ P ☐ C ☐ S

_ **IF RECEIVED A SCORE OF 3 ON THE CURRENT RATINGS FOR ANY OF THE PREVIOUS ITEMS, COMPLETE THE CURRENT MANIA/HYPOMANIA SECTION OF THE DEPRESSIVE AND BIPOLAR RELATED DISORDERS SUPPLEMENT.**

_ **IF RECEIVED A SCORE OF 3 ON THE PAST RATINGS FOR ANY OF THE PREVIOUS ITEMS, COMPLETE THE PAST MANIA/HYPOMANIA SECTION OF THE DEPRESSIVE AND BIPOLAR RELATED DISORDERS SUPPLEMENT.**

_ **NO EVIDENCE OF (HYPO) MANIA**

NOTES: (RECORD DATES OF POSSIBLE CURRENT AND PAST HYPOMANIA OR MANIA).

1. Irritability

Do you often feel cranky, irritable, or angry? Have you had these feelings in the past few weeks at all? Have you felt this way most days in the past year? (If not) How often do you have these feelings? Has there been a period of time when you didn't have those feelings for as long as a couple of months at a time?
When you are feeling cranky or angry, how much of the day do you feel this way?
Do you have these feelings at home, at school, or when you are with other children? Do other people notice the way you feel? What do your parents, teachers, or peers say about how you are feeling?

NOTE: IN THIS SECTION CODE SEVERITY OF CHRONIC IRRITABILITY OF ONE YEAR DURATION OR LONGER

P	C	S	
( )	( )	( )	**0 -** No information.
( )	( )	( )	**1 -** Not present.
( )	( )	( )	**2 -** Subthreshold: Irritable mood present less than half the day or less than most days in the past 12 months, or not severe enough to be noticeable to other people
( )	( )	( )	**3 -** Threshold: Irritable and/ or angry mood present at least half the day most days for at least 12 months. Severity is sufficient to be noticeable to other people (parents, teachers, peers).

PAST: ☐ ☐ ☐
P C S

2. Recurrent Temper Outbursts

Is it pretty easy or common for you to become irritable, angry, or to explode? When you are feeling very angry, do you yell or scream? Do you swear a lot, call people names or put them down? Do you throw or destroy things? Have you ever threatened or actually hurt another person? Did you punch, kick, or beat anyone?
What was going on at the time when this happened? What set you off? Have you felt so irritable and angry for so long that you exploded at least 3 times a week for the past year or even longer?

P	C	S	
( )	( )	( )	**0 -** No information.
( )	( )	( )	**1 -** Not present.
( )	( )	( )	**2 -** Subthreshold: Verbal or physical outbursts have not occurred as often as 3 times a week or have not persisted for as long as 12 months.
( )	( )	( )	**3 -** Threshold: Subject has verbal rages, and/ or displays aggressive behaviors toward people or property. Such events occur, on average, at least 3 times a week and have been consistently present over the past 12months.

PAST: ☐ ☐ ☐
P C S

_ **IF RECEIVED A SCORE OF 3 ON THE CURRENT RATINGS ON EITHER OF THE PREVIOUS ITEMS, COMPLETE THE DYSRUPTIVE MOOD DYSREGULATION DISORDER (CURRENT) SECTION OF THE DEPRESSIVE AND BIPOLAR RELATED DISORDERS SUPPLEMENT AFTER FINISHING THE SCREEN INTERVIEW.**

_ **IF RECEIVED A SCORE OF 3 ON THE PAST RATINGS ON EITHER OF THE PREVIOUS ITEMS, COMPLETE THE DYSRUPTIVE MOOD DYSREGULATION DISORDER (PAST) SECTION OF THE DEPRESSIVE AND BIPOLAR RELATED DISORDERS SUPPLEMENT AFTER FINISHING THE SCREEN INTERVIEW.**

_ **NO EVIDENCE OF DYSRUPTIVE MOOD DYSREGULATION DISORDER**

NOTES: (RECORD DATES OF POSSIBLE CURRENT AND PAST DYSRUPTIVE MOOD DYSREGULATION DISORDER)

	P	C	S
1. Hallucinations	( )	( )	( )
	( )	( )	( )
	( )	( )	( )
	( )	( )	( )

0 - No information.

1 - Not present.

2 - Subthreshold: Suspected or likely.

3 - Threshold: Definitely present.

PAST: [ ] [ ] [ ]
P C S

DSM-5 DR# 14: Heard Voices:

Parent Rating: _____ Child Rating: _____

DSM-5 DR# 15: Had visions:

Parent Rating: _____ Child Rating: _____

Has there ever been a time when your mind played tricks on you? Sometimes children might hear voices or see things, or smell things that other people cannot hear, see or smell.
Has this ever happened to you? Tell me about it.

Has there ever been a time when you heard voices that other people could not hear?
What did you hear? What kind of things did you hear?
Did you ever hear music which other people could not?

Has there ever been a time when you saw things like people or figures that other people could not see? If yes ... can you tell me about it?
What did you see? How often did it happen? When did it happen?
Did this only happen at night while you were trying to sleep, or did it happen in the daytime too?

Has there ever been a time when you smelled things that other people could not smell or felt things that were not there?

NOTE: IF HALLUCINATIONS ARE POSSIBLY PRESENT, PRIOR TO SCORING THIS ITEM, ASSESS THE SUBJECT'S CONVICTION OF THE REALITY OF THE HALLUCINATIONS WITH THE PROBES BELOW.

What did you think it was?
Did you think it was your imagination or real?
Did you think it was real when you (heard, saw, etc.) it?

What did you do when you (heard, saw, etc.) it?
These voices you heard (or other hallucinations) did they occur when you were awake or asleep? Could it have been a dream?
Did they happen when you were falling asleep? Waking up? Only when it was dark?
Did they happen at any other time also?
Were you sick with fever when they occurred?
Have you ever been drinking beer, wine, liquor? Or taking any drugs when it happened? Was it like a thought or more like a voice (noise) or a vision?

NOTE: IF HALLUCINATIONS ARE PRESENT, *CAREFULLY ASSESS* TIMELINE TO DETERMINE IF IN RELATION TO MOOD SYMPTOMS OR INDEPENDENT OF MOOD SYMPTOMS. THIS WILL FACILITATE DIFFERENTIAL DIAGNOSIS.

NOTE: DO NOT RATE AS POSITIVE IF ONLY ENDORSES HAVING HEARD SOMEONE CALLING THEIR NAME OCCURRING ONLY ONCE OR TWICE.

DON'T RATE ILLUSIONS POSITIVELY. Illusions are defined as false perceptions based on a real sensory stimuli which is momentarily transformed. They frequently occur due to poor perceptual resolution (darkness, noisy locale) or inattention and they are immediately corrected when attention is focused on the external sensory stimulus or perceptual resolution improves.

NOTE: TAKE INTO ACCOUNT CULTURAL BACKGROUND OF THE SUBJECT.

NOTE: IT IS IMPORTANT TO NOTE IF THE CHILD IS ACTING ON HALLUCINATIONS.

	P	C	S
2. Delusions	( )	( )	( )
	( )	( )	( )
	( )	( )	( )
	( )	( )	( )

0 - No information.

1 - Not present.

2 - Subthreshold: Suspected or likely delusional.

3 - Threshold: Definite delusions.

PAST: ☐ P ☐ C ☐ S

Have you ever had any ideas about things that you didn't tell anyone because you were afraid they might not understand?
What were they?
Do you have any secret thoughts? Tell me about them.
Have you ever believed in things that other people didn't believe in? Like what?

Ask about each of the delusions surveyed below:

Has there ever been a time you felt that someone was out to hurt you or that someone was following you or spying on you? Who? Why?
Does anyone control your mind or body (like a robot)?
Did you ever think you were an important or great person?
Do you have any special powers?
When you are with people you do not know, do you think that they are talking about you?
Was there ever a time when you felt something was happening to your body? Like believing it was rotting from the inside, or that something was very wrong with it?
Did you ever feel convinced that the world was coming to an end?
How often did you think about _____?

NOTE: IF DELUSIONS ARE PRESENT, CAREFULLY ASSESS THE TIMELINE TO DETERMINE IF IN RELATION TO MOOD SYMPTOMS OR INDEPENDENT OF MOOD SYMPTOMS. THIS WILL FACILITATE THE DIAGNOSIS.

_ **IF RECEIVED A SCORE OF 3 ON THE CURRENT RATINGS ON EITHER OF THE PREVIOUS ITEMS, COMPLETE THE CURRENT SECTION OF THE SCHIZOPHRENIA SPECTRUM AND OTHER PSYCHOTIC DISORDERS SUPPLEMENT AFTER FINISHING THE SCREEN INTERVIEW.**

_ **IF RECEIVED A SCORE OF 3 ON THE PAST RATINGS ON EITHER OF THE PREVIOUS ITEMS, COMPLETE THE PAST SECTION OF THE SCHIZOPHRENIA SPECTRUM AND OTHER PSYCHOTIC DISORDERS SUPPLEMENT AFTER FINISHING THE SCREEN INTERVIEW.**

_ **NO EVIDENCE OF PSYCHOSIS.**

NOTES: (RECORD DATES OF POSSIBLE CURRENT AND PAST HALLUCINATIONS AND DELUSIONS).

	P	C	S
1. Panic Attacks	( )	( )	( )
DSM-5 DR# 11: Felt nervous, anxious, or scared:	( )	( )	( )
Parent Rating: _____ Child Rating: _____	( )	( )	( )
Have you ever had a time when, all of a sudden, out of the blue, for no reason at all, you suddenly felt anxious, nervous, or frightened? Tell me about it.	( )	( )	( )
The first time you had an attack like this, what did you think brought it on?			
Did the feeling come from out of the blue?			
What was it like?			
How long did it last?			
After the first time this happened, did you worry about it happening again?			

0 - No information.

1 - Not present.

2 - Subthreshold: Occasional unanticipated attacks, or less than 4 of the associated symptoms

3 - Threshold: Recurrent unexpected attacks with four or more associated symptoms.

PAST: ☐ P ☐ C ☐ S

Note: DSM-V does not have threshold criteria for the minimum number of attacks.

If specific symptoms are not elicited spontaneously when describing attacks, ask about each of the following symptoms:

Associated Symptoms:

1. Heart palpitations
2. Sweating
3. Trembling or shaking
4. Sensations of shortness of breath, or smothering sensations
5. Feelings of choking
6. Chest pains
7. Nausea or abdominal distress
8. Dizziness or lightheadedness
9. Heat sensations or chills
10. Numbing of hands or feet
11. Depersonalization or derealization
12. Fear of losing control
13. Fear of dying

NOTE: DO NOT COUNT IF LASTS ALL DAY OR DIRECTLY CAUSED BY DRUGS OR MEDICATIONS.

_ **IF A SCORE OF 3 ON CURRENT RATING OF PANIC ATTACK ITEM, COMPLETE THE PANIC DISORDER (CURRENT) SECTION OF THE ANXIETY, OBSESSIVE COMPULSIVE, AND TRAUMA-RELATED DISORDERS SUPPLEMENT AFTER FINISHING THE SCREEN INTERVIEW.**

_ **IF A SCORE OF 3 ON PAST RATING OF PANIC ATTACK ITEM, COMPLETE THE PANIC DISORDER (PAST) SECTION OF THE ANXIETY, OBSESSIVE COMPULSIVE, AND TRAUMA-RELATED DISORDERS SUPPLEMENT AFTER FINISHING THE SCREEN INTERVIEW.**

_ **NO EVIDENCE OF PANIC DISORDER.**

NOTES: (RECORD DATES OF POSSIBLE CURRENT AND PAST PANIC DISORDER).

	P	C	S	
1. Agoraphobia	( )	( )	( )	**0 -** No information.
	( )	( )	( )	**1 -** Not present.
	( )	( )	( )	**2 -** Subthreshold: Fear limited to one situation or fear only mild or transient, but more severe than a typical child his/her age.
	( )	( )	( )	**3 -** Threshold: Fears two or more situations and fears have persisted and are clearly out of proportion to the circumstances.

