

M.I.N.I.

MINI INTERNATIONAL NEUROPSYCHIATRIC INTERVIEW

English Version 7.0.0

FOR

DSM-5

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DISCLAIMER

Our aim is to assist in the assessment and tracking of patients with greater efficiency and accuracy. Before action is taken on any data collected and processed by this program, it should be reviewed and interpreted by a licensed clinician.

This program is not designed or intended to be used in the place of a full medical and psychiatric evaluation by a qualified licensed physician – psychiatrist. It is intended only as a tool to facilitate accurate data collection and processing of symptoms elicited by trained personnel. It is not a diagnostic test.

Patient Name: _____	Patient Number: _____
Date of Birth: _____	Time Interview Began: _____
Interviewer's Name: _____	Time Interview Ended: _____
Date of Interview: _____	Total Time: _____

	MODULES	TIME FRAME	MEETS CRITERIA	DSM-5	ICD-10	PRIMARY DIAGNOSIS
A	MAJOR DEPRESSIVE EPISODE	Current (2 weeks)	<input type="checkbox"/>			
		Past	<input type="checkbox"/>			
		Recurrent	<input type="checkbox"/>			
	MAJOR DEPRESSIVE DISORDER	Current (2 weeks)	<input type="checkbox"/>	296.20-296.26 Single	F32.x	<input type="checkbox"/>
		Past	<input type="checkbox"/>	296.20-296.26 Single	F32.x	<input type="checkbox"/>
		Recurrent	<input type="checkbox"/>	296.30-296.36 Recurrent	F33.x	<input type="checkbox"/>
B	SUICIDALITY	Current (Past Month)	<input type="checkbox"/>			<input type="checkbox"/>
		Lifetime attempt	<input type="checkbox"/>	<input type="checkbox"/> Low <input type="checkbox"/> Moderate <input type="checkbox"/> High		<input type="checkbox"/>
	SUICIDE BEHAVIOR DISORDER	Current	<input type="checkbox"/>	(In Past Year)		<input type="checkbox"/>
		In early remission	<input type="checkbox"/>	(1 - 2 Years Ago)		<input type="checkbox"/>
C	MANIC EPISODE	Current	<input type="checkbox"/>			
		Past	<input type="checkbox"/>			
	HYPOMANIC EPISODE	Current	<input type="checkbox"/>			
		Past	<input type="checkbox"/>	<input type="checkbox"/> Not Explored		
	BIPOLAR I DISORDER	Current	<input type="checkbox"/>	296.41-296.56	F31.0--F31.76	<input type="checkbox"/>
		Past	<input type="checkbox"/>	296.41-296.56	F31.0- F31.76	<input type="checkbox"/>
	BIPOLAR II DISORDER	Current	<input type="checkbox"/>	296.89	F31.81	<input type="checkbox"/>
		Past	<input type="checkbox"/>	296.89	F31.81	<input type="checkbox"/>
	BIPOLAR DISORDER UNSPECIFIED	Current	<input type="checkbox"/>	296.40/296.50	F31.9	<input type="checkbox"/>
		Past	<input type="checkbox"/>	296.40/296.50	F31.9	<input type="checkbox"/>
	BIPOLAR I DISORDER WITH PSYCHOTIC FEATURES	Current	<input type="checkbox"/>	296.44/296.54	F31.2/31.5	<input type="checkbox"/>
		Past	<input type="checkbox"/>	296.44/296.54	F31.2/31.5	<input type="checkbox"/>
D	PANIC DISORDER	Current (Past Month)	<input type="checkbox"/>	300.01	F41.0	<input type="checkbox"/>
		Lifetime	<input type="checkbox"/>	300.01	F40.0	<input type="checkbox"/>
E	AGORAPHOBIA	Current	<input type="checkbox"/>	300.22	F40.00	<input type="checkbox"/>
F	SOCIAL ANXIETY DISORDER (Social Phobia)	Current (Past Month)	<input type="checkbox"/>	300.23	F40.10	<input type="checkbox"/>
G	OBSESSIVE-COMPULSIVE DISORDER	Current (Past Month)	<input type="checkbox"/>	300.3	F42	<input type="checkbox"/>
H	POSTTRAUMATIC STRESS DISORDER	Current (Past Month)	<input type="checkbox"/>	309.81	F43.10	<input type="checkbox"/>
I	ALCOHOL USE DISORDER	Past 12 Months	<input type="checkbox"/>	303.9	F10.10-20	<input type="checkbox"/>
J	SUBSTANCE USE DISORDER (Non-alcohol)	Past 12 Months	<input type="checkbox"/>	304.00-.90/305.20-.90	F11.1x-F19.288	<input type="checkbox"/>
K	PSYCHOTIC DISORDERS	Lifetime	<input type="checkbox"/>	297.3/297.9/ 293.81/298.83/298.89	F20.81-F29	<input type="checkbox"/>
		Current	<input type="checkbox"/>	297.3/297.9/ 293.81/298.83/298.89	F20.81-F29	<input type="checkbox"/>
	MOOD DISORDER WITH PSYCHOTIC FEATURES	Lifetime	<input type="checkbox"/>	296.24/296.34-296.44 296.54	F31.2/F32.2/F33.3	<input type="checkbox"/>
		Current	<input type="checkbox"/>	296.24/296.34/296.44/296.54	F31.2/F32.2/F33.3	<input type="checkbox"/>
L	ANOREXIA NERVOSA	Current (Past 3 Months)	<input type="checkbox"/>	307.1	F50.01-02	<input type="checkbox"/>
M	BULIMIA NERVOSA	Current (Past 3 Months)	<input type="checkbox"/>	307.51	F50.2	<input type="checkbox"/>
MB	BINGE-EATING DISORDER	Current (Past 3 Months)	<input type="checkbox"/>	307.51	F50.8	<input type="checkbox"/>
N	GENERALIZED ANXIETY DISORDER	Current (Past 6 Months)	<input type="checkbox"/>	300.02	F41.1	<input type="checkbox"/>
O	MEDICAL, ORGANIC, DRUG CAUSE RULED OUT		<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Uncertain			
P	ANTISOCIAL PERSONALITY DISORDER	Lifetime	<input type="checkbox"/>	301.7	F60.2	<input type="checkbox"/>

IDENTIFY THE PRIMARY DIAGNOSIS BY CHECKING THE APPROPRIATE CHECK BOX.
 (Which problem troubles you the most or dominates the others or came first in the natural history?) _____ ↑

GENERAL INSTRUCTIONS

The M.I.N.I. was designed as a brief structured interview for the major Axis I psychiatric disorders in DSM-5 and ICD-10. Validation and reliability studies have been done comparing the M.I.N.I. to the SCID-P for DSM-III-R and the CIDI (a structured interview developed by the World Health Organization). The results of these studies show that the M.I.N.I. has similar reliability and validity properties, but can be administered in a much shorter period of time (mean 18.7 ± 11.6 minutes, median 15 minutes) than the above referenced instruments. Clinicians can use it, after a brief training session. Lay interviewers require more extensive training.

INTERVIEW:

In order to keep the interview as brief as possible, inform the patient that you will conduct a clinical interview that is more structured than usual, with very precise questions about psychological problems which require a yes or no answer.

