

Carol Clifton, Ph.D. Diagnosis Questionnaire

Instructions: The following questions, concern thoughts, feelings and experiences you may have had in the recent past. Please read each question carefully and select the answer which most closely applies to you.

1. In the last month, has there been a period two weeks or longer when nearly every day you felt sad, blue, or depressed? 1. Yes 2. No
2. In the last month, has there been a period of two weeks or longer when you were less interested in most things like work or hobbies or things you usually like to do for fun? 1. Yes 2. No
3. In the last month, has there been at least two weeks or longer when your appetite was decreased or you lost a significant amount of weight without trying to? 1. Yes 2. No
4. In the last month, has there been at least two weeks when your appetite was increased or you ate so much that you gained a significant amount of weight? 1. Yes 2. No
5. In the last month, has there been two weeks or more when nearly every night you had trouble falling asleep, staying asleep, or trouble waking up too early? 1. Yes 2. No
6. In the last month, have you had two weeks or longer when nearly everyday you were sleeping much longer than normal for you? 1. Yes 2. No
7. In the last month, has there been a period lasting two weeks or more when you lacked energy or felt tired all the time even when you had not been working hard? 1. Yes 2. No
8. In the last month, has there been two weeks or more when nearly every day you were talking or moving more slowly than is normal for you? 1. Yes 2. No
9. In the last month, has there been two weeks or more when nearly every day you had to be moving all the time that is, you couldn't sit still and paced up and down? 1. Yes 2. No

10. In the last month, has there been two weeks or more when nearly every day you felt worthless, sinful, or guilty about things you hadn't done? 1. Yes 2. No
11. In the last month, has there been two weeks or more when nearly every day you had a lot more trouble concentrating than is normal for you or were unable to make up your mind about things you ordinarily have no trouble deciding about? 1. Yes 2, No
12. In the last month, has there been a period of two weeks or more when you thought a lot about death-either your own, someone else's or death in general or that you wanted to die? 1. Yes 2. No
13. In the last month, have you felt so low that you thought about committing suicide or that you made a suicide attempt? 1. Yes 2. No
14. For the last two years, have you felt depressed or sad most days, even if you felt OK sometimes? 1. Yes 2. No
15. In the last month, have you had a spell or attack when all of a sudden you felt frightened, anxious or very uneasy in situations when most people would not be afraid or anxious? 1. Yes 2. No
16. In the last month, during one of your worst spells of suddenly feeling very frightened or uneasy did you notice that you:
- a. were short of breath or had trouble catching your breath? 1. Yes 2. No
 - b. did your heart pound or race? 1. Yes 2. No
 - c. were you dizzy or lightheaded? 1. Yes 2. No
 - d. did you have tightness, pain or discomfort in your chest or stomach? 1. Yes 2. No
17. Some people have such an unreasonably strong fear of being in a crowd, leaving home alone, traveling on buses, cars and trains, or crossing a bridge, that they get very upset in such a situation or avoid it altogether. In the last month, did you go through a period when the thought of being in such a situation made you anxious or you avoided such situations altogether? 1. Yes 2. No
18. In the last month, did you think you needed to lose weight even though people such as your friends said you had got too thin? 1. Yes 2. No
19. In the last month, have you had a period when your eating was out of control and you would eat abnormally large amounts of

- food within a few hours-that is, binge eating? 1. Yes 2. No
20. Have you been bothered by certain unpleasant thoughts that kept entering your mind against your wishes? An example would be the persistent idea that your hands are dirty or have germs on them in the last month, have you had any unpleasant thoughts like that when it really did not make sense to have them? 1. Yes 2. No
21. Some people have the unpleasant feeling that they have to do something over and over again even when they know it is really foolish, but they can't resist doing it-things like washing their hands again and again or going back several times to be sure they've locked a door or turned off the stove. In the past month, have you ever had to do something like that over and over? 1. Yes 2. No
22. During the last six months or more, have you been anxious and worrying a lot about things for most of the time? 1. Yes 2. No
23. Does your doctor think that you worry too much about your physical health? 1. Yes 2. No
24. In the last 12 months, was there a time when you had five or more drinks (beer, wine, or liquor) on one occasion? 1. Yes 2. No
25. In the last 12 months, were there objections about your drinking from your family, friends, your doctor, or your clergyman? 1. Yes 2. No
26. In the last 12 months:
- a. Did your drinking cause you trouble at work or school? 1. Yes 2. No
 - b. Did you get into fights while drinking? 1. Yes 2. No
 - c. Have the police stopped or arrested you or taken you to a treatment center because of drinking? 1. Yes 2. No
 - d. Did your drinking cause a breakup between you and a family member? 1. Yes 2. No
 - e. Has the money you've spent on drinking caused you financial problems? 1. Yes 2. No
27. In the last 12 months, have you been drinking in situations in which it was dangerous to be drinking, like driving a car, operation

machinery, climbing, swimming? 1. Yes 2. No

28. In the last 12 months, has your drinking or being hung over kept you from working, going to school, or taking care of children? 1. Yes 2. No

The next six questions refer to the following list of drugs:

- 1) Marijuana, hashish, bhang, ganja
- 2) Stimulants: amphetamines, "speed", Ritalin
- 3) Sedatives: tranquilizers, sleeping pills, barbiturates, seconal, valium, Librium, xanax, quaaludes
- 4) Opioids: heroin, codeine, Demerol, morphine, percodan, methadone, darvon, opium, dilaudid, "smack"
- 5) Cocaine, crack, coca leaves
- 6) PCP, "angel dust"
- 7) Psychedelics, LSD, mescaline, peyote, psilocybin, DMT, ecstasy
- 8) Inhalants/solvents: glue, toluene, gasoline

29. In the last 12 months, has a doctor ever prescribed for you any of the drugs listed above to take every day for two weeks or more? 1. Yes 2. No

30. In the last 12 months, did you use these medications in larger amounts than was prescribed or for longer period that was prescribed? 1. Yes 2. No

31. In the last 12 months, have you taken any of the drugs (1 through 8) more than 5 times either to get high, to relax, or to make you feel better, more active, or alert? 1. Yes 2. No

32. In the last 12 months, have you often been under the influence of these medicines or drugs or suffering from their after-effects while at work or school or taking care of children? 1. Yes 2. No

33. In the last 12 months, has your use of any of these medicines or drugs ever led to problems with your family, friends, at work, at school, or with police? 1. Yes 2. No

34. In the last 12 months, have there been times when you were under the influence of a medicine or drug or suffering from its after-effects when that increased your chances of getting hurt-for instance, when riding a bicycle, driving a car or boat, or operating a machine? 1. Yes 2. No

35. Has there ever been a period of at least four days when you were so happy or excited that you got into trouble or your family, friends worried about it, or a doctor said you were manic? 1. Yes 2. No
36. Has there ever been a period of at least four days when you were so irritable that you threw or broke things, started arguments, shouted at people, or hit someone? 1. Yes 2. No
37. Have you ever believed people were spying on you? 1. Yes 2. No
38. Was there ever a time when you believed people were following you? 1. Yes 2. No
39. Have you ever believed that someone was plotting against you or trying to hurt you or poison you? 1. Yes 2. No
40. Have you more than once had the experience of hearing things other people couldn't hear, such as a voice? 1. Yes 2. No
41. Have you ever had the experience of seeing something or someone that others who were present could not see-that is, had a vision when you were completely awake? 1. Yes 2. No
42. Have you ever had occasion to talk to a doctor about problems with your memory? 1. Yes 2. No

Thank you for completing this questionnaire.