Marked fear or anxiety about at least one situation from two or more of the following five groups: 1) being outside home or alone in other situations; 2) standing in line or being in a crowd; 3) being in closed spaces (e.g., shops, theaters or cinemas); 4) open spaces (e.g., parking lots, marketplaces, bridges); 5) using public transportation.

Have you ever gone through a period when you did not want to leave your home?
Have you ever been really afraid of being in a crowded place or going outside in public?
Were you bothered by standing in lines? Were you ever afraid to go to the mall, movie theaters, or any other places? Did being in open spaces bother you?
Have you ever avoided public transportation including buses or subways?
Did these feelings last for several months or longer?

NOTE: RATE POSITIVELY ONLY IF BEHAVIOR IS ABOVE AND BEYOND WHAT WOULD BE EXPECTED IN CHILDREN OF SAME AGE AND DEVELOPMENTAL LEVEL.

Do not rate positively if exclusively accounted for by other psychiatric disorders (i.e. psychosis, depression) separation anxiety, social anxiety or medical problems.

PAST: ☐ ☐ ☐
P C S

	P	C	S	
2. Distress / Avoidance	( )	( )	( )	**0 -** No information.
	( )	( )	( )	**1 -** Not present.
	( )	( )	( )	**2 -** Subthreshold: Associated with only mild transient symptoms of distress. Minimal or inconsistent avoidance.
	( )	( )	( )	**3 -** Threshold: Feared stimuli or situations associated with moderate to severe symptoms of distress. Stimuli or situations consistently avoided or requires presence of companion/ support.

How scared did ____ make you?
Did it make your stomach upset or your heart race? How long did ___ last?
Are you more scared of ____ than any of your friends?
Has there ever been a time when your fear of ____ kept you from doing anything?
Did you try to avoid ____?
Were there times you could ____?
If someone was with you, could you ____?

PAST: ☐ ☐ ☐
P C S

_ **IF RECEIVED A SCORE OF 3 ON THE CURRENT RATINGS ON EITHER OF THE PREVIOUS ITEMS, COMPLETE THE AGORAPHOBIA (CURRENT) SECTION OF THE ANXIETY, OBSESSIVE COMPULSIVE, AND TRAUMA-RELATED DISORDERS SUPPLEMENT AFTER FINISHING THE SCREEN INTERVIEW.**

_ **IF RECEIVED A SCORE OF 3 ON THE PAST RATINGS ON EITHER OF THE PREVIOUS ITEMS, COMPLETE THE AGORAPHOBIA (PAST) SECTION OF THE ANXIETY, OBSESSIVE COMPULSIVE, AND TRAUMA-RELATED DISORDERS SUPPLEMENT AFTER FINISHING THE SCREEN INTERVIEW.**

_ **NO EVIDENCE OF AGORAPHOBIA.**

NOTES: (RECORD DATES OF POSSIBLE CURRENT AND PAST AGORAPHOBIA)

NOTE: KEEP IN MIND THE DEVELOPMENTAL LEVEL OF THE CHILD. RATE POSITIVELY ONLY IF SYMPTOM IS ABOVE AND BEYOND WHAT WOULD BE EXPECTED IN A CHILD OF THE SAME AGE AND DEVELOPMENTAL LEVEL.

P C S

1. Fears Calamitous Event that will Cause Separation

Did you ever worry that something bad might happen to you where you would never see your parents again?
Like getting lost, kidnapped, killed, or getting into an accident?
How much do you worry about this?

( ) ( ) ( ) **0 -** No information.

( ) ( ) ( ) **1 -** Not present.

( ) ( ) ( ) **2 -** Subthreshold: Occasionally worries. Worries more severely and more often than a typical child his/her age.

( ) ( ) ( ) **3 -** Threshold: Frequently worries in separation situations. Persistent and excessive worry that an untoward event will lead to separation from major attachment figure.

PAST: ☐ ☐ ☐
P C S

P C S

2. Fears Harm Befalling Attachment Figure

Has there ever been a time when you worried about something bad happening to your parents? Like what?
Were you afraid of them being in an accident or getting killed?
Were you afraid that they would leave you and not come back?
How much did you worry about this?

( ) ( ) ( ) **0 -** No information.

( ) ( ) ( ) **1 -** Not present.

( ) ( ) ( ) **2 -** Subthreshold: Occasionally worries. Worries more severely and more often than a typical child his/her age.

( ) ( ) ( ) **3 -** Threshold: Frequently worries in separation situations. Persistent and excessive worry about losing, or about possible harm befalling major attachment figure.

PAST: ☐ ☐ ☐
P C S

P C S

3. School Reluctance/Refusal

Was there ever a time when you had to be forced to go to school?
Did you have worries about going to school? Tell me about those feelings.
What were you afraid of?
Had you been going to school?
How often did you miss school or did you leave school early?

NOTE: ONLY COUNT IF SCHOOL AVOIDED IN ORDER TO STAY WITH ATTACHMENT FIGURE

( ) ( ) ( ) **0 -** No information.

( ) ( ) ( ) **1 -** Not present.

( ) ( ) ( ) **2 -** Subthreshold: Frequently somewhat resistant about going to school but usually can be persuaded to go, missed no more than 1 day in 2 weeks.

( ) ( ) ( ) **3 -** Threshold: Protests intensely about going to school, or sent home or refuses to go at least 1 day per week. Persistent reluctance or refusal to go to school.

PAST: ☐ ☐ ☐
P C S

	P	C	S	
4. Fears Sleeping Away From Home/Sleeping Alone	( )	( )	( )	**0 -** No information.
Has there ever been a time after the age of four, when you were afraid of sleeping alone?	( )	( )	( )	**1 -** Not present.
Did you get scary feelings if you had to sleep away from home without your parents being with you? *Do you move to your parent's bed in the middle of the night?* *Or do you need your parent to sleep in your bedroom?* *Do you avoid sleepovers?*	( )	( )	( )	**2 -** Subthreshold: Occasionally fearful. Fears of sleeping away or alone more severe and more frequent than a typical child his/her age.
	( )	( )	( )	**3 -** Threshold: Frequently fearful, some avoidance of sleeping alone or away from home. Persistent refusal to go to sleep without being near a major attachment figure or to sleep away from home.

PAST: ☐ P ☐ C ☐ S

	P	C	S	
5. Fears Being Alone at Home	( )	( )	( )	**0 -** No information.
Was there ever a time, after the age of 4, when you used to follow your mother wherever she went?	( )	( )	( )	**1 -** Not present.
Did you get upset if she was not in the same room with you? *Did you cling to your mother?* *Did you check up on your mother a lot?* *Did you always want to know where your mother was?* *How afraid were you?* *How often did this happen?*	( )	( )	( )	**2 -** Subthreshold: Occasionally fearful. Fears of being alone more severe and more frequent than a typical child his/her age.
	( )	( )	( )	**3 -** Threshold: Clings to mother; fearful, some avoidance of being alone. Persistent and excessively fearful or reluctant to be alone or without major attachment figures at home.

PAST: ☐ P ☐ C ☐ S

_ **IF RECEIVED A SCORE OF 3 ON THE CURRENT RATINGS OF ANY OF THE PRECEDING ITEMS, COMPLETE THE SEPARATION ANXIETY DISORDER (CURRENT) SECTION IN THE ANXIETY, OBSESSIVE COMPULSIVE, AND TRAUMA-RELATED DISORDERS SUPPLEMENT AFTER FINISHING THE SCREEN INTERVIEW.**

_ **IF RECEIVED A SCORE OF 3 ON THE PAST RATINGS OF ANY OF THE PRECEDING ITEMS, COMPLETE THE SEPARATION ANXIETY DISORDER (PAST) SECTION IN THE ANXIETY, OBSESSIVE COMPULSIVE, AND TRAUMA-RELATED DISORDERS SUPPLEMENT AFTER FINISHING THE SCREEN INTERVIEW.**

_ **NO EVIDENCE OF SEPARATION ANXIETY DISORDER.**

NOTE: (RECORD DATES OF POSSIBLE CURRENT AND PAST SEPARATION ANXIETY DISORDER)

P C S

1. Fear of Social Situations ( ) ( ) ( )

Are you a very shy person?
Have you ever felt nervous, self-conscious or shy around people that you didn't know very well?
Is it difficult for you to be with other kids - even kids you know?
What kind of situations make you feel uncomfortable?

--Speaking in front of others (e.g., answering questions in class, giving oral reports, show & tell)?

--Eating in front of others (e.g., school cafeteria, fast food restaurant)?

--Writing in front of others (e.g., at chalkboard, taking tests)?

--Using public bathrooms when others are around?

--Performance situations (e.g., gym class, recess, sports activities)?

--Changing clothes when others are present (e.g., in gym/ pool locker room)?

--Going to parties or social events?

How old were you when you first started to feel this way?
For how long have you been feeling this way?

( ) ( ) ( ) **0 -** No information.

( ) ( ) ( ) **1 -** Not present.

( ) ( ) ( ) **2 -** Subthreshold: Clearly self-conscious and uncomfortable in social performance situations; avoids only 1 or 2 activities that are not critical to the child's well being (e.g., avoiding large parties where child knows no one).

( ) ( ) ( ) **3 -** Threshold: Considerable self-consciousness that makes the child uncomfortable in several social settings; at least 1 activity is avoided (e.g., repeatedly and persistently refusing to answer questions in class, avoiding gatherings where child does not know everyone). A marked and persistent fear of social performance situations - fears acting in a way (or showing anxiety symptoms) that will be humiliating or embarrassing. **DO NOT CODE AS THRESHOLD IF THE CHILD'S ONLY FEAR IS GIVING ORAL PRESENTATIONS AT SCHOOL.**

PAST: ☐ ☐ ☐
P C S

2. Failure to Speak in Specific Social Situations ( ) ( ) ( ) **0 -** No information.

Have you ever felt like you couldn't talk in school or other situations? Have you ever felt so shy that you just couldn't say anything?
Even to another kid?
Are there certain situations that you just can't talk in?

( ) ( ) ( ) **1 -** Not present.

( ) ( ) ( ) **2 -** Subthreshold: Child unable to speak in novel situations, including the start of school year, but symptom does not persist.

( ) ( ) ( ) **3 -** Threshold: Consistent failure to speak in social situations when expected to speak.

PAST: ☐ ☐ ☐
P C S

_ **IF RECEIVED A SCORE OF 3 ON THE CURRENT RATINGS OF THE PREVIOUS ITEM, COMPLETE THE SOCIAL ANXIETY DISORDER/SELECTIVE MUTISM (CURRENT) SECTION IN THE ANXIETY, OBSESSIVE COMPULSIVE, AND TRAUMA-RELATED DISORDERS SUPPLEMENT AFTER COMPLETING THE SCREEN INTERVIEW.**

_ **IF RECEIVED A SCORE OF 3 ON THE PAST RATINGS OF EITHER ITEM, COMPLETE THE SOCIAL ANXIETY DISORDER/SELECTIVE MUTISM (PAST) SECTION IN THEANXIETY, OBSESSIVE COMPULSIVE, AND TRAUMA-RELATED DISORDERS SUPPLEMENT AFTER COMPLETING THE SCREEN INTERVIEW.**

_ **NO EVIDENCE OF SOCIAL ANXIETY DISORDER**

NOTES: (RECORD DATES OF POSSIBLE CURRENT AND PAST SOCIAL ANXIETY OR SELECTIVE MUTISM DISORDER)

Only rate most intense phobia.

	P	C	S
1. Specific Phobias	( )	( )	( )
Are you very, very afraid of anything? *Like really, really scared to death of spiders, other insects, dogs, horses, heights, elevators, the subway, or the dark?* *What about crowds, being outside alone, being on a bridge or traveling in a bus, train or automobile? (*ask about all situations listed*).* *Were you afraid of any other things?*	( )	( )	( )
	( )	( )	( )

0 - No information.

1 - Not present.

2 - Subthreshold: Fear of stimuli or situation more severe than a typical child his/her age.

3 - Threshold: Marked and persistent fear that is excessive and unreasonable, cued by the presence or anticipation of a specific object or situation.