GENERAL FORMAT:

The M.I.N.I. is divided into **modules** identified by letters, each corresponding to a diagnostic category.

- At the beginning of each diagnostic module (except for psychotic disorders module), screening question(s) corresponding to the main criteria of the disorder are presented in a **gray box**.
- At the end of each module, diagnostic box(es) permit the clinician to indicate whether diagnostic criteria are met.

CONVENTIONS:

Sentences written in « normal font » should be read exactly as written to the patient in order to standardize the assessment of diagnostic criteria.

Sentences written in « CAPITALS » should not be read to the patient. They are instructions for the interviewer to assist in the scoring of the diagnostic algorithms.

Sentences written in « bold » indicate the time frame being investigated. The interviewer should read them as often as necessary. Only symptoms occurring during the time frame indicated should be considered in scoring the responses.

Answers with an arrow above them (➔) indicate that one of the criteria necessary for the diagnosis or diagnoses is not met. In this case, the interviewer should go to the end of the module, circle « **NO** » in all the diagnostic boxes and move to the next module.

When terms are separated by a *slash (/)* the interviewer should read only those symptoms known to be present in the patient (for example, questions J2b or K6b).

Phrases in (parentheses) are clinical examples of the symptom. These may be read to the patient to clarify the question.

RATING INSTRUCTIONS:

All questions must be rated. The rating is done at the right of each question by circling either Yes or No. Clinical judgment by the rater should be used in coding the responses. Interviewers need to be sensitive to the diversity of cultural beliefs in their administration of questions and rating of responses. The rater should ask for examples when necessary, to ensure accurate coding. The patient should be encouraged to ask for clarification on any question that is not absolutely clear.

The clinician should be sure that each dimension of the question is taken into account by the patient (for example, time frame, frequency, severity, and/or alternatives).

Symptoms better accounted for by an organic cause or by the use of alcohol or drugs should not be coded positive in the M.I.N.I. The M.I.N.I. has questions that investigate these issues.

For any questions, suggestions, need for a training session or information about updates of the M.I.N.I., please contact:

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A. MAJOR DEPRESSIVE EPISODE

(➡ MEANS: GO TO THE DIAGNOSTIC BOX, CIRCLE **NO** IN THE DIAGNOSTIC BOX, AND MOVE TO THE NEXT MODULE)

A1	a	Were you <u>ever</u> depressed or down, or felt sad, empty or hopeless most of the day, nearly every day, for two weeks? IF NO, CODE NO TO A1b : IF YES ASK:	NO	YES
	b	For the <u>past two weeks</u> , were you depressed or down, or felt sad, empty or hopeless most of the day, nearly every day?	NO	YES
A2	a	Were you <u>ever</u> much less interested in most things or much less able to enjoy the things you used to enjoy most of the time, for two weeks? IF NO, CODE NO TO A2b : IF YES ASK:	NO	YES
	b	In the <u>past two weeks</u> , were you much less interested in most things or much less able to enjoy the things you used to enjoy, most of the time?	NO	YES
		IS A1a OR A2a CODED YES?	➡ NO	YES

A3 IF **A1b** OR **A2b** = YES: EXPLORE THE CURRENT AND THE MOST SYMPTOMATIC PAST EPISODE, OTHERWISE
IF **A1b** AND **A2b** = NO: EXPLORE ONLY THE MOST SYMPTOMATIC PAST EPISODE

Over that two week period, when you felt depressed or uninterested:

		<u>Past 2 Weeks</u>		<u>Past Episode</u>	
a	Was your appetite decreased or increased nearly every day? Did your weight decrease or increase without trying intentionally (i.e., by $\pm 5\%$ of body weight or ± 8 lb or ± 3.5 kg, for a 160 lb/70 kg person in a month)? IF YES TO EITHER, CODE YES.	NO	YES	NO	YES
b	Did you have trouble sleeping nearly every night (difficulty falling asleep, waking up in the middle of the night, early morning wakening or sleeping excessively)?	NO	YES	NO	YES
c	Did you talk or move more slowly than normal or were you fidgety, restless or having trouble sitting still almost every day? Did anyone notice this?	NO	YES	NO	YES
d	Did you feel tired or without energy almost every day?	NO	YES	NO	YES
e	Did you feel worthless or guilty almost every day? IF YES, ASK FOR EXAMPLES. LOOK FOR DELUSIONS OF FAILURE, OF INADEQUACY, OF RUIN OR OF GUILT, OR OF NEEDING PUNISHMENT OR DELUSIONS OF DISEASE OR DEATH OR NIHILISTIC OR SOMATIC DELUSIONS. THE EXAMPLES ARE CONSISTENT WITH A DELUSIONAL IDEA. Current Episode <input type="checkbox"/> No <input type="checkbox"/> Yes Past Episode <input type="checkbox"/> No <input type="checkbox"/> Yes	NO	YES	NO	YES
f	Did you have difficulty concentrating, thinking or making decisions almost every day?	NO	YES	NO	YES
g	Did you repeatedly think about death (FEAR OF DYING DOES NOT COUNT HERE), or have any thoughts of killing yourself, or have any intent or plan to kill yourself? Did you attempt suicide? IF YES TO EITHER, CODE YES.	NO	YES	NO	YES
A4	Did these symptoms cause significant distress or problems at home, at work, at school, socially, in your relationships, or in some other important way, and are they a change from your previous functioning?	NO	YES	NO	YES

A5 In between 2 episodes of depression, did you ever have an interval of at least 2 months, without any significant depression or any significant loss of interest?

N/A NO YES

ARE **5** OR MORE ANSWERS (**A1-A3**) CODED **YES** AND IS **A4** CODED YES FOR THAT TIME FRAME?

AND

IS "RULE OUT ORGANIC CAUSE (**O2** SUMMARY)" CODED **YES**?

SPECIFY IF THE EPISODE IS CURRENT AND / OR PAST.

IF **A5** IS CODED **YES**, CODE **YES** FOR RECURRENT.

NO	YES
MAJOR DEPRESSIVE EPISODE	
CURRENT	<input type="checkbox"/>
PAST	<input type="checkbox"/>
RECURRENT	<input type="checkbox"/>

A6 a How many episodes of depression did you have in your lifetime? _____

Between each episode there must be at least 2 months without any significant depression.

B. SUICIDALITY

Points

In the past month did you:

- | | | | | | | | | | | | | | | |
|--|---|-------------------------------|--------------------------------|--|---------------------------------------|---------------------------------|--------------------------------|-----------------------------------|-------------------------------------|---------------------------------|--|--|--|--|
| B1 | Have any accident? This includes taking too much of your medication accidentally.
IF NO TO B1, SKIP TO B2; IF YES, ASK B1a: | NO | YES | 0 | | | | | | | | | | |
| B1a | Plan or intend to hurt yourself in any accident, either by not avoiding a risk or by causing the accident on purpose?

IF NO TO B1a, SKIP TO B2; IF YES, ASK B1b: | NO | YES | 0 | | | | | | | | | | |
| B1b | Intend to die as a result of any accident? | NO | YES | 0 | | | | | | | | | | |
| B2 | Think (even momentarily) that you would be better off dead or wish you were dead or needed to be dead? | NO | YES | 1 | | | | | | | | | | |
| B3 | Think (even momentarily) about harming or of hurting or of injuring yourself
- with at least some intent or awareness that you might die as a result
- or think about suicide (i.e. about killing yourself)?