PAST: ☐ P ☐ C ☐ S

	P	C	S
2. Distress/Avoidance	( )	( )	( )
How scared did ___ make you? *Did it make your stomach upset or your heart race?*	( )	( )	( )
How long did ___ last? *Are you more scared of ___ than any of your friends?* *Has there ever been a time when your fear of ___ kept you from doing anything?*	( )	( )	( )
Did you try to avoid ___? *Were there times you could ___?* *If someone was with you, could you___?*	( )	( )	( )

0 - No information.

1 - Not present.

2 - Subthreshold: Associated with only mild transient symptoms of distress. Minimal or inconsistent avoidance.

3 - Threshold: Fear of stimuli or situation associated with moderate to severe symptoms of distress. Feared stimuli or situation consistently avoided.

PAST: ☐ P ☐ C ☐ S

Specify most intense phobia:

Specify other phobias:

_ **IF RECEIVED A SCORE OF 3 ON THE CURRENT RATINGS OF EITHER OF THE PREVIOUS ITEMS, COMPLETE THE SPECIFIC PHOBIA (CURRENT) SECTION IN THE ANXIETY, OBSESSIVE COMPULSIVE, AND TRAUMA-RELATED DISORDERS SUPPLEMENT AFTER COMPLETING THE SCREEN INTERVIEW.**

_ **IF RECEIVED A SCORE OF 3 ON THE PAST RATINGS OF EITHER OF THE PREVIOUS ITEMS, COMPLETE THE SPECIFIC PHOBIA (PAST) SECTION IN THE ANXIETY, OBSESSIVE COMPULSIVE, AND TRAUMA-RELATED DISORDERS SUPPLEMENT AFTER COMPLETING THE SCREEN INTERVIEW.**

_ **NO EVIDENCE OF SPECIFIC PHOBIAS**

NOTES: (RECORD DATES OF POSSIBLE CURRENT AND PAST SPECIFIC PHOBIC DISORDERS)

1. Excessive worries

DSM-5 DR# 12: Not been able to stop worrying:

Parent Rating: _____ Child Rating: _____

Are you a worrier? Do you worry too much?
Do you worry more than other kids your age? Have people said you worry too much?
Has there ever been a time when you worried about things before they happened?
Can you give me some examples?

NOTE: IF THE ONLY WORRIES THE CHILD BRINGS UP RELATE TO THE ATTACHMENT FIGURE OR A SIMPLE PHOBIA, DO NOT SCORE HERE. ONLY RATE POSITIVELY IF THE CHILD WORRIES ABOUT MULTIPLE THINGS.

In order to rate positively, child must worry above and beyond other children of the same age. Worries must be exaggerated and out of context.

	P	C	S
	( )	( )	( )
	( )	( )	( )
	( )	( )	( )
	( )	( )	( )

0 - No information.

1 - Not present.

2 - Subthreshold: Frequently worries somewhat excessively (at least 3 times per week) about anticipated events or current behavior.

3 - Threshold: Most days of the week is excessively worried about at least two different life circumstances or anticipated events or current behavior.

PAST: ☐ P ☐ C ☐ S

2. Somatic Complaints

DSM-5 DR# 1: Bothered by stomachaches, etc.:

Parent Rating: _____ Child Rating: _____

DSM-5 DR# 2: Worried about getting sick:

Parent Rating: _____ Child Rating: _____

Do you worry a lot about your health?
Do you get a lot of headaches? Stomachaches?
Have a lot of aches and pains?
Do you worry that you might have a serious illness?

	P	C	S
	( )	( )	( )
	( )	( )	( )
	( )	( )	( )
	( )	( )	( )

0 - No information.

1 - Not present.

2 - Subthreshold: occasional worries/ complaints. Worries/ complaints more severe and more often than experienced by a typical child his/ her age.

3 - Threshold: Frequent worries/ complaints. Worries about health preoccupy child and cause distress.

PAST: ☐ P ☐ C ☐ S

NOTE: DO NOT COUNT IF SYMPTOMS ARE KNOWN TO BE CAUSED BY A REAL MEDICAL ILLNESS.

IF RECEIVED A SCORE OF 3 ON THE CURRENT RATINGS OF EITHER OF THE PREVIOUS ITEMS, COMPLETE
_ **THE GENERALIZED ANXIETY DISORDER (CURRENT) SECTION IN THE ANXIETY, OBSESSIVE COMPULSIVE, AND TRAUMA-RELATED DISORDERS SUPPLEMENT AFTER FINISHING THE SCREEN INTERVIEW.**

_ **IF RECEIVED A SCORE OF 3 ON THE PAST RATINGS OF** EITHER **OF THE PREVIOUS ITEMS, COMPLETE THE GENERALIZED ANXIETY DISORDER (PAST) SECTION IN THE ANXIETY, OBSESSIVE COMPULSIVE, AND TRAUMA-RELATED DISORDERS SUPPLEMENT AFTER FINISHING THE SCREEN INTERVIEW.**

_ **NO EVIDENCE OF GENERALIZED ANXIETY DISORDER.**

NOTES: RECORD DATES OF POSSIBLE CURRENT AND PAST GENERALIZED ANXIETY DISORDER).

1. Obsessions

P	C	S	
( )	( )	( )	**0 -** No information.
( )	( )	( )	**1 -** Not present.
( )	( )	( )	**2 -** Subthreshold: Suspected or likely.
( )	( )	( )	**3 -** Threshold: Definite obsessions, causes some effect on functioning or distress.

PAST: ☐ P ☐ C ☐ S

DSM-5 DR# 16: Recurrent thoughts that you would do something bad or something bad would happen to you or someone else:

Parent Rating: _____ Child Rating: _____

DSM-5 DR# 18: Worried a lot that things you touch were dirty, etc:

Parent Rating: _____ Child Rating: _____

Recurrent and intrusive thoughts, impulses, or images that are distressing and debilitating and over which the person has little control.

Has there ever been a time when thoughts popped into your mind over and over and you couldn't get rid of them?
Has there ever been a time when you were bothered by thoughts, "pictures" or words which kept coming into your head for no reason and that you could not stop or get rid of?

Did you ever worry a lot about having dirt or germs on your hands, or worry that you might get ill from dirt or germs?

Did you ever worry about doing things perfectly or about making things even or arranging things in a certain way?
What about thoughts that something bad might happen, or that you did something terrible, even though you knew it wasn't true?
Any other types of thoughts that kept running around your mind?
What about silly thoughts, words, or numbers which wouldn't go away?
How often did you think about them?
Were they like a hiccup that won't go away, just kept coming again and again?
Were these thoughts annoying to you?
Did they not seem to make any sense?
Do these thoughts get in your way or stop you from doing things?

NOTE: DO NOT SCORE OBSESSIONS ITEMS POSITIVELY IF IDEAS /THOUGHTS ARE DELUSIONAL, OR ARE EXCLUSIVELY DUE TO ANOTHER AXIS I DISORDER (e.g. thoughts of food in the presence of an eating disorder; thoughts that parents will get harmed in the presence of a separation anxiety disorder; increased worries from GAD). DO NOT RATE POSITIVELY IF SAYS, "I cannot stop thinking about boy/girlfriend or music."

that you might get ill from dirt or germs?

2. Compulsions

P	C	S	
( )	( )	( )	**0 -** No information.
( )	( )	( )	**1 -** Not present.
( )	( )	( )	**2 -** Subthreshold: Suspected or likely.
( )	( )	( )	**3 -** Threshold: Definite compulsions, causes some effect on functioning or distress.

DSM-5 DR# 17: Felt the need to check things over and over again, etc:

Parent Rating: _____ Child Rating: _____

DSM-5 DR# 19: Felt you had to do things in a certain way, like counting, etc:

Parent Rating: _____ Child Rating: _____

Recurrent intrusive, repetitive, purposeful behaviors performed in response to an obsession, according to certain rules, or in stereotyped fashion that are distressing and debilitating and over which the person has little control.

Has there ever been a time when you found yourself having to do things that seemed silly over and over, or things which you could not resist repeating like touching things, or counting or washing your hands many times, or checking locks or other things?
Have you ever found yourself having to repeat certain actions over and over?Did you feel you had any control over them? Did these things bother you? Were there things you always felt you had to do exactly the same way or in a special way?
Did you ever have trouble finishing your school work because you had to read parts of an assignment over and over or because you were writing and re-writing your homework over and over again?
Did you ever have trouble making it to school on time because it takes too long to get ready in the morning?
If you made a mistake on your school work, did you have to start at the beginning?
What about when you went to sleep, did you have to check something several times before you fell asleep?
Or did you have to arrange things in your room in a particular way?
Have other people ever commented about these habits?

PAST: ☐ P ☐ C ☐ S

NOTE: DO NOT RATE POSITIVELY IF BEHAVIOR IS EXCLUSIVELY ACCOUNTED FOR BY ANOTHER DISORDER (e.g., PDD, Asperger's, tics, psychosis, eating disorder).

_ **IF RECEIVED A SCORE OF 3 ON CURRENT RATINGS OF EITHER OBSESSIONS OR COMPULSIONS ITEM, COMPLETE OBSESSIVE COMPULSIVE DISORDER (CURRENT) SECTION IN THE ANXIETY, OBSESSIVE COMPULSIVE, AND TRAUMA-RELATED DISORDERS SUPPLEMENT AFTER FINISHING SCREEN INTERVIEW.**

_ **IF RECEIVED A SCORE OF 3 ON PAST RATINGS OF EITHER OBSESSIONS OR COMPULSIONS ITEM, COMPLETE OBSESSIVE COMPULSIVE DISORDER (PAST) SECTION IN THE ANXIETY, OBSESSIVE COMPULSIVE, AND TRAUMA-RELATED DISORDERS SUPPLEMENT AFTER FINISHING SCREEN INTERVIEW.**

_ **NO EVIDENCE OF OBSESSIVE COMPULSIVE DISORDER.**

NOTES: (RECORD DATES OF POSSIBLE CURRENT AND PAST OBSESSIVE COMPULSIVE DISORDER).

1. Repeated Voiding

A lot of kids sometimes have accidents and wet their beds when they sleep at night. Has there ever been a time when this happened to you?
Did you ever have accidents during the day?
What about if you laughed or sneezed real hard?

a. Night time

How often did this happen at night?

	P	C	S
	( )	( )	( )
	( )	( )	( )
	( )	( )	( )
	( )	( )	( )

0 - No information.
1 - Not present.
2 - At least one to four times a month for three or more months.
3 - At least two times a week for three consecutive months.

PAST: ☐ P ☐ C ☐ S

b. Daytime

How often did this happen during the day?

	P	C	S
	( )	( )	( )
	( )	( )	( )
	( )	( )	( )
	( )	( )	( )

0 - No information.
1 - Not present.
2 - At least one to four times a month for three or more months.
3 - At least two times a week for three consecutive months.

PAST: ☐ P ☐ C ☐ S

c. Total

Estimate frequency of combined nighttime and daytime accidents.

NOTE: Do not rate positively if enuresis due to medical condition.

	P	C	S
	( )	( )	( )
	( )	( )	( )
	( )	( )	( )
	( )	( )	( )

0 - No information.
1 - Not present.
2 - At least one to four times a month for three or more months.
3 - At least two times a week for three consecutive months.

PAST: ☐ P ☐ C ☐ S

_ **IF RECEIVED A SCORE OF 3 OR ABOVE ON THE CURRENT RATINGS OF ANY OF THE PREVIOUS ITEMS, COMPLETE THE QUESTIONS ON THE FOLLOWING PAGE.**

_ **IF RECEIVED A SCORE OF 3 OR ABOVE ON THE PAST RATINGS OF ANY OF THE PREVIOUS ITEMS, COMPLETE THE QUESTIONS ON THE FOLLOWING PAGE.**

_ **IF NO EVIDENCE OF ENURESIS, GO TO ENCOPRESIS SECTION ON PAGE 24.**

Distress

What did you usually do when you had an accident? Did you tell your mom? Your teacher? What did they do? Did the kids at school know you sometimes had accidents? How much did it bother you when you had an accident?

Impairment: (home, school, peers)

Duration: (specify)

2. Evidence of Enuresis

DSM-5 Criteria

A. Repeated voiding of urine into bed or clothes, whether involuntary or intentional;
B. The behavior is clinically significant as manifested by either a frequency of twice a week for at least three consecutive months, or the presence of clinically significant distress or impairment in social, academic (occupational), or other important areas of functioning;
C. Chronological age is at least 5 years (or equivalent developmental level);
D. The behavior is not attributable physiological effect of a substance (e.g., a diuretic, an antipsychotic medication) or another medical condition (e.g., diabetes, spina bifida, a seizure disorder).

— **MEETS DSM-5 CRITERIA FOR ENURESIS (CURRENT). (Scored 3 plus impairment).**

Specify: Nocturnal Only: _____ Diurnal Only: _____ Nocturnal and Diurnal: _____

— **MEETS DSM-5 CRITERIA FOR ENURESIS (PAST). (Scored 3 plus impairment).**

Specify: Nocturnal Only: _____ Diurnal Only: _____ Nocturnal and Diurnal: _____

NOTES: (RECORD DATES OF CURRENT AND PAST ENURESIS).

1. Repeated Passage of Feces

Some kids have accidents and soil their beds when they sleep at night. Did this ever happen to you?
Has there ever been a time when you had accidents and went to the bathroom in your pants during the day?
What about when you were really scared, or for some reason couldn't get to a bathroom when you needed to?
What kinds of accidents were you having?
Number one or number two?

NOTE: ONLY RATE POSITIVELY IF THERE ARE STOOLS IN THE PATIENT'S UNDERWEAR.

a. Night time

How often did this happen at night?

P	C	S	
( )	( )	( )	**0 -** No information.
( )	( )	( )	**1 -** Not present.
( )	( )	( )	**2** - Subthreshold: Less than 1 time a month.
( )	( )	( )	**3 -** Threshold: 1 or more times a month for at least 3 months.

PAST: ☐ P ☐ C ☐ S

b. Daytime

How often did this happen during the day?

P	C	S	
( )	( )	( )	**0 -** No information.
( )	( )	( )	**1 -** Not present.
( )	( )	( )	**2 -** Subthreshold: Less than 1 time a month.
( )	( )	( )	**3 -** Threshold: 1 or more times a month for at least 3 months.

PAST: ☐ P ☐ C ☐ S

c. Total

Estimate total number of nighttime and daytime accidents.

P	C	S	
( )	( )	( )	**0 -** No information.
( )	( )	( )	**1 -** Not present.
( )	( )	( )	**2 -** Subthreshold: Less than 1 time a month.
( )	( )	( )	**3 -** Threshold: 1 or more times a month for at least 3 months.

PAST: ☐ P ☐ C ☐ S

_ **IF RECEIVED A SCORE OF 3 OR ABOVE ON THE CURRENT RATINGS OF ANY OF THE PREVIOUS ITEMS, COMPLETE THE QUESTIONS ON THE FOLLOWING PAGE.**

_ **IF RECEIVED A SCORE OF 3 OR ABOVE ON THE PAST RATINGS OF ANY OF THE PREVIOUS ITEMS, COMPLETE THE QUESTIONS ON THE FOLLOWING PAGE.**

_ **IF NO EVIDENCE OF ENCOPRESIS, GO TO ANOREXIA NERVOSA SECTION ON PAGE 26.**

Distress

What did you usually do when you had an accident? Did you tell your mom? Your teacher? What did they do? Did the kids at school know you sometimes had accidents? How much did it bother you when you had an accident?

Impairment: (home, school, peers)

Duration: (specify)

2. Evidence of Encopresis

DSM-5 Criteria

A. Repeated passage of feces into inappropriate places (e.g., clothing or floor) whether involuntary or intentional;
B. At least one such event occurs each month for at least 3 months;
C. Chronological age is at least 4 years (or equivalent developmental level);
D. The behavior is not attributable to the physiological effect of a substance (e.g., laxatives) or another medical condition except through a mechanism involving constipation.

— **MEETS DSM-5 CRITERIA FOR ENCOPRESIS (CURRENT).**
Specify: ___ With constipation and overflow incontinence or ___ Without constipation and overflow incontinenece

_ **MEETS DSM-5 CRITERIA FOR ENCOPRESIS (PAST).**
Specify: ___ With constipation and overflow incontinence **or** ___ Without constipation and overflow incontinenece

NOTES: (RECORD DATES OF CURRENT AND PAST ENCOPRESIS).

Begin this section with a brief (2-3 minute) semi-structured interview to obtain information about eating habits:

Are you happy with your weight?
Do you eat regular meals? Are you a dieter?
Has there ever been a time when you weighed a lot more or a lot less?
What was your weight? What did you want your weight to be?

1. Fear of Becoming Obese

Has there ever been a time when you were afraid of getting fat?
Did you believe you were fat?
Have you ever been really overweight?
Did you watch what you ate and think about what you ate all the time?
Were you afraid of eating certain foods because you were afraid they'd make you fat? What foods?
How much time did you spend thinking about food and worrying about getting fat?
If you saw that you had gained a pound or two, did you change your eating habits?
Fast for a day or do anything else?

NOTE: KEEP IN MIND DIFFERENTIAL DIAGNOSES OF ANXIETY DISORDER, OCD, AND PSYCHOSIS.

P	C	S	
( )	( )	( )	**0 -** No information.
( )	( )	( )	**1 -** Not present.
( )	( )	( )	**2 -** Subthreshold: Intense and persistent fear of becoming fat, which defies prior weight history and/ or present weight, reassurance, etc. Fears have only moderate impact on behavior and/or functioning (e.g., weight loss methods utilized at least once a month, but less than once a week).
( )	( )	( )	**3 -** Threshold: Intense and persistent fear of becoming fat, that has severe impact on behavior and/ or functioning (e.g., constantly preoccupied with weight concerns; or use of weight loss methods 1 time a week or more).

PAST: ☐ P ☐ C ☐ S

2. Emaciation

Weight is proportionally lower than ideal weight for height.

If, by observation, there is any suspicion of emaciation, you must weigh the child, and look at the table (see attached). If in doubt do not ask, just weigh the child.

NOTE: DO NOT RATE POSITIVELY IF WEIGHT LOSS IS DUE TO A MEDICAL CONDITION, MOOD DISORDER, OR FOOD SCARCITY RELATED TO POVERTY.

P	C	S	
( )	( )	( )	**0 -** No information.
( )	( )	( )	**1 -** Not present.
( )	( )	( )	**2 -** Subthreshold: Weight below 90% of ideal.
( )	( )	( )	**3 -** Threshold: Weight below 85% of ideal.

PAST: ☐ P ☐ C ☐ S

3. Weight Loss Methods

Have you ever used diet pills to control your weight?
How about laxatives, or water pills to lose weight?
Did you sometimes make yourself throw up?
Did you exercise a lot, more than was usual for you, in order to lose weight? How much? How many hours a day?
Did you have periods of at least 1 week during which you had nothing but liquids with no calories (teas, diet sodas, coffee, water)?

Criteria
0 = No Information
1 = Not present
2 = Less than one time a week
3 = One or more times a week

	Parent CE	Parent MSP	Child CE	Child MSP	Summary CE	Summary MSP
	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
a. using diet pills	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )
b. taking laxatives	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )
c. taking water pills	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )
d. throwing up	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )
e. exercising a lot	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )
f. taking only non-caloric fluids for a week or more; restricting energy (e.g., food) intake	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )
g. combined frequency weight loss methods	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )

	P	C	S
4. Eating Binges or Attacks	( )	( )	( )
Binge eating episode associated with three or more of the following:	( )	( )	( )
1. Eating much more rapidly than normal.			
2. Eating until feeling uncomfortably full.	( )	( )	( )
3. Eating large amounts of food when not physically hungry.			
4. Eating alone because of being embarrassed.			
5. Feeling disgusted, depressed, or very guilty after overeating	( )	( )	( )

0 - No information

1 - Not present.

2 - Subthreshold: Eating binges that occur less than once a week or have fewer than three associated features..

3 - Threshold: Eating binges once a week or more.

PAST: ☐ ☐ ☐
P C S

Has there ever been a time when you had "eating attacks" or binges? What's the most you ever ate at one time?
Have there ever been times you ate so much you felt sick? How often did it happen?
(ascertain all details in definition)
What triggered a binge?
What did you usually eat when you binged?
What was the most food you have eaten during a binge?
Did you ever make yourself throw up after a binge?
How did you feel after you binged?
Did you usually binge alone or with other people?
Did other people know you binged?

NOTE: ONLY RATE EATING BINGES THAT ARE PATHOLOGICAL (e.g., hidden from family members and peers, followed by depressed mood, and/ or throwing up behavior). DO NOT RATE TYPICAL ADOLESCENT EATING ORGIES (e.g., outings with friends for pizza and ice cream).

_ **IF RECEIVED A SCORE OF 3 ON CURRENT RATINGS OF ANY OF THE EATING DISORDER ITEMS (CURRENT), COMPLETE THE EATING DISORDERS SECTION IN THE EATING DISORDERS AND SUBSTANCE-RELATED DISORDERS SUPPLEMENT AFTER FINISHING THE SCREEN INTERVIEW.**

_ **IF RECEIVED A SCORE OF 3 ON PAST RATINGS OF ANY OF THE EATING DISORDER ITEMS (PAST), COMPLETE THE EATING DISORDERS SECTION IN THE EATING DISORDERS AND SUBSTANCE-RELATED DISORDERS SUPPLEMENT AFTER FINISHING THE SCREEN INTERVIEW.**

_ **NO EVIDENCE OF AN EATING DISORDER.**

NOTE: (RECORD DATES OF POSSIBLE CURRENT AND PAST EATING DISORDERS).

Compared to other children/adolescents this age, how would parent/adult rate this child/ adolescent. Also ask if teachers or others have complained about particular symptoms or behaviors.

If the child is being treated with stimulants, rate for most severe period prior to medication or during drug holidays and note in margin which symptoms are improved with medication.

Determine the age of onset for first positively endorsed ADHD symptom. If symptom has persisted since early childhood, use the current rating to describe the symptom's most intense severity over the past year. Score symptom as 'not present' in the past unless prior episode of symptomatology was followed by a period of six months or more in which the child was free of ADHD problems.

If the symptoms are episodic, consider the presence of a mood disorder or other causes (e.g., alcohol, drugs or medical problems).

Probe: For how long has _____ been a problem? Has it been a problem since kindergarten? First grade? Did the problem start even earlier? Note: According to the DSM-5, onset of ADHD symptoms can appear up to age 12.

P C S

1. Difficulty Sustaining Attention on Tasks or Play Activities

( ) ( ) ( ) **0 -** No information.

( ) ( ) ( ) **1 -** Not present.

( ) ( ) ( ) **2 -** Subthreshold: Occasionally has difficulty sustaining attention on tasks or play activities. Problem has only minimal effect on functioning.

( ) ( ) ( ) **3 -** Threshold: Often (4-7 days/week) has difficulty sustaining attention. Problem has significant effect on functioning.

DSM-5 DR# 4: Not able to pay attention:

Parent Rating: _____ Child Rating: _____

Has there ever been a time when you had trouble paying attention in school? Did it affect your school work?
Did you get into trouble because of this?
When you were working on your homework, did your mind wander?
What about when you were playing games? Did you forget to go when it was your turn?
Did teachers complain?

PAST: ☐ ☐ ☐
P C S

NOTE: RATE BASED ON DATA REPORTED BY INFORMANT (e.g., parent or teacher) OR OBSERVATIONAL DATA.

NOTE: DO NOT RATE POSITIVELY IF OCCURS ONLY DURING MOOD EPISODE, PSYCHOSIS, EPISODES OF DRUG USE, OR SECONDARY TO A MEDICAL CONDITION.

P C S

2. Easily Distracted

( ) ( ) ( ) **0 -** No information.

( ) ( ) ( ) **1 -** Not present.

( ) ( ) ( ) **2 -** Subthreshold: Occasionally distractible. Problem has only minimal effect on functioning.

( ) ( ) ( ) **3 -** Threshold: Attention often (4-7 days/ week) disrupted by minor distractions other kids would be able to ignore. Problem has significant effect on functioning.