IF NO TO B2 + B3, SKIP TO B4. OTHERWISE ASK: | NO | YES | 6 | | | | | | | | | | |
| | <table border="0" style="width: 100%;"> <tr> <td style="width: 50%;">Frequency</td> <td style="width: 50%;">Intensity</td> </tr> <tr> <td style="border: 1px solid black; padding: 5px;"> <table border="0" style="width: 100%;"> <tr> <td style="width: 50%;">Occasionally <input type="checkbox"/></td> <td style="width: 50%;">Mild <input type="checkbox"/></td> </tr> <tr> <td>Often <input type="checkbox"/></td> <td>Moderate <input type="checkbox"/></td> </tr> <tr> <td>Very often <input type="checkbox"/></td> <td>Severe <input type="checkbox"/></td> </tr> </table> </td> <td></td> </tr> </table> | Frequency | Intensity | <table border="0" style="width: 100%;"> <tr> <td style="width: 50%;">Occasionally <input type="checkbox"/></td> <td style="width: 50%;">Mild <input type="checkbox"/></td> </tr> <tr> <td>Often <input type="checkbox"/></td> <td>Moderate <input type="checkbox"/></td> </tr> <tr> <td>Very often <input type="checkbox"/></td> <td>Severe <input type="checkbox"/></td> </tr> </table> | Occasionally <input type="checkbox"/> | Mild <input type="checkbox"/> | Often <input type="checkbox"/> | Moderate <input type="checkbox"/> | Very often <input type="checkbox"/> | Severe <input type="checkbox"/> | | | | |
| Frequency | Intensity | | | | | | | | | | | | | |
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| Occasionally <input type="checkbox"/> | Mild <input type="checkbox"/> | | | | | | | | | | | | | |
| Often <input type="checkbox"/> | Moderate <input type="checkbox"/> | | | | | | | | | | | | | |
| Very often <input type="checkbox"/> | Severe <input type="checkbox"/> | | | | | | | | | | | | | |
| B4 | Hear a voice or voices telling you to kill yourself or have dreams with any suicidal content?
If YES, was it either or both: <input type="checkbox"/> was it a voice or voices? <input type="checkbox"/> was it a dream? | NO | YES | 4 | | | | | | | | | | |
| B5 | Have a suicide method in mind (i.e. how)? | NO | YES | 8 | | | | | | | | | | |
| B6 | Have a suicide means in mind (i.e. with what)? | NO | YES | 8 | | | | | | | | | | |
| B7 | Have any place in mind to attempt suicide (i.e. where)? | NO | YES | 8 | | | | | | | | | | |
| B8 | Have any date/timeframe in mind to attempt suicide (i.e. when)? | NO | YES | 8 | | | | | | | | | | |
| B9 | Think about any task you would like to complete before trying to kill yourself?
(e.g. writing a suicide note) | NO | YES | 8 | | | | | | | | | | |
| B10 | Intend to act on thoughts of killing yourself?
If YES, mark either or both: <input type="checkbox"/> did you intend to act at the time?
<input type="checkbox"/> did you intend to act at some time in the future? | NO | YES | 8 | | | | | | | | | | |
| B11 | Intend to die as a result of a suicidal act?
If YES, mark either or both: <input type="checkbox"/> did you intend to die by suicide at the time?
<input type="checkbox"/> did you intend to die by suicide at some time in the future? | NO | YES | 8 | | | | | | | | | | |
| B12 | Feel the need or impulse to kill yourself or to plan to kill yourself sooner rather than later?
If YES, mark either or both: <input type="checkbox"/> was this to kill yourself? <input type="checkbox"/> was this to plan to kill yourself?
If YES, mark either or both: <input type="checkbox"/> was this largely unprovoked? <input type="checkbox"/> was this provoked? | NO | YES | 8 | | | | | | | | | | |

IN ASSESSING WHETHER THIS WAS LARGELY UNPROVOKED ASK: "5 minutes before this impulse, could you have predicted it would occur at that time?"

B13	Have difficulty resisting these impulses?	NO	YES	8
B14	Take any active steps to prepare for a suicide attempt in which you expected or intended to die (include anything done or purposely not done that put you closer to making a suicide attempt)? This includes times when you were going to kill yourself, but were interrupted or stopped yourself, before harming yourself. IF NO TO B14, SKIP TO B15.	NO	YES	
B14a	Take active steps to prepare to kill yourself, but you did not start the suicide attempt?	NO	YES	9
B14b	Take active steps to prepare to kill yourself, but then you stopped yourself just before harming yourself ("aborted").	NO	YES	10
B14c	Take active steps to prepare to kill yourself, but then someone or something stopped you just before harming yourself ("interrupted")?	NO	YES	11
B15	Injure yourself on purpose without intending to kill yourself?	NO	YES	0
B16	Attempt suicide (to kill yourself)? IF NO TO B16, SKIP TO B17.	NO	YES	
B16a	Start a suicide attempt (to kill yourself), but then you decided to stop and did not finish the attempt?	NO	YES	12
B16b	Start a suicide attempt (to kill yourself), but then you were interrupted and did not finish the attempt?	NO	YES	13
B16c	Went through with a suicide attempt (to kill yourself), completely as you meant to? A suicide attempt means you did something where you could possibly be injured, with at least a slight intent to die. IF NO, SKIP TO B17:	NO	YES	14
	Hope to be rescued / survive <input type="checkbox"/>			
	Expected / intended to die <input type="checkbox"/>			
B17	TIME SPENT PER DAY WITH ANY SUICIDAL IMPULSES, THOUGHTS OR ACTIONS: Usual time spent per day: ____ hours ____ minutes. Least amount of time spent per day: ____ hours ____ minutes. Most amount of time spent per day: ____ hours ____ minutes. In your lifetime:			
B18	Did you ever make a suicide attempt (try to kill yourself)? If YES, how many times? _____ If YES, when was the last suicide attempt? Current: within the past 12 months <input type="checkbox"/> In early remission: between 12 and 24 months ago <input type="checkbox"/> In remission: more than 24 months ago <input type="checkbox"/>	NO	YES	4
	"A suicide attempt is any self injurious behavior, with at least some intent (> 0) to die as a result of the act. Evidence that the individual intended to kill him- or herself, at least to some degree, can be explicit or inferred from the behavior or circumstance. For example, it is defined as a suicide attempt if it is clearly not an accident or if the individual thinks the act could be lethal, even though denying intent." (FDA Guidance for Industry Suicidal Ideation and Behavior Document 2012 and C-CASA definition). Posner K et al. Am J Psychiatry 2007; 164 (7): 1035-1043 & http://www.fda.gov/Drugs/GuidanceComplianceRegulatoryInformation/Guidances/default.htm/			
B19	How likely are you to try to kill yourself within the next 3 months on a scale of 0-100% _____% ANY LIKELIHOOD > 0% ON B19 SHOULD BE CODED YES	NO	YES	13

IS AT LEAST **1** OF THE ABOVE (EXCEPT B1) CODED **YES**?