Was there ever a time when little distractions would make it very hard for you to keep your mind on what you were doing?
Like if another kid in class asked the teacher a question while the class was working quietly, was it hard for you to keep your mind on your work?
When there was an interruption, like when the phone rang, was it hard to get back to what you were doing before the interruption?
Were there times when you could keep your mind on what you were doing, and little noises and things didn't bother you?
How often were they a problem?
Did teachers complain?

PAST: ☐ ☐ ☐
P C S

NOTE: RATE BASED ON DATA REPORTED BY INFORMANT OR OBSERVATIONAL DATA.

NOTE: DO NOT RATE POSITIVELY IF OCCURS ONLY DURING MOOD EPISODE, PSYCHOSIS, EPISODES OF DRUG USE, OR SECONDARY TO A MEDICAL CONDITION.

	P	C	S
3. Difficulty Remaining Seated	( )	( )	( )

Was there ever a time when you got out of your seat a lot at school?
Did you get into trouble for this?
Was it hard to stay in your seat at school? What about dinner time?

Parents: *When your child was young, were you able to take him/her to church? Restaurants?*
Were these difficulties beyond what you would expect for a child his/ her age?

NOTE: RATE BASED ON DATA REPORTED BY INFORMANT OR OBSERVATIONAL DATA.

Take into account that these symptoms tend to improve with age. Carefully check if this symptom was present when the child was younger.

0 - No information.

1 - Not present.

2 - Subthreshold: Occasionally has difficulty remaining seated when required to do so. Problem has only minimal effect on functioning.

3 - Threshold: Often (4-7 days/ week) has difficulty remaining seated when required to do so. Problem has significant effect on functioning.

PAST: ☐ P ☐ C ☐ S

	P	C	S
4. Impulsivity	( )	( )	( )

Do you act before you think, or think before you act?
Has there ever been a time when these kinds of behaviors got you into trouble? Give some examples.

(THIS ITEM IS NOT A DSM-5 CRITERION - DO NOT INCLUDE IN SYMPTOM COUNT).

0 - No information.

1 - Not present.

2 - Subthreshold: Occasionally impulsive. Problem has only minimal effect on functioning.

3 - Threshold: Often (4-7 days/ week) impulsive. Problem has significant effect on functioning.

PAST: ☐ P ☐ C ☐ S

— **IF RECEIVED A SCORE OF 3 ON THE CURRENT RATINGS OF ANY OF THE PREVIOUS ITEMS, COMPLETE THE ATTENTION DEFICIT HYPERACTIVITY DISORDER (CURRENT) SECTION IN THE NEURODEVELOPMENTAL, DISRUPTIVE, AND CONDUCT DISORDERS SUPPLEMENT AFTER COMPLETING THE SCREEN INTERVIEW.**

— **IF RECEIVED A SCORE OF 3 ON THE PAST RATINGS OF ANY OF THE PREVIOUS ITEMS, COMPLETE THE ATTENTION DEFICIT HYPERACTIVITY DISORDER (PAST) SECTION IN THE NEURODEVELOPMENTAL, DISRUPTIVE, AND CONDUCT DISORDERS SUPPLEMENT AFTER COMPLETING THE SCREEN INTERVIEW.**

— **NO EVIDENCE OF ATTENTION DEFICIT DISORDER.**

NOTE: (RECORD DATES OF POSSIBLE CURRENT AND PAST ATTENTION DEFICIT HYPERACTIVITY DISORDER).

The essential feature of this disorder is a recurrent pattern of negativistic, defiant, disobedient, and hostile behavior toward authority figures that persists for at least 6 months and occurs more frequently than is typically observed in individuals of comparable age and developmental level.

Keep in mind differential diagnoses of depressive disorder, bipolar disorder, anxiety disorders, ADHD, psychosis, substance use disorders or medical illness. Also consider environmental issues.

While the DSM-5 is not clear regarding this issue, consider making this diagnosis if symptoms are present in more than one setting (i.e., home and school) consider diagnosis of Parent-Child Relational Problem if symptoms occur ONLY at home.

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1. Loses Temper

DSM-5 DR# 8: Felt angry or lost your temper:

Parent Rating: _____ Child Rating: _____

Has there ever been a time when you would get upset easily and lose your temper?
Did it take much to get you mad?
How often did you get really mad or annoyed and lose your temper?

In order to be sure this is a temper outburst, ask:
Where do you lose your temper?
What do you do when you have a temper tantrum?

P	C	S	
( )	( )	( )	**0 -** No information.
( )	( )	( )	**1 -** Not present.
( )	( )	( )	**2 -** Subthreshold: Occasional severe temper outbursts. **(less than 1 time weekly)**.
( )	( )	( )	**3 -** Threshold: Less severe outbursts daily or severe temper outbursts at least once a week Outbursts more severe and more often than a typical child his/ her age; cause impairment.

PAST: ☐ P ☐ C ☐ S

2. Argues a Lot with Adults/ Authority Figures

Was there ever a time when you would argue, talk back, "smart mouth" a lot with adults? Your parents or teachers?
What kinds of things did you argue with them about?
Did you argue with them a lot?
How bad did the fights get?

NOTE: ARGUING INCLUDES AN UNWILLINGNESS TO COMPROMISE, GIVE IN, OR NEGOTIATE WITH ADULTS OR PEERS.

P	C	S	
( )	( )	( )	**0 -** No information.
( )	( )	( )	**1 -** Not present.
( )	( )	( )	**2 -** Subthreshold: Occasionally argues with parents and/or teachers; less than once per week.
( )	( )	( )	**3 -** Threshold: Often argues with parents and/or teachers (at least one time per week). Arguments more severe and more often than a typical child his/ her age.

PAST: ☐ P ☐ C ☐ S

	P	C	S	
3. Disobeys Rules A Lot/Defies or Refuses to Comply with Adult Requests	( )	( )	( )	**0 -** No information.
Do you ever deliberately defy or disobey the rules at home? School? How often?	( )	( )	( )	**1 -** Not present.
Do you think that your parents/teachers ask you to do things that you shouldn't have to do? Like what?	( )	( )	( )	**2 -** Subthreshold: Occasionally actively defies or refuses adult requests or rules; less than one time per week.
In addition ask the following for adolescents: *How often do you get away with things without getting into trouble or without getting caught? Does this get you into trouble?*	( )	( )	( )	**3 -** Threshold: Often actively defies or refuses adult requests or rules (at least once a week). Disobedient more often than a typical child his/ her age.

PAST: ☐ P ☐ C ☐ S

— **IF RECEIVED A SCORE OF 3 ON THE CURRENT RATINGS OF ANY OF THE PREVIOUS ITEMS, COMPLETE THE OPPOSITIONAL DEFIANT DISORDER (CURRENT) SECTION OF THE NEURODEVELOPMENTAL, DISRUPTIVE, AND CONDUCT DISORDERS SUPPLEMENT AFTER FINISHING THE SCREENING INTERVIEW.**

— **IF RECEIVED A SCORE OF 3 ON THE PAST RATINGS OF ANY OF THE PREVIOUS ITEMS, COMPLETE THE OPPOSITIONAL DEFIANT DISORDER (PAST) SECTION OF THE NEURODEVELOPMENTAL, DISRUPTIVE, AND CONDUCT DISORDERS SUPPLEMENT AFTER FINISHING THE SCREENING INTERVIEW.**

— **NO EVIDENCE OF OPPOSITIONAL DEFIANT DISORDER.**

NOTE: (RECORD DATES OF POSSIBLE CURRENT AND PAST OPPOSITIONAL DEFIANT DISORDER).

The essential feature of Conduct Disorder is a repetitive and persistent pattern of behavior in which the basic rights of others or major age appropriate societal rules are violated. Three behaviors must have been present during the past 12 months with at least one present in the past 6 months.

Keep in mind differential diagnoses of mood disorders, ADHD, psychosis, substance abuse.

If symptoms occur only during a manic episode, consider NOT giving both diagnoses.

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1. Lies

P	C	S	
( )	( )	( )	**0 -** No information.
( )	( )	( )	**1 -** Not present.
( )	( )	( )	**2 -** Subthreshold: Occasionally lies. Lies more often than a typical child his/her age.
( )	( )	( )	**3 -** Threshold: Lies often, multiple times per week or more **(to con or cheat)**.

PAST: [ ] [ ] [ ]
P C S

Everybody lies. Some kids tell lies to exaggerate, some kids tell lies to get out of trouble, while others tell lies to con/ cheat others.

Do you ever tell lies?
What type of lies do you tell?
Who do you lie to?
Have people ever called you a liar?
What's the worst lie you ever told?
Did you lie to get other people to do things for you?
Did you lie to get out of paying people back money or some favor you owe them?
Has anyone ever called you a con?
Complained that you broke promises a lot?
How often did you lie?

NOTE: ONLY RATE POSITIVE EVIDENCE OF LYING TO CHEAT OR "CON."

2. Truant

P	C	S	
( )	( )	( )	**0 -** No information.
( )	( )	( )	**1 -** Not present.
( )	( )	( )	**2 -** Subthreshold: Truant on one isolated incident.
( )	( )	( )	**3 -** Threshold: Truant on numerous occasions **(e.g., 2 or more days or numerous partial days)**.

PAST: [ ] [ ] [ ]
P C S

Has there ever been a time when you skipped a whole day of school when your parents didn't know about it?
Did you ever go to school and leave early when you were not really supposed to? How about going in late?
Did you sometimes miss or skip classes in the morning?
Did you get into trouble? How often?

For adolescents: *How old were you when you first started to play hooky?*

NOTE: ONLY RATE POSITIVE INCIDENTS OF TRUANCY BEGINNING BEFORE THE AGE OF 13. IN ADDITION, TRUANCY IS ACTIVELY MISSING PART OR ALL OF A SCHOOL DAY REGARDLESS OF PARENT ABILITY TO ENFORCE ATTENDANCE.

	P	C	S
3. Initiates Physical Fights	( )	( )	( )

Has there ever been a time when you got into many fist fights?
Who usually started the fights?
What's the worst fight you ever got into? What happened? Did anyone get hurt?
Who did you usually fight with?
Have you ever hit a teacher? One of your parents? Another adult?
How often did you fight?
Have you ever tried or wanted to kill someone?

NOTE: TAKE INTO ACCOUNT CULTURE, BACKGROUND, AND NEIGHBORHOOD.

0 - No information.

1 - Not present.

2 - Subthreshold: Fights with peers only. No fight has resulted in serious injury to peer (e.g., no medical intervention required, stitches, etc.).

3 - Threshold: Reports at least one physical fight involving an adult (e.g., teacher, parent) OR reports starting frequent fights, with one or more fights resulting in serious injury to a peer, or frequent fights not resulting in injury (at least 1-2 times per month).

INQUIRE ABOUT BOTH OF THE FOLLOWING:

PAST: ☐ P ☐ C ☐ S

1 - Gang Involvement. Are you or any of your friends in a gang? The Crips? Bloods? Another gang?

○ Check here if evidence of gang involvement.

2 - Homicidal Intent. Have you ever thought about wanting to kill someone or a group of people? Do you have a gun or any other weapons?

○ Check here if evidence of homicidal intent.

	P	C	S
4. Bullies, Threatens, or Intimidates Others	( )	( )	( )

Do you ever try to bully kids or threaten kids to get them to do something you want them to do?

How often did you do these things:
__ call names or make fun of other kids
__ threaten to hurt other kids
__ push
__ trip
__ come up from behind and slap or knock kids down
__ knock items out of kids hands
__ make other kids do things for you

NOTE: DO NOT COUNT TRIVIAL SIBLING RIVALRY.

0 - No information.

1 - Not present.

2 - Subthreshold: Occasionally bullies, threatens, or intimidates.

3 - Threshold: Bullies, threatens, or intimidates others on multiple occasions, daily, almost daily, or at least several times per week.

PAST: ☐ P ☐ C ☐ S

	P	C	S
5. Nonaggressive Stealing	( )	( )	( )

In the past year, have you stolen anything?
What is the most expensive thing you stole?
What other things have you stolen? From whom? From which stores?
Have you stolen a toy from a store? Money from your mom? Anything else? How often have you stolen things?