IF YES, ADD THE TOTAL POINTS FOR THE ANSWERS (B1-B19) CHECKED 'YES' AND SPECIFY THE SUICIDALITY SCORE CATEGORY AS INDICATED IN THE DIAGNOSTIC BOX:

INDICATE WHETHER THE SUICIDALITY IS CURRENT (PAST MONTH) OR A LIFETIME SUICIDE ATTEMPT OR BOTH BY MARKING THE APPROPRIATE BOXES OR BY LEAVING EITHER OR BOTH OF THEM UNMARKED.

CURRENT = ANY POSITIVE RESPONSE IN B1a THROUGH B16c OR ANY TIME SPENT IN B17. LIFETIME ATTEMPT = B18 CODED YES.

LIKELY IN THE NEAR FUTURE = B19 CODED YES.

MAKE ANY ADDITIONAL COMMENTS ABOUT YOUR ASSESSMENT OF THIS PATIENT'S CURRENT AND NEAR FUTURE SUICIDALITY IN THE SPACE BELOW:

NO	YES
SUICIDALITY	
1-8 points	Low <input type="checkbox"/>
9-16 points	Moderate <input type="checkbox"/>
≥ 17 points	High <input type="checkbox"/>
CURRENT	<input type="checkbox"/>
LIFETIME ATTEMPT	<input type="checkbox"/>
LIKELY IN NEAR FUTURE	<input type="checkbox"/>

IS **B18** CODED YES?

AND A YES RESPONSE TO

Was the suicidal act started when the subject not in a state of confusion or delirium?

AND A YES RESPONSE TO

Was the suicidal act done without a political or religious purpose?

IF YES, SPECIFY WHETHER THE DISORDER IS CURRENT, IN EARLY REMISSION OR IN REMISSION.

NO	YES
SUICIDAL BEHAVIOR DISORDER	
CURRENT	
Current	<input type="checkbox"/>
In early remission	<input type="checkbox"/>
In remission	<input type="checkbox"/>

C. MANIC AND HYPOMANIC EPISODES

(➔ MEANS: GO TO THE DIAGNOSTIC BOXES, CIRCLE **NO** IN MANIC AND HYPOMANIC DIAGNOSTIC BOXES, AND MOVE TO NEXT MODULE)

Do you have any family history of manic-depressive illness or bipolar disorder, or any family member who had mood swings treated with a medication like lithium, sodium valproate (Depakote) or lamotrigine (Lamictal)?

NO YES

THIS QUESTION IS NOT A CRITERION FOR BIPOLAR DISORDER, BUT IS ASKED TO INCREASE THE CLINICIAN'S VIGILANCE ABOUT THE RISK FOR BIPOLAR DISORDER.

IF YES, PLEASE SPECIFY WHO: _____

C1 a Have you **ever** had a period of time when you were feeling 'up' or 'high' or 'hyper' and so active or full of energy or full of yourself that you got into trouble, - or that other people thought you were not your usual self? (Do not consider times when you were intoxicated on drugs or alcohol.)

NO YES

IF PATIENT IS PUZZLED OR UNCLEAR ABOUT WHAT YOU MEAN

BY 'UP' OR 'HIGH' OR 'HYPER', CLARIFY AS FOLLOWS: By 'up' or 'high' or 'hyper'

I mean: having elated mood; increased energy or increased activity; needing less sleep; having rapid thoughts; being full of ideas; having an increase in productivity, motivation, creativity, or impulsive behavior; phoning or working excessively or spending more money.

IF NO, CODE NO TO **C1b**: IF YES ASK:

b Are you currently feeling 'up' or 'high' or 'hyper' or full of energy?

NO YES

C2 a Have you **ever** been persistently irritable, for several days, so that you had arguments or verbal or physical fights, or shouted at people outside your family? Have you or others noticed that you have been more irritable or over reacted, compared to other people, even in situations that you felt were justified?

NO YES

IF NO, CODE NO TO **C2b**: IF YES ASK:

b Are you currently feeling persistently irritable?

NO YES

IS **C1a** OR **C2a** CODED YES? ➔

NO YES

C3 IF **C1b** OR **C2b** = **YES**: EXPLORE THE **CURRENT** EPISODE FIRST AND THEN THE MOST SYMPTOMATIC **PAST** EPISODE, OTHERWISE IF **C1b** AND **C2b** = **NO**: EXPLORE ONLY THE MOST SYMPTOMATIC **PAST** EPISODE

WHEN EXPLORING THE CURRENT EPISODE, PREFACE EACH QUESTION AS FOLLOWS:

Over the past few days including today, when you felt high and full of energy or irritable, did you:

WHEN EXPLORING THE PAST EPISODE, PREFACE EACH QUESTION AS FOLLOWS:

Over a period of a few days in the past, when you felt most high and most full of energy or most irritable, did you:

	Current Episode		Past Episode	
a Feel that you could do things others couldn't do, or that you were an especially important person? If YES, ASK FOR EXAMPLES. <small>THE EXAMPLES ARE CONSISTENT WITH A DELUSIONAL IDEA.</small>	NO	YES	NO	YES
Current Episode <input type="checkbox"/> No <input type="checkbox"/> Yes				
Past Episode <input type="checkbox"/> No <input type="checkbox"/> Yes				
b Need less sleep (for example, feel rested after only a few hours sleep)?	NO	YES	NO	YES

	<u>Current Episode</u>		<u>Past Episode</u>	
c Talk too much without stopping, or felt a pressure to keep talking?	NO	YES	NO	YES
d Notice your thoughts going very fast or running together or racing or moving very quickly from one subject to another?	NO	YES	NO	YES
e Become easily distracted so that any little interruption could distract you?	NO	YES	NO	YES
f Have a significant increase in your activity or drive, at work, at school, socially or sexually or did you become physically or mentally restless? This increase in activity may be with or without a purpose.	NO	YES	NO	YES
g Want so much to engage in pleasurable activities that you ignored the risks or consequences (for example, spending sprees, reckless driving, or sexual indiscretions)?	NO	YES	NO	YES
C3 SUMMARY: WHEN RATING CURRENT EPISODE:	NO	YES	NO	YES
IF C1b IS NO, ARE 4 OR MORE C3 ANSWERS INCLUDING C3f CODED YES?				
IF C1b IS YES, ARE 3 OR MORE C3 ANSWERS INCLUDING C3f CODED YES?				
WHEN RATING PAST EPISODE:				
IF C1a IS NO, ARE 4 OR MORE C3 ANSWERS INCLUDING C3f CODED YES?				
IF C1a IS YES, ARE 3 OR MORE C3 ANSWERS INCLUDING C3f CODED YES?				
CODE YES ONLY IF THE ABOVE 3 OR 4 SYMPTOMS OCCURRED DURING THE SAME TIME PERIOD.				
RULE: ELATION/EXPANSIVENESS REQUIRES ONLY THREE C3 SYMPTOMS, WHILE IRRITABLE MOOD ALONE REQUIRES 4 OF THE C3 SYMPTOMS.				
C4 What is the longest time these symptoms lasted (most of the day nearly every day)? ASSESS THIS DURATION FROM THE VERY START TO THE VERY END OF SYMPTOMS, NOT JUST THE PEAK.				
a) 3 days or less		<input type="checkbox"/>		<input type="checkbox"/>
b) 4 days or more		<input type="checkbox"/>		<input type="checkbox"/>
c) 7 days or more		<input type="checkbox"/>		<input type="checkbox"/>
C5 Were you hospitalized for these problems?	NO	YES	NO	YES
IF YES, CIRCLE YES IN MANIC EPISODE FOR THAT TIME FRAME AND GO TO C7.				
C6 Did these symptoms cause significant problems at home, at work, socially, in your relationships, at school or in some other important way?	NO	YES	NO	YES
C7 Were these symptoms associated with a clear change in the way that you previously functioned and that was different from the way that you usually are?	NO	YES	NO	YES

ARE **C3** SUMMARY AND **C7** AND (**C4c** OR **C5** OR **C6** OR ANY PSYCHOTIC FEATURE IN **K1** THROUGH **K8**) CODED **YES**

AND

IS "RULE OUT ORGANIC CAUSE (**O2** SUMMARY)" CODED **YES**?

SPECIFY IF THE EPISODE IS CURRENT AND / OR PAST.

NO	YES
MANIC EPISODE	
CURRENT	<input type="checkbox"/>
PAST	<input type="checkbox"/>

IS **C3** SUMMARY CODED **YES** AND ARE **C5** AND **C6** CODED **NO** AND **C7** CODED **YES**,
AND IS EITHER **C4b** OR **C4c** CODED **YES**?

AND

IS "RULE OUT ORGANIC CAUSE (**O2** SUMMARY)" CODED **YES**?

AND

ARE ALL PSYCHOTIC FEATURES IN K1 THROUGH K8 CODED **NO**?

SPECIFY IF THE EPISODE IS CURRENT AND / OR PAST.

IF **YES** TO CURRENT MANIC EPISODE, THEN CODE CURRENT HYPOMANIC EPISODE AS **NO**.

IF **YES** TO PAST MANIC EPISODE, THEN CODE PAST HYPOMANIC EPISODE AS **NOT EXPLORED**.

HYPOMANIC EPISODE

CURRENT **NO**

YES

PAST **NO**

YES

NOT EXPLORED

ARE **C3** SUMMARY AND **C4a** CODED **YES** AND IS **C5** CODED **NO**?

SPECIFY IF THE EPISODE IS CURRENT AND / OR PAST.

IF **YES** TO CURRENT MANIC EPISODE OR HYPOMANIC EPISODE,
THEN CODE CURRENT HYPOMANIC SYMPTOMS AS **NO**.

IF **YES** TO PAST MANIC EPISODE OR YES TO PAST HYPOMANIC EPISODE,
THEN CODE PAST HYPOMANIC SYMPTOMS AS **NOT EXPLORED**.

HYPOMANIC SYMPTOMS

CURRENT **NO**

YES

PAST **NO**

YES

NOT EXPLORED

C8

a) IF MANIC EPISODE IS POSITIVE FOR EITHER CURRENT OR PAST ASK:

Did you have 2 or more of these (manic) episodes lasting 7 days or more (**C4c**) in your lifetime (including the current episode if present)?

NO YES

b) IF MANIC OR HYPOMANIC EPISODE IS POSITIVE FOR EITHER CURRENT OR PAST ASK:

Did you have 2 or more of these (hypomanic) episodes lasting 4 days or more (**C4b**) in your lifetime (including the current episode)?

NO YES

c) IF THE PAST "HYPOMANIC SYMPTOMS" CATEGORY IS CODED POSITIVE ASK:

Did you have these hypomanic symptoms lasting only 1 to 3 days (**C4a**) 2 or more times in your lifetime, (including the current episode if present)?

NO YES

D. PANIC DISORDER

(➡ MEANS: GO TO THE DIAGNOSTIC BOX, CIRCLE NO AND MOVE TO THE NEXT MODULE)

D1	a	Have you, on more than one occasion, had spells or attacks when you suddenly felt anxious, very frightened, uncomfortable or uneasy, even in situations where most people would not feel that way?	➡ NO	YES
	b	Did the spells surge to a peak within 10 minutes of starting?	➡ NO	YES
D2		At any time in the past, did any of those spells or attacks come on unexpectedly or occur in an unpredictable or unprovoked manner?	➡ NO	YES
D3		Have you ever had one such attack followed by a month or more of persistent concern about having another attack, or worries about the consequences of the attack - or did you make any significant change in your behavior because of the attacks (e.g., avoiding unfamiliar situations, or avoiding leaving your house or shopping alone, or doing things to avoid having a panic attack or visiting your doctor or the emergency room more frequently)?	NO	YES
D4		During the worst attack that you can remember:		
	a	Did you have skipping, racing or pounding of your heart?	NO	YES
	b	Did you have sweating or clammy hands?	NO	YES
	c	Were you trembling or shaking?	NO	YES
	d	Did you have shortness of breath or difficulty breathing or a smothering sensation?	NO	YES
	e	Did you have a choking sensation or a lump in your throat?	NO	YES
	f	Did you have chest pain, pressure or discomfort?	NO	YES
	g	Did you have nausea, stomach problems or sudden diarrhea?	NO	YES
	h	Did you feel dizzy, unsteady, lightheaded or feel faint?	NO	YES
	i	Did you have hot flushes or chills?	NO	YES
	j	Did you have tingling or numbness in parts of your body?	NO	YES
	k	Did things around you feel strange, unreal, detached or unfamiliar, or did you feel outside of or detached from part or all of your body?	NO	YES
	l	Did you fear that you were losing control or going crazy?	NO	YES
	m	Did you fear that you were dying?	NO	YES
D5		ARE BOTH D3 , AND 4 OR MORE D4 ANSWERS, CODED YES?	➡ NO	YES <i>PANIC DISORDER LIFETIME</i>
D6		In the past month did you have persistent concern about having another attack, or worry about the consequences of the attacks, or did you change your behavior in any way because of the attacks?	NO	YES <i>PANIC DISORDER CURRENT</i>

IS EITHER **D5** OR **D6** CODED YES,

AND

IS "RULE OUT ORGANIC CAUSE (**O2** SUMMARY)" CODED YES?

SPECIFY IF THE EPISODE IS CURRENT AND / OR LIFETIME.

NO	YES
PANIC DISORDER	
LIFETIME	<input type="checkbox"/>
CURRENT	<input type="checkbox"/>

E. AGORAPHOBIA

(➔ MEANS: GO TO THE DIAGNOSTIC BOX, CIRCLE **NO** AND MOVE TO THE NEXT MODULE)

E1 Do you feel anxious or uneasy in places or situations where help might not be available or escape might be difficult if you had a panic attack or panic-like or embarrassing symptoms, like: being in a crowd, or standing in a line (queue), being in an open space or when crossing a bridge, being in an enclosed space, when you are alone away from home, or alone at home, or traveling in a bus, train or car or using public transportation? ➔ NO YES

ARE 2 OR MORE **E1** SITUATIONS CODED YES? ➔ NO YES

E2 Do these situations almost always bring on fear or anxiety? ➔ NO YES

E3 Do you fear these situations so much that you avoid them, or suffer through them, or need a companion to face them? ➔ NO YES

E4 Is this fear or anxiety excessive or out of proportion to the real danger in the situation? ➔ NO YES

E5 Did this avoidance, fear or anxiety persist for at least 6 months? ➔ NO YES

E6 Did these symptoms cause significant distress or problems at home, at work, socially, at school or in some other important way? ➔ NO YES

IS **E6** CODED YES?