NOTE: ONLY COUNT THEFTS OF NON-TRIVIAL VALUE (e.g., $20.00 or more) . EXCEPTION: MULTIPLE THEFTS OUTSIDE THE HOME OF TRIVIAL VALUE.

0 - No information.

1 - Not present.

2 - Subthreshold: Has stolen without confrontation of victim on only one occasion.

3 - Threshold: Has stolen without confrontation of victim on 2 or more occasions.

PAST: ☐ P ☐ C ☐ S

— **IF RECEIVED A SCORE OF 3 ON THE CURRENT RATINGS OF ANY OF THE PREVIOUS ITEMS, COMPLETE THE CONDUCT DISORDER (CURRENT) SECTION IN THE NEURODEVELOPMENTAL, DISRUPTIVE, AND CONDUCT DISORDERS SUPPLEMENT AFTER FINISHING THE SCREENING INTERVIEW.**

— **IF RECEIVED A SCORE OF 3 ON THE PAST RATINGS OF ANY OF THE PREVIOUS ITEMS, COMPLETE THE CONDUCT DISORDERS (PAST) SECTION IN THE NEURODEVELOPMENTAL, DISRUPTIVE, AND CONDUCT DISORDERS SUPPLEMENT AFTER FINISHING THE SCREENING INTERVIEW.**

— **NO EVIDENCE OF CONDUCT DISORDER.**

NOTES: (RECORD DATES OF POSSIBLE CURRENT AND PAST CONDUCT DISORDER. MAKE NOTES ABOUT GANG INVOLVEMENT).

1 Motor Tics

Has there ever been a time when you noticed your muscles moved in a way that you did not want them to, or that you didn't expect?
Like raising your eyebrows (demonstrate), blinking a whole lot (demonstrate), scrunching up your nose (demonstrate), shrugging your shoulders (demonstrate), or moving your head like this (demonstrate)?
Ever blink a whole lot or real hard and not be able to stop?
About how often did this happen?

NOTE: RATE BASED ON REPORT AND OBSERVATION.

Do not rate positively if due to compulsions of OCD or stereotypic movements of PDD.

	P	C	S
	( )	( )	( )
	( )	( )	( )
	( )	( )	( )
	( )	( )	( )

0 - No information.

1 - Not present.

2 - Subthreshold: Specific tic behaviors present. Tics have not persisted for a full year.

3 - Threshold: Specific tic behaviors are present. The frequency may wax and wane, but tics have been present for at least a year.

PAST: ☐ P ☐ C ☐ S

2. Phonic Tics

Has there ever been a time when you made noises that you didn't want to make, repeated sounds or words that you don't want to say?
Like sniffing, coughing, or clearing your throat when you didn't have a cold?
Making animal sounds or grunting sounds, or even repeating things that you or other people said?

NOTE: RATE BASED ON REPORT AND OBSERVATION.

	P	C	S
	( )	( )	( )
	( )	( )	( )
	( )	( )	( )
	( )	( )	( )

0 - No information.

1 - Not present.

2 - Subthreshold: Specific tic behaviors present Tics have not persisted for a full year.

3 - Threshold: Specific tic behaviors are present. The frequency may wax and wane, but tics have been present for at least a year.

PAST: ☐ P ☐ C ☐ S

— **IF RECEIVED SCORE OF 3 ON CURRENT RATINGS OF MOTOR OR PHONIC TIC ITEMS, COMPLETE THE TIC DISORDERS (CURRENT) SECTION IN THE NEURODEVELOPMENTAL, DISRUPTIVE, AND CONDUCT DISORDERS SUPPLEMENT AFTER FINISHING THE SCREEN INTERVIEW.**

— **IF RECEIVED SCORE OF 3 ON PAST RATINGS OF MOTOR OR PHONIC TIC ITEMS, COMPLETE THE TIC DISORDERS (PAST) SECTION IN THE NEURODEVELOPMENTAL, DISRUPTIVE, AND CONDUCT DISORDERS SUPPLEMENT AFTER FINISHING THE SCREEN INTERVIEW.**

— **NO EVIDENCE OF TIC DISORDER.**

NOTE: (RECORD DATES OF POSSIBLE CURRENT AND PAST TIC DISORDERS).

Autism Spectrum Disorders are characterized by severe and pervasive impairment in several areas of development: reciprocal social interaction skills, communication skills, and the presence of stereotyped behavior, interests, and activities. The qualitative impairments that define these conditions are distinctly deviant relative to the individual's developmental level or mental age.

1) These disorders are usually evident early in life. For each item below, remember to assess the duration of the symptom and whether it has been present by preschool or before. Also, for each item, please remember to synthesize your clinical observation of behavior observed during the interview into the Summary rating.
2) If the child denies it, but parents report and/ or you also observe symptom while interviewing the child, give more weight to parents and/ or your observation than the child's report because he/ she may not be aware of his/her problem.
3) For all symptoms below, take into account whether they are better accounted by other psychiatric disorder (mainly OCD, ADHD, psychosis, mental retardation, severe social anxiety), or medical or neurological conditions. Also, take into account the developmental stage of the child, normal behaviors and emotions, history of abuse or neglect, and the cultural background of the family and the child.
4) Remember to rate the symptoms as positive if you observe them during the interview. For example, parents and/or child may deny that the child has odd movements and the child keeps flapping his/ her hands or shows persistent toe walking in your office. Parents or child report that he/ she is very personable, friendly and has good non-verbal communication; however, you do not observe this during the interview. In this case, you can bring this to the parents' attention in a polite way. For example, you can tell parents, "During the interview, I noticed that your child does not or avoids looking at me (or I saw such and such movements), is this something new or have you and others observed the same?

NOTE: MOST SECTIONS OF THE K-SADS-PL HAVE SAMPLE PROBES TO ELICIT SYMPTOMS FROM CHILDREN. THIS SECTION HAS SAMPLE PROBES TO USE WITH PARENTS, AS IT IS ASSUMED PARENTS WILL BE THE BEST INFORMANTS OF THESE BEHAVIORS, AND MANY CHILDREN WITH AUTISM SPECTRUM DISORDERS WILL NOT HAVE INSIGHT REGARDING THE PRESENCE AND SIGNIFICANCE OF THESE SYMPTOMS. THESE ITEMS SHOULD BE SURVEYED WITH THE CHILDREN, BUT GREATER WEIGHT GIVEN TO PARENT REPORT AND INTERVIEWER OBSERVATIONS WHEN SCORING INDIVIDUAL ITEMS.

---

1. Stereotyped or Repetitive Speech, Motor Movements or Use of Objects

P	C	S
( )	( )	( )
( )	( )	( )
( )	( )	( )
( )	( )	( )

Does your child have any unusual motor mannerisms like hand flapping, head weaving, body rocking, or body spinning?
What about a preoccupation with wiggling his/her fingers?

Does your child repeat what you say? Parrot your speech or the speech of others? Repeatedly use idiosyncratic phrases?

Any other repetitive habits? Maybe an unusual or odd use of a toy or household object?

Child: *Do you like to watch your hands while you wiggle your fingers?*
Does rocking back and forth calm you when you are upset?
Do people ever tell you to stay still and stop spinning?

NOTE: RATE BASED ON PARENT AND CHILD REPORT AND BEHAVIORAL OBSERVATION.

0 - No information.

1 - Not present. No odd hand of finger mannerisms.

2 - Subthreshold: A few isolated incidents, rarely observed.

3 - Threshold: Occasional or more frequent occurrence.

PAST:

P	C	S

2. Insistence on Sameness, Inflexible Adherence to Routines, Ritualized Patterns of Verbal or Nonverbal Behavior

Is your child rigid and unable to tolerate small changes in plans or routines that you would not expect to cause a problem (like driving to school a different way, going down the grocery store aisles in a different order, or having a picnic on the family room floor instead of eating at the table)?
Do you work real hard to avoid changes in schedule as to not upset your child?
Has he or she been that way since before kindergarten?

For example, when your child outgrows his/ her clothes, does he resist wearing new clothes?

Does your child hate changes in routine, like if he/ she usually takes a bath or get dressed at a certain time and is unable to do so for some particular reason, does your child get very upset?

Child: *Do you get really upset when there is an unexpected change in your plans or the way you usually do things, like if there is a delay in the start of school, if dinner is a little earlier than usual, or if you have to drive home a different way than usual?*

P	C	S	
( )	( )	( )	**0 -** No information.
( )	( )	( )	**1 -** Not present. Flexibility within normal range.
( )	( )	( )	**2 -** Subthreshold: Only mildly inflexible, or inflexibility not evident in early childhood.
( )	( )	( )	**3 -** Threshold: Significant and persistent rigid adherence to routines and rituals that elicit distress when interrupted. Pattern of behavior evident since early childhood.

PAST: ☐ P ☐ C ☐ S

3. Highly Restricted, Fixated Interests that are Abnormal in Intensity or Focus

Often these are primarily manifested in the development of encompassing preoccupations about a circumscribed topic or interest, about which the individual can amass a great deal of facts and information. These interests and activities are pursued with great intensity often to the exclusion of other activities. Rate focus and/or intensity.

Parent: *Does your child have interests that are not typical for other children his/ her age, like an interest in ceiling fans or radiators?*
Has he/ she memorized unusual facts like bus schedules, history facts, or other sorts of facts that preoccupy him/ her daily?
Does your child have one specific activity that he/ she is focused on?
Do you think that he/ she is "too obsessed" with certain activities or interests beyond what you would expect for a child of his/ her age?

Child: *Is there something special you are interested in that you really like to talk about, read about, or do? Tell me about it.*

NOTE: RATE THIS AS POSITIVE IF IT IS INAPPROPRIATE FOR THE AGE AND CULTURE OF THE CHILD, AND IT IS EXAGGERATED. DO NOT SCORE PREOCCUPATION WITH VIDEOGAMES OR COMPUTER GAMES HERE.

Do not rate positively if behavior related to other diagnosis such as OCD or a psychosis.

P	C	S	
( )	( )	( )	**0 -** No information.
( )	( )	( )	**1 -** Not present.
( )	( )	( )	**2 -** Subthreshold: Unusual preoccupations that do not cause significant impairment or take excessive amounts of time.
( )	( )	( )	**3 -** Threshold: Definitely preoccupied with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus. Causes significant impairment in social functioning or limits participation in other activities.

PAST: ☐ P ☐ C ☐ S

	P	C	S
4. Deficits in Nonverbal Communicative Behaviors Used for Social Interaction	( )	( )	( )

Eye to Eye Gaze: *Do you frequently have to remind your child to look at you or the person he/ she is talking to?*

Facial Expressions: *Does your child show the typical range of facial expressions?*
Can you see joy on his/ her face when he/ she is happy?
Does he/ she pout when he/ she is sad?
Does he/ she show less common facial expressions like surprise, interest, and guilt?

Gestures: *As a toddler or preschooler, did your child use common gestures like pointing to show interest, clapping when happy, and nodding to indicate 'yes'?*

For school age children and adolescents: *Does he/ she use gestures to help show how something works or while they are explaining something?*

Indicate problematic areas of non-verbal behavior:

○ Gaze ○ Expressions ○ Gestures

Note: Do not rate positive if due to shyness or anxiety and more pronounced with unfamiliar others.

	P	C	S
	( )	( )	( )
	( )	( )	( )
	( )	( )	( )
	( )	( )	( )

0 - No information.

1 - Not present. No problems in any of these areas.

2 - Subthreshold: Subtle problems in one or more area, which is evident to family members and professionals but not to teachers or classmates.

3 - Threshold: Problems with one or more aspects of non-verbal behaviors cause functional impairment.