NO	YES
AGORAPHOBIA CURRENT	

F. SOCIAL ANXIETY DISORDER (Social Phobia)

(➔ MEANS: GO TO THE DIAGNOSTIC BOX, CIRCLE NO AND MOVE TO THE NEXT MODULE)

F1	In the past month, did you have persistent fear and significant anxiety at being watched, being the focus of attention, or of being humiliated or embarrassed or rejected? This includes things like speaking in public, eating in public or with others, writing while someone watches, performing in front of others or being in social situations.	➔ NO	YES
----	---	---------	-----

EXAMPLES OF SUCH SOCIAL SITUATIONS TYPICALLY INCLUDE

- INITIATING OR MAINTAINING A CONVERSATION,
- PARTICIPATING IN SMALL GROUPS,
- DATING,
- SPEAKING TO AUTHORITY FIGURES,
- ATTENDING PARTIES,
- PUBLIC SPEAKING,
- EATING IN FRONT OF OTHERS,
- PERFORMING IN FRONT OF OTHERS,
- URINATING IN A PUBLIC WASHROOM, ETC.

F2	Do these social situations almost always bring on fear or anxiety?	➔ NO	YES
F3	Do you fear these social situations so much that you avoid them, or suffer through them, or need a companion to face them?	➔ NO	YES
F4	Is this social fear or anxiety excessive or unreasonable in these social situations?	➔ NO	YES
F5	Did this social avoidance, fear or anxiety persist for at least 6 months?	➔ NO	YES
F6	Did these social fears cause significant distress or interfere with your ability to function at work, at school or socially or in your relationships or in some other important way?	➔ NO	YES

IS **F6** CODED YES

and

IS "RULE OUT ORGANIC CAUSE (**O2** SUMMARY)" CODED YES?

NOTE TO INTERVIEWER: PLEASE SPECIFY IF THE SUBJECT'S FEARS ARE RESTRICTED TO SPEAKING OR PERFORMING IN PUBLIC.

NO	YES
 SOCIAL ANXIETY DISORDER (Social Phobia) CURRENT	
RESTRICTED TO PERFORMANCE	
SAD ONLY	<input type="checkbox"/>

G. OBSESSIVE-COMPULSIVE DISORDER

(➔ MEANS: GO TO THE DIAGNOSTIC BOX, CIRCLE NO AND MOVE TO THE NEXT MODULE)

G1a	In the past month, have you been bothered by recurrent thoughts, impulses, or images that were unwanted, distasteful, inappropriate, intrusive, or distressing? - (For example, the idea that you were dirty, contaminated or had germs, or fear of contaminating others, or fear of harming someone even though it disturbs or distresses you, or fear you would act on some impulse, or fear or superstitions that you would be responsible for things going wrong, or obsessions with sexual thoughts, images or impulses, or religious obsessions.)	NO	YES
		↓ SKIP TO G3a	
G1b	In the past month, did you try to suppress these thoughts, impulses, or images or to neutralize or to reduce them with some other thought or action? -	NO	YES
		↓ SKIP TO G3a	
(DO NOT INCLUDE SIMPLY EXCESSIVE WORRIES ABOUT REAL LIFE PROBLEMS. DO NOT INCLUDE OBSESSIONS DIRECTLY RELATED TO HOARDING, HAIR PULLING, SKIN PICKING, BODY DYSMORPHIC DISORDER, EATING DISORDERS, SEXUAL DEVIATIONS, PATHOLOGICAL GAMBLING, OR ALCOHOL OR DRUG ABUSE BECAUSE THE PATIENT MAY DERIVE PLEASURE FROM THE ACTIVITY AND MAY WANT TO RESIST IT ONLY BECAUSE OF ITS NEGATIVE CONSEQUENCES.)			

G2	Did they keep coming back into your mind even when you tried to ignore or get rid of them?	NO	YES
<div style="border: 1px solid black; padding: 2px; display: inline-block;">obsessions</div>			

G3a	In the past month, did you feel driven to do something repeatedly in response to an obsession or in response to a rigid rule, like washing or cleaning excessively, counting or checking things over and over, or repeating or arranging things, or other superstitious rituals?	NO	YES
G3b	Are these rituals done to prevent or reduce anxiety or distress or to prevent something bad from happening and are they excessive or unreasonable?	NO	YES
<div style="border: 1px solid black; padding: 2px; display: inline-block;">compulsions</div>			

➔

ARE (G1a AND G1b AND G2) OR (G3a AND G3b) CODED YES? NO YES

G4 In the past month, did these obsessive thoughts and/or compulsive behaviors cause significant distress, or interfere with your ability to function at home, at work, at school or socially or in your relationships or in some other important way or did they take more than one hour a day?

and

IS "RULE OUT ORGANIC CAUSE (O2 SUMMARY)" CODED YES?
 (CHECK FOR ANY OC SYMPTOMS STARTING WITHIN 3 WEEKS OF AN INFECTION)

SPECIFY THE LEVEL OF INSIGHT AND IF THE EPISODE IS TIC-RELATED.

NO	YES
O.C.D. CURRENT	
INSIGHT:	
GOOD OR FAIR	<input type="checkbox"/>
POOR	<input type="checkbox"/>
ABSENT	<input type="checkbox"/>
DELUSIONAL	<input type="checkbox"/>
TIC-RELATED	<input type="checkbox"/>

H. POSTTRAUMATIC STRESS DISORDER

(➔ MEANS: GO TO THE DIAGNOSTIC BOX, CIRCLE NO, AND MOVE TO THE NEXT MODULE)

H1	<p>Have you ever experienced or witnessed or had to deal with an extremely traumatic event that included actual or threatened death or serious injury or sexual violence to you or someone else?</p> <p>EXAMPLES OF TRAUMATIC EVENTS INCLUDE: SERIOUS ACCIDENTS, SEXUAL OR PHYSICAL ASSAULT, A TERRORIST ATTACK, BEING HELD HOSTAGE, KIDNAPPING, FIRE, DISCOVERING A BODY, WAR, OR NATURAL DISASTER, WITNESSING THE VIOLENT OR SUDDEN DEATH OF SOMEONE CLOSE TO YOU, OR A LIFE THREATENING ILLNESS.</p>	➔ NO	YES
H2	<p>Starting after the traumatic event, did you repeatedly re-experience the event in an unwanted mentally distressing way, (such as in recurrent dreams related to the event, intense recollections or memories, or flashbacks or as if the event was recurring) or did you have intense physical or psychological reactions when you were reminded about the event or exposed to a similar event?</p>	➔ NO	YES
H3	<p>In the past month:</p> <p>a Did you persistently try to avoid thinking about or remembering distressing details or feelings related to the event ?</p> <p>b Did you persistently try to avoid people, conversations, places, situations, activities or things that bring back distressing recollections of the event?</p> <p>ARE 1 OR MORE H3 ANSWERS CODED YES?</p>	NO ➔ NO	YES YES
H4	<p>In the past month:</p> <p>a Did you have trouble recalling some important part of the trauma? (but not because of or related to head trauma, alcohol or drugs).</p> <p>b Were you constantly and unreasonably negative about yourself or others or the world?</p> <p>c Did you constantly blame yourself or others in unreasonable ways for the trauma?</p> <p>d Were your feelings always negative (such as fear, horror, anger, guilt or shame)?</p> <p>e Have you become much less interested in participating in activities that were meaningful to you before?</p> <p>f Did you feel detached or estranged from others?</p> <p>g Were you unable to experience any good feelings (such as happiness, satisfaction or loving feelings)?</p> <p>ARE 2 OR MORE H4 ANSWERS CODED YES?</p>	NO ➔ NO	YES YES
H5	<p>In the past month:</p> <p>a Were you especially irritable or did you have outbursts of anger with little or no provocation?</p> <p>b Were you more reckless or more self destructive?</p> <p>c Were you more nervous or constantly on your guard?</p>	NO NO	YES YES