PAST: ☐ ☐ ☐
P C S

_ **IF RECEIVED A SCORE OF 3 ON CURRENT RATING OF ANY OF THE PREVIOUS ITEMS, COMPLETE THE AUTISM SPECTRUM DISORDERS (CURRENT) SECTION IN THE NEURODEVELOPMENTAL, DISRUPTIVE, AND CONDUCT DISORDERS SUPPLEMENT AFTER FINISHING THE SCREEN INTERVIEW.**

_ **IF RECEIVED A SCORE OF 3 ON PAST RATING OF ANY OF THE PREVIOUS ITEMS, COMPLETE THE AUTISM SPECTRUM DISORDERS (PAST) SECTION IN THE NEURODEVELOPMENTAL, DISRUPTIVE, AND CONDUCT DISORDERS SUPPLEMENT AFTER FINISHING THE SCREEN INTERVIEW.**

_ **NO EVIDENCE OF AUTISM SPECTRUM DISORDERS**

NOTE: (RECORD DATES OF POSSIBLE CURRENT AND PAST AUTISM SPECTRUM DISORDERS).

Codes for the Following Items: **0** = No Information **1** = No **2** = Yes

	Parent			Child			Summary		
1. Use	**0**	**1**	**2**	**0**	**1**	**2**	**0**	**1**	**2**
A. Ever smoked	( )	( )	( )	( )	( )	( )	( )	( )	( )
B. Ever chewed tobacco	( )	( )	( )	( )	( )	( )	( )	( )	( )
C. Ever smoked (or chewed) tobacco daily for 1 month or more	( )	( )	( )	( )	( )	( )	( )	( )	( )

Notes:

DSM-5 DR# 21: Smoked?

Parent Rating: _____ Child Rating: _____

— **IF EVER USED TOBACCO, COMPLETE QUESTIONS BELOW.**

— **IF NO EVIDENCE OF TOBACCO USE, GO TO ALCOHOL USE SECTION ON THE FOLLOWING PAGE.**

	Parent	Child	Summary
2. Quantity of Tobacco Use			
A. Current Use (cigarettes/day or "dips" of chew/ day)	☐☐	☐☐	☐☐
B. Greatest amount of Use (cigarettes/ day or "dips" of chew/ day)	☐☐	☐☐	☐☐
Age (years):	☐☐		
3. Have you ever smoked or "dipped" chew at least once a day for a month or more?	**0** **1** **2** ( ) ( ) ( )	**0** **1** **2** ( ) ( ) ( )	**0** **1** **2** ( ) ( ) ( )
(1 cigarette or 1 "dip" of chew/ day or more for at least 30 days)			
Age of first regular use (in months):	☐☐☐	☐☐☐	☐☐☐
4. Ever attempt to quit	**0** **1** **2** ( ) ( ) ( )	**0** **1** **2** ( ) ( ) ( )	**0** **1** **2** ( ) ( ) ( )
5. Ever quit	**0** **1** **2** ( ) ( ) ( )	**0** **1** **2** ( ) ( ) ( )	**0** **1** **2** ( ) ( ) ( )
If yes, report longest number of months:	☐☐	☐☐	☐☐

Notes:

Codes for Remaining Items: **0** = No Information **1** = No **2** = Yes

Begin this section with a brief (2-3 minute) semi-structured interview to obtain information about drinking habits.

Probes: *How old were you when you had your first drink? What's your favorite thing to drink? Do you have a group of friends you usually drink with, or do you usually drink alone? Where do you usually drink? At home? Parties? A friend's house? The street? Bars? Are there special times when you are more likely to drink than others? School dances or other parties?How old were you when you started to drink regularly, say two drinks or more per week? In the past six months has there been at least one week in which you had at least two drinks?*

DSM-5 DR# 20: Alcoholic Beverage:

Parent Rating: _____ Child Rating: _____

	Parent	Child	Summary
1. Use			
A. Drank two drinks in one week four or more times *(one drink is equivalent to a 12oz bottle of beer, 5oz glass of wine, or 1.5oz shot of spirits/ hard liquor)*	**0 1 2** ( ) ( ) ( )	**0 1 2** ( ) ( ) ( )	**0 1 2** ( ) ( ) ( )
B. Age above (at first regular use - years):	☐☐	☐☐	☐☐
C. Current frequency of use (days per month):	☐☐	☐☐	☐☐
D. Have you ever had 3 or more drinks in a single day?	**0 1 2** ( ) ( ) ( )	**0 1 2** ( ) ( ) ( )	**0 1 2** ( ) ( ) ( )
2. Problems related to alcohol *Has drinking ever caused you any problems at home? With your parents? With your schoolwork? With your teachers? With your friends? With a job? Have you ever gotten in trouble while drinking?*	**0 1 2** ( ) ( ) ( )	**0 1 2** ( ) ( ) ( )	**0 1 2** ( ) ( ) ( )
3. Received treatment for alcohol problems?	**0 1 2** ( ) ( ) ( )	**0 1 2** ( ) ( ) ( )	**0 1 2** ( ) ( ) ( )

Notes:

— **IF RECEIVED A SCORE OF 2 ON ANY OF THE PREVIOUS ITEMS, CONTINUE WITH QUESTIONS ON THE FOLLOWING PAGE.**

— **IF NO EVIDENCE OF CURRENT OR PAST ALCOHOL USE, GO TO SUBSTANCE USE SECTION ON PAGE 43.**

	P	C	S	
1. Quantity	( )	( )	( )	**0 -** No information.
A. *How many drinks do you usually have when you sit down to drink?*	( )	( )	( )	**1 -** 1 - 2 drinks.
	( )	( )	( )	**2 -** 3 or more drinks.

PAST: [ ] [ ] [ ]
P C S

	P	C	S	
B. What's the most you ever drank in a single day? When was that? How about in the last six months? What's the most you drank in a day?	( )	( )	( )	**0 -** No information.
	( )	( )	( )	**1 -** 1 - 2 drinks.
	( )	( )	( )	**2 -** 3 or more drinks.

PAST: [ ] [ ] [ ]
P C S

	P	C	S	
2. Frequency	( )	( )	( )	**0 -** No information.
What's the most number of days in a given week that you had something to drink? Do you usually drink Friday and Saturday night? Midweek too?	( )	( )	( )	**1 -** 1 - 2 days.
	( )	( )	( )	**2 -** 3 or more days.

PAST: [ ] [ ] [ ]
P C S

	P	C	S	
3. Concern from Others about Drinking	( )	( )	( )	**0 -** No information.
Has anyone ever complained about your drinking? Friends? Parents? Teachers? Have you ever been worried about it at all?	( )	( )	( )	**1 -** No.
	( )	( )	( )	**2 -** Yes.

PAST: [ ] [ ] [ ]
P C S

— **IF RECEIVED A SCORE OF 2 ON THE CURRENT RATINGS OF ANY OF THE ABOVE ITEMS, COMPLETE THE ALCOHOL USE DISORDER (CURRENT) SECTION IN THE EATING DISORDERS AND SUBSTANCE-RELATED DISORDERS SUPPLEMENT AFTER COMPLETING THE SCREEN INTERVIEW.**

— **IF RECEIVED A SCORE OF 2 ON THE PAST RATINGS OF ANY OF THE ABOVE ITEMS, COMPLETE THE ALCOHOL USE DISORDER (PAST) SECTION IN THE EATING DISORDERS AND SUBSTANCE-RELATED DISORDERS SUPPLEMENT AFTER COMPLETING THE SCREEN INTERVIEW.**

— **NO EVIDENCE OF ALCOHOL USE DISORDER.**

NOTE: (RECORD DATE OF POSSIBLE CURRENT AND PAST ALCOHOL USE DISORDERS).

Codes for Remaining Items: **0** = No Information **1** = No **2** = Yes

Prior to beginning this section, give the subject the list of drugs included in the back of this interview packet. Remind child about the confidential nature of the interview prior to beginning probes (if appropriate).

1. Drug Use *Let me know if you have used any of the drugs on this list before, even if you have only tried them once. Which ones have you used?*

DSM-5 DR# 22: Marijuana, cocaine, etc:

Parent: _____ Child: _____

DSM-5 DR# 23: Use medications without MD prescription:

Parent: _____ Child Rating: _____

	Parent Ever			Child Ever			Summary Ever		
	0	1	2	0	1	2	0	1	2
a. Cannabis *Marijuana, pot, hash, THC*	( )	( )	( )	( )	( )	( )	( )	( )	( )
b. Stimulants *Speed, uppers, amphetamines, dexedrine, diet pills, crystal meth*	( )	( )	( )	( )	( )	( )	( )	( )	( )
c. Sedatives/Hypnotics/Anxiolytics *Barbiturates (sedatives, downers), Benzodiazepine, quaalude (ludes), valium, librium, xanax*	( )	( )	( )	( )	( )	( )	( )	( )	( )
d. Cocaine *Coke, crack*	( )	( )	( )	( )	( )	( )	( )	( )	( )
e. Opioids *Heroin, morphine, codeine, methadone, demerol, percodan, oxycontin*	( )	( )	( )	( )	( )	( )	( )	( )	( )
f. PCP *Angel dust*	( )	( )	( )	( )	( )	( )	( )	( )	( )
g. Hallucinogens *Psychedelics, LSD, mescaline, peyote*	( )	( )	( )	( )	( )	( )	( )	( )	( )
h. Solvents/Inhalants *Glue, gasoline, chloroform, ether, paint*	( )	( )	( )	( )	( )	( )	( )	( )	( )
i. Other *Prescription drugs, nitrous oxide, ecstasy, MDA, etc.* Specify: _____	( )	( )	( )	( )	( )	( )	( )	( )	( )
j. Polysubstance (Assess for combined use of all listed substances)	( )	( )	( )	( )	( )	( )	( )	( )	( )

Notes:

— **IF USED ANY DRUGS, COMPLETE ITEM ON THE FOLLOWING PAGE.**

— **IF NO EVIDENCE OF CURRENT OR PAST SUBSTANCE USE, GO TO POST-TRAUMATIC STRESS DISORDER SECTION ON PAGE 46.**

1. Frequency

In the past six months, what is the most you have used _____? Every day or almost every day for at least one week? Less? More? Was there a time when you used _____ more?

Criteria:
0 = No information.
1 = Not present.
2 = Less than once a month.
3 = More than once a month.

	Parent CE	Parent MSP	Child CE	Child MSP	Summary CE	Summary MSP
a. Cannabis *Marijuana, pot, hash, THC*	0 1 2 3 ( ) ( ) ( ) ( )	0 1 2 3 ( ) ( ) ( ) ( )	0 1 2 3 ( ) ( ) ( ) ( )	0 1 2 3 ( ) ( ) ( ) ( )	0 1 2 3 ( ) ( ) ( ) ( )	0 1 2 3 ( ) ( ) ( ) ( )
b. Stimulants *Speed, uppers, amphetamines, dexedrine, diet pills, crystal meth*	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )
c. Sedatives/Hypnotics/Anxiolytics *Barbiturates (sedatives, downers), Benzodiazepine, quaalude (ludes), valium, librium, xanax*	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )
d. Cocaine *Coke, crack*	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )
e. Opioids *Heroin, morphine, codeine, oxycontin methadone, demerol, percodan*	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )
f. PCP *Angel dust*	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )
g. Hallucinogens *Psychedelics, LSD, mescaline, peyote*	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )
h. Solvents/Inhalants *Glue, gasoline, chloroform, ether, paint*	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )
i. Other *Prescription drugs, nitrous oxide, ecstasy, MDA, etc.* Specify: _____	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )
j. Polysubstance (Assess for combined use of all listed substances)	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )

Notes:

Codes for Remaining Items: **0** = No Information **1** = No **2** = Yes

	Parent			Child			Summary		
2. Problems related to substance use/ abuse *Has your use of ___ ever caused you any problems at home? With your parents? With your schoolwork? With teachers? With friends? With the police?*	**0** ( )	**1** ( )	**2** ( )	**0** ( )	**1** ( )	**2** ( )	**0** ( )	**1** ( )	**2** ( )

Notes:

— **IF RECEIVED A SCORE OF 3 ON THE CURRENT FREQUENCY ITEM FOR ANY DRUG, COMPLETE THE SUBSTANCE ABUSE (CURRENT) SECTION IN THE EATING DISORDERS AND SUBSTANCE-RELATED DISORDERS SUPPLEMENT AFTER FINISHING SCREEN INTERVIEW.**

— **IF RECEIVED A SCORE OF 3 ON THE PAST FREQUENCY ITEM FOR ANY DRUG, COMPLETE THE SUBSTANCE ABUSE (PAST) SECTION IN THE EATING DISORDERS AND SUBSTANCE-RELATED DISORDERS SUPPLEMENT AFTER FINISHING SCREEN INTERVIEW.**

— **NO EVIDENCE OF SUBSTANCE USE DISORDER.**

NOTE: (RECORD DATE OF POSSIBLE CURRENT AND PAST SUBSTANCE ABUSE).