- | | | | |
|---|---|----|-----|
| d | Were you more easily startled? | NO | YES |
| e | Did you have more difficulty concentrating? | NO | YES |
| f | Did you have more difficulty sleeping? | NO | YES |

ARE 2 OR MORE H5 ANSWERS CODED YES?

➔
NO YES

H6 Did all these problems start after the traumatic event and last for more than one month?

➔
NO YES

H7 During the past month, did these problems cause significant distress, or interfere with your ability to function at home, at work, at school or socially or in your relationships or in some other important way?

and

IS "RULE OUT ORGANIC CAUSE (O2 SUMMARY)" CODED YES?

SPECIFY IF THE CONDITION IS ASSOCIATED WITH DEPERSONALIZATION, DEREALIZATION OR WITH DELAYED EXPRESSION.

NO	YES
<i>POSTTRAUMATIC STRESS DISORDER CURRENT</i>	
WITH	
DEPERSONALIZATION	<input type="checkbox"/>
DEREALIZATION	<input type="checkbox"/>
DELAYED EXPRESSION	<input type="checkbox"/>

I. ALCOHOL USE DISORDER

(➡ MEANS: GO TO DIAGNOSTIC BOX, CIRCLE **NO** AND MOVE TO THE NEXT MODULE)

		➡	
I1	In the past 12 months , have you had 3 or more alcoholic drinks, - within a 3 hour period, - on 3 or more occasions?	NO	YES
I2	In the past 12 months:		
a.	During the times when you drank alcohol, did you end up drinking more than you planned when you started?	NO	YES
b.	Did you repeatedly want to reduce or control your alcohol use? Did you try to cut down or control your alcohol use, but failed? IF YES TO EITHER, CODE YES.	NO	YES
c.	On the days that you drank, did you spend substantial time obtaining alcohol, drinking, or recovering from the effects of alcohol?	NO	YES
d.	Did you crave or have a strong desire or urge to use alcohol?	NO	YES
e.	Did you spend less time meeting your responsibilities at work, at school, or at home, because of your repeated drinking?	NO	YES
f.	If your drinking caused problems with your family or other people, did you still keep on drinking?	NO	YES
g.	Were you intoxicated more than once in any situation where you or others were physically at risk, for example, driving a car, riding a motorbike, using machinery, boating, etc.?	NO	YES
h.	Did you continue to use alcohol, even though it was clear that the alcohol had caused or worsened psychological or physical problems?	NO	YES
i.	Did you reduce or give up important work, social or recreational activities because of your drinking?	NO	YES
j.	Did you need to drink a lot more in order to get the same effect that you got when you first started drinking or did you get much less effect with continued use of the same amount?	NO	YES
k1.	When you cut down on heavy or prolonged drinking did you have any of the following:	NO	YES
	1. increased sweating or increased heart rate, <input type="checkbox"/>		
	2. hand tremor or "the shakes" <input type="checkbox"/>		
	3. trouble sleeping <input type="checkbox"/>		
	4. nausea or vomiting <input type="checkbox"/>		
	5. hearing or seeing things other people could not see or hear or having sensations in your skin for no apparent reason <input type="checkbox"/>		
	6. agitation <input type="checkbox"/>		
	7. anxiety <input type="checkbox"/>		
	8. seizures <input type="checkbox"/>		
	IF YES TO 2 OR MORE OF THE ABOVE 8, CODE k1 AS YES.		
k2.	Did you drink alcohol to reduce or avoid withdrawal symptoms or to avoid being hung-over?	NO	YES

K SUMMARY: IF YES TO k1 OR k2, CODE YES

NO YES

ARE **2** OR MORE **I2** ANSWERS FROM **I2a** THROUGH **12j** AND **12k** **SUSUMMARY** CODED YES?

NO	YES
ALCOHOL USE DISORDER	
PAST 12 MONTHS	

SPECIFIERS FOR ALCOHOL USE DISORDER:

MILD = 2-3 OF THE I2 SYMPTOMS
MODERATE = 4-5 OF THE I2 SYMPTOMS
SEVERE = 6 OR MORE OF THE I2 SYMPTOMS

IN EARLY REMISSION = CRITERIA NOT MET FOR BETWEEN 3 & 12 MONTHS
IN SUSTAINED REMISSION = CRITERIA NOT MET FOR 12 MONTHS OR MORE
(BOTH WITH THE EXCEPTION OF CRITERION d. – (CRAVING) ABOVE).

IN A CONTROLLED ENVIRONMENT = WHERE ALCOHOL ACCESS IS RESTRICTED

SPECIFY IF:	
MILD	<input type="checkbox"/>
MODERATE	<input type="checkbox"/>
SEVERE	<input type="checkbox"/>
IN EARLY REMISSION	<input type="checkbox"/>
IN SUSTAINED REMISSION	<input type="checkbox"/>
IN A CONTROLLED ENVIRONMENT	<input type="checkbox"/>

J. SUBSTANCE USE DISORDER (NON-ALCOHOL)

(➔ MEANS: GO TO THE DIAGNOSTIC BOX, CIRCLE NO AND MOVE TO THE NEXT MODULE)

Now I am going to show you / read to you a list of street drugs or medicines.



NO YES

- J1 a In the past 12 months, did you take any of these drugs more than once, to get high, to feel elated, to get “a buzz” or to change your mood?

CIRCLE EACH DRUG TAKEN:

Stimulants: amphetamines, "speed", crystal meth, "crank", Dexedrine, Ritalin, diet pills.

Cocaine: snorting, IV, freebase, crack, "speedball".

Opiates: heroin, morphine, Dilaudid, opium, Demerol, methadone, Darvon, codeine, Percodan, Vicodin, OxyContin.

Hallucinogens: LSD ("acid"), mescaline, peyote, psilocybin, STP, "mushrooms", "ecstasy", MDA, MDMA.

Dissociative Drugs: PCP (Phencyclidine, "Angel Dust", "Peace Pill", "Hog"), or ketamine ("Special K").

Inhalants: "glue", ethyl chloride, "rush", nitrous oxide ("laughing gas"), amyl or butyl nitrate ("poppers").