Codes for the Following Items: **0** = No Information **1** = No **2** = Yes

1. Traumatic Events

Probe:

I am going to ask you about a number of bad things that sometimes happen to children your age, and I want you to tell me if any of these things have ever happened to you. Be sure to tell me if any of these things have ever happened, even if they only happened one time.

	Criteria	Parent Ever	Child Ever	Summary Ever
A. Car Accident *Have you ever been in a bad car accident?* *What happened?* *Were you hurt?* *Was anyone else in the car hurt?*	Significant car accident in which child or other individual in car was injured and required medical intervention.	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )
B. Other Accident *Have you ever been in any other type of bad accidents?* *What about a biking accident?* *Other accidents?* *What happened?* *Were you hurt?*	Significant accident in which child was injured and required medical intervention.	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )
C. Fire *Were you ever in a serious fire?* *Did your house or school ever catch on fire?* *Did you ever start a fire that got out of control? What happened?* *Did anyone get hurt?* *Was there a lot of damage?*	Child close witness to fire that caused significant property damage or moderate to severe physical injuries.	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )
D. Witness of a Disaster *Have you ever been in a really bad storm, like a tornado or a hurricane?* *Have you ever been caught in floods with waters that were deep enough to swim in?*	Child witness to natural disaster that caused significant devastation.	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )

Codes for the Following Items: **0** = No Information **1** = No **2** = Yes

1. Traumatic Events (cont')

Probe:

I am going to ask you about a number of bad things that sometimes happen to children your age, and I want you to tell me if any of these things have ever happened to you. Be sure to tell me if any of these things have ever happened, even if they only happened one time.

	Criteria	Parent Ever	Child Ever	Summary Ever
E. Witness of a Violent Crime *Did you ever see someone rob someone or shoot them? Steal from a store or jump someone? Take someone hostage? What happened? Where were you when this happened?Was anyone hurt?*	Child close witness to threatening or violent crime.	**0** **1** **2** ( ) ( ) ( )	**0** **1** **2** ( ) ( ) ( )	**0** **1** **2** ( ) ( ) ( )
F. Victim of Violent Crime *Did anyone ever mug you or attack you in some other way? What happened? Were you hurt?*	Child victim of seriously threatening or violent crime.	**0** **1** **2** ( ) ( ) ( )	**0** **1** **2** ( ) ( ) ( )	**0** **1** **2** ( ) ( ) ( )
G. Confronted with Traumatic News *Have you ever gotten some really bad news unexpectedly? Like found out someone you loved just died or was sick and would never get better?*	Learned about sudden, unexpected death of a loved one, or that loved one has life-threatening disease.	**0** **1** **2** ( ) ( ) ( )	**0** **1** **2** ( ) ( ) ( )	**0** **1** **2** ( ) ( ) ( )
H. Terrorism Related Trauma *Were you affected by the events of Boston Marathon bombing or any other terrorist attack?*	Loved one missing for extended period of time or seriously injured or killed by terrorist attack.	**0** **1** **2** ( ) ( ) ( )	**0** **1** **2** ( ) ( ) ( )	**0** **1** **2** ( ) ( ) ( )

Codes for the Following Items: **0** = No Information **1** = No **2** = Yes

1. Traumatic Events (cont')

Probe:

I am going to ask you about a number of bad things that sometimes happen to children your age, and I want you to tell me if any of these things have ever happened to you. Be sure to tell me if any of these things have ever happened, even if they only happened one time.

	Criteria	Parent Ever	Child Ever	Summary Ever
I. War Zone Trauma		0 1 2	0 1 2	0 1 2
		( ) ( ) ( )	( ) ( ) ( )	( ) ( ) ( )
Have you ever lived in a war zone? *Had your home attacked?* *Witnessed the killing or rape of others?* *Seen everything around you set on fire?*	Lived in war zone. Witnessed death and mass destruction.			

Protective Services: Has your family ever received services from CYS/ DCF? ○ **Current** ○ **Past**

J. Witness to Domestic Violence		0 1 2	0 1 2	0 1 2
		( ) ( ) ( )	( ) ( ) ( )	( ) ( ) ( )
Some kids' parents have a lot of nasty fights. They call each other bad names, throw things, threaten to do bad things to each other, or sometimes really hurt each other. *Did your parents (or does your mother and her boyfriend) ever get in really bad fights?* *Tell me about the worst fight you remember your parents having. What happened?*	Child witness to explosive arguments involving threatened or actual harm to parent.			

K. Physical Abuse		0 1 2	0 1 2	0 1 2
		( ) ( ) ( )	( ) ( ) ( )	( ) ( ) ( )
When your parents got mad at you, did they hit you? *Have you ever been hit so that you had bruises or marks on your body, or were hurt in some way? What happened?*	Bruises sustained on more than one occasion, or more serious injury sustained.			

Codes for the Following Items: **0** = No Information **1** = No **2** = Yes

1. Traumatic Events (cont')

Probe:

I am going to ask you about a number of bad things that sometimes happen to children your age, and I want you to tell me if any of these things have ever happened to you. Be sure to tell me if any of these things have ever happened, even if they only happened one time.

	Criteria	Parent Ever	Child Ever	Summary Ever
L. Sexual Abuse *Did anyone ever touch you in your private parts when they shouldn't have? What happened?* *Has someone ever touched you in a way that made you feel bad?* *Has anyone who shouldn't have ever made you undress, touch you between the legs, make you get in bed with him/ her, or make you play with his private parts?* *Was CYF ever involved with your family?*	Isolated or repeated incidents of genital fondling, oral sex, or vaginal or anal intercourse.	**0 1 2** ( ) ( ) ( )	**0 1 2** ( ) ( ) ( )	**0 1 2** ( ) ( ) ( )
M. Other *Is there anything else that happened to you that was really bad, or something else you saw that was really scary, that you want to tell me about?* **If parental substance abuse and/ or neglect known or suspected:** *Has there ever been a time when your mom or dad went on a drug binge and left you and your siblings alone for a day or longer? Were you worried they wouldn't come home or that something bad happened to them?*	Record incident below. Incident:	**0 1 2** ( ) ( ) ( )	**0 1 2** ( ) ( ) ( )	**0 1 2** ( ) ( ) ( )

— **IF EVIDENCE OF PAST TRAUMA (A SCORE OF "2" ON ANY ITEM), COMPLETE THE POST-TRAUMATIC STRESS DISORDER QUESTIONS ON THE FOLLOWING PAGE.**

— **IF NO EVIDENCE OF PAST TRAUMA, END THE SCREENING INTERVIEW. COMPLETE PRELIMINARY LIFETIME DIAGNOSES WORKSHEET AND APPROPRIATE SUPPLEMENTS.**

NOTE: (RECORD DATES OF PAST TRAUMATIC EVENTS).

Codes for the Following Items: **0** = No Information **1** = No **2** = Yes

***NOTE**: If more than one traumatic event was endorsed, inquire about symptom presence in relation to **ANY** of the traumas.*

NOTE: IN DISCUSSING TRAUMATIC EVENTS WITH CHILDREN, IT IS IMPORTANT TO USE THEIR LANGUAGE IN YOUR DIALOGUE. (e.g., Do you think about when he stuck his pee-pee up your bum often?)

	Parent CE	Parent MSP	Child CE	Child MSP	Summary CE	Summary MSP
1. Recurrent Memories, Thoughts, or Images *Has there ever been a time when you kept seeing _____ again and again?* *How often did this happen?* *Did what happened keep coming into your mind?* *Did you think about it a lot?*	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )
2. Feelings of Detachment *Is it hard for you to trust other people?* *Do you feel like being alone more often than before?* *Like you just don't feel like being around people now that you used to like being around before?* *Do you feel alone even when you are with other people?*	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )
3. Efforts to Avoid Activities or Situations that Remind you of the Trauma *Are there places or things that remind you of ____? Do you try to avoid them? You said before that ___ sometimes reminds you of what happened. Do you try to avoid ___?*	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )
4. Nightmares *Has there ever been a time when you had a lot of nightmares?* *Did you ever dream about _____? How often?* *Do you have other scary dreams?*	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )

Note: **In children content of dreams may be frightening without directly relating to trauma**.

Codes for the Following Items: **0** = No Information **1** = No **2** = Yes

	Parent CE	Parent MSP	Child CE	Child MSP	Summary CE	Summary MSP
5. **Hypervigilance**	**0 1 2**	**0 1 2**	**0 1 2**	**0 1 2**	**0 1 2**	**0 1 2**
Since _____ happened, are you more careful? Do you feel like you always have to watch what's going on around you? Do you double check the doors or windows to make sure they are locked?	( ) ( ) ( )	( ) ( ) ( )	( ) ( ) ( )	( ) ( ) ( )	( ) ( ) ( )	( ) ( ) ( )

— **IF RECEIVED A SCORE OF 2 ON CURRENT RATINGS OF ANY OF THE PRECEDING ITEMS, COMPLETE THE CURRENT AND PAST POST-TRAUMATIC STRESS DISORDER ITEMS IN THE ANXIETY, OBSESSIVE COMPULSIVE, AND TRAUMA-RELATED DISORDERS SUPPLEMENT.**

— **IF RECEIVED A SCORE OF 2 ON PAST RATINGS OF ANY OF THE PRECEDING ITEMS, COMPLETE THE CURRENT AND PAST POST-TRAUMATIC STRESS DISORDER ITEMS IN THE ANXIETY, OBSESSIVE COMPULSIVE, AND TRAUMA-RELATED DISORDERS SUPPLEMENT.**

— **NO EVIDENCE OF POST-TRAUMATIC STRESS DISORDER .**

NOTE: (RECORD DATES OF POSSIBLE CURRENT AND PAST POST-TRAUMATIC STRESS DISORDER).

DIRECTIONS: *Check the sections to be completed in each supplement. Note dates and/or ages of onset for each current and past possible disorder.*

Supplement #1: Depressive and Bipolar Related Disorders

_____ Depressive Disorders - Current
_____ Depressive Disorders - Past
_____ Mania - Current
_____ Mania - Past
_____ Disruptive Mood Dysregulation Disorder - Current
_____ Disruptive Mood Dysregulation Disorder - Past

Supplement #2: Schizophrenia Spectrum and Other Psychotic Disorders

_____ Psychosis - Current
_____ Psychosis - Past

Supplement #3: Anxiety, Obsessive Compulsive, and Trauma-Related Disorders

_____ Panic Disorders - Current
_____ Panic Disorders - Past
_____ Agoraphobia - Current
_____ Agoraphobia - Past
_____ Separation Disorders - Current
_____ Separation Disorders - Past
_____ Social Anxiety/Selective Mutism - Current
_____ Social Anxiety/Selective Mutism - Past
_____ Specific Phobias - Current
_____ Specific Phobias - Past
_____ Generalized Disorders - Current
_____ Generalized Disorders - Past
_____ Obsessive Compulsive Disorder -Current
_____ Obsessive Compulsive Disorder - Past
_____ Posttraumatic Stress Disorder - Current
_____ Posttraumatic Stress Disorder - Past

Supplement #4: Neurodevelopmental, Disruptive, and Conduct Disorders

_____ ADHD - Current
_____ ADHD - Past
_____ Oppositional Disorder -Current
_____ Oppositional Disorder - Past
_____ Conduct Disorder - Current
_____ Conduct Disorder - Past
_____ Tic Disorders - Current
_____ Tic Disorders - Past
_____ Autism Spectrum Disorders - Current
_____ Autism Spectrum Disorders - Past

Supplement #5: Eating Disorders and Substance-Related Disorders

_____ Eating Disorders - Current
_____ Eating Disorders - Past
_____ Alcohol Use Disorder - Current
_____ Alcohol Use Disorder - Past
_____ Substance Use Disorders - Current
_____ Substance Use Disorders - Past