Cannabis: marijuana, hashish ("hash"), THC, "pot", "grass", "weed", "reefer".

Tranquilizers: Quaalude, Seconal ("reds"), Valium, Xanax, Librium, Ativan, Dalmane, Halcion, barbiturates, Miltown, GHB, Roofinol, "Roofies".

Miscellaneous: steroids, nonprescription sleep or diet pills. Cough Medicine? Any others?

SPECIFY THE MOST USED DRUG(S): _____

WHICH DRUG(S) CAUSE THE BIGGEST PROBLEMS? _____

FIRST EXPLORE THE CRITERIA BELOW FOR THE DRUG CLASS CAUSING THE BIGGEST PROBLEMS AND THE ONE MOST LIKELY TO MEET CRITERIA

FOR SUBSTANCE USE DISORDER. IF SEVERAL DRUG CLASSES HAVE BEEN MISUSED, EXPLORE AS MANY OR AS FEW AS REQUIRED BY THE PROTOCOL.

- J2 **Considering your use of (NAME OF DRUG / DRUG CLASS SELECTED), in the past 12 months:**

- | | | |
|--|----|-----|
| a. During the times when you used the drug, did you end up using more (NAME OF DRUG / DRUG CLASS SELECTED) than you planned when you started? | NO | YES |
| b. Did you repeatedly want to reduce or control your (NAME OF DRUG / DRUG CLASS SELECTED) use? Did you try to cut down or control your (NAME OF DRUG / DRUG CLASS SELECTED) use, but failed? IF YES TO EITHER, CODE YES. | NO | YES |
| c. On the days that you used more (NAME OF DRUG / DRUG CLASS SELECTED), did you spend substantial time obtaining (NAME OF DRUG / DRUG CLASS SELECTED), using it, or recovering from the its effects? | NO | YES |
| d. Did you crave or have a strong desire or urge to use (NAME OF DRUG / DRUG CLASS SELECTED)? | NO | YES |
| e. Did you spend less time meeting your responsibilities at work, at school, or at home, because of your repeated (NAME OF DRUG / DRUG CLASS SELECTED) use? | NO | YES |
| f. If your (NAME OF DRUG / DRUG CLASS SELECTED) use caused problems with your family or other people, did you still keep on using it? | NO | YES |
| g. Did you use the drug more than once in any situation where you or others were physically at risk, for example, driving a car, riding a motorbike, using machinery, boating, etc.? | NO | YES |
| h. Did you continue to use (NAME OF DRUG / DRUG CLASS SELECTED), even though it was clear that the (NAME OF DRUG / DRUG CLASS SELECTED) had caused or worsened psychological or physical problems? | NO | YES |

- i. Did you reduce or give up important work, social or recreational activities because of your (NAME OF DRUG / DRUG CLASS SELECTED) use? NO YES
- j. Did you need to use (NAME OF DRUG / DRUG CLASS SELECTED) a lot more in order to get the same effect that you got when you first started using it or did you get much less effect with continued use of the same amount? NO YES
THIS CRITERION IS CODED NO IF THE MEDICATION IS PRESCRIBED AND USED UNDER MEDICAL SUPERVISION.
- k1. When you cut down on heavy or prolonged use of the drug did you have any of the following withdrawal symptoms: NO YES
IF YES TO THE REQUIRED NUMBER OF WITHDRAWAL SYMPTOMS FOR EACH CLASS, CODE J2k1 AS YES.
THIS CRITERION IS CODED NO IF THE MEDICATION IS PRESCRIBED AND USED UNDER MEDICAL SUPERVISION.

Sedative, Hypnotic or Anxiolytic (2 or more)

- 1. increased sweating or increased heart rate
- 2. hand tremor or “the shakes”
- 3. trouble sleeping
- 4. nausea or vomiting
- 5. hearing or seeing things other people could not see or hear or having sensations in your skin for no apparent reason
- 6. agitation
- 7. anxiety
- 8. seizures

Opiates (3 or more)

- 1. feeling depressed
- 2. nausea or vomiting
- 3. muscle aches
- 4. runny nose or teary eyes
- 5. dilated pupils, goose bumps or hair standing on end or sweating
- 6. diarrhea
- 7. yawning
- 8. hot flashes
- 9. trouble sleeping

Stimulants (2 or more)

- 1. fatigue
- 2. vivid or unpleasant dreams
- 3. difficulty sleeping or sleeping too much
- 4. increased appetite
- 5. feeling or looking physically or mentally slowed down

Cannabis (3 or more)

- 1. irritability, anger or aggression
- 2. nervousness or anxiety
- 3. trouble sleeping
- 4. appetite or weight loss
- 5. restlessness
- 6. feeling depressed
- 7. significant discomfort from one of the following: “stomach pain”, tremors or “shakes”, sweating, hot flashes, chills, headaches.

k2. Did you use (NAME OF DRUG / DRUG CLASS SELECTED) to reduce or avoid withdrawal symptoms?

NO YES

J2k SUMMARY: IF YES TO J2k1 OR J2k2, CODE YES

NO YES

ARE 2 OR MORE J2 ANSWERS FROM J2a THROUGH J2k SUMMARY CODED YES?
(J2k1 AND J2k2 TOGETHER COUNT AS ONE AMONG THESE CHOICES)

NO	YES
<i>SUBSTANCE</i> <i>(Drug or Drug Class Name)</i> <i>USE DISORDER</i>	
<i>PAST 12 MONTHS</i>	

SPECIFIERS FOR SUBSTANCE USE DISORDER:

MILD = 2-3 OF THE J2 SYMPTOMS
MODERATE = 4-5 OF THE J2 SYMPTOMS
SEVERE = 6 OR MORE OF THE J2 SYMPTOMS

IN EARLY REMISSION = CRITERIA NOT MET FOR BETWEEN 3 & 12 MONTHS
IN SUSTAINED REMISSION = CRITERIA NOT MET FOR 12 MONTHS OR MORE
(BOTH WITH THE EXCEPTION OF CRITERION d. – (CRAVING) ABOVE).

IN A CONTROLLED ENVIRONMENT = WHERE SUBSTANCE / DRUG ACCESS IS RESTRICTED

SPECIFY IF:	
MILD	<input type="checkbox"/>
MODERATE	<input type="checkbox"/>
SEVERE	<input type="checkbox"/>
IN EARLY REMISSION	<input type="checkbox"/>
IN SUSTAINED REMISSION	<input type="checkbox"/>
IN A CONTROLLED ENVIRONMENT	<input type="checkbox"/>

K. PSYCHOTIC DISORDERS AND MOOD DISORDER WITH PSYCHOTIC FEATURES

ASK FOR AN EXAMPLE OF EACH QUESTION ANSWERED POSITIVELY. CODE YES ONLY IF THE EXAMPLES CLEARLY SHOW A DISTORTION OF THOUGHT OR OF PERCEPTION OR IF THEY ARE NOT CULTURALLY APPROPRIATE. THE PURPOSE OF THIS MODULE IS TO EXCLUDE PATIENTS WITH PSYCHOTIC DISORDERS. THIS MODULE NEEDS EXPERIENCE.

Now I am going to ask you about unusual experiences that some people have.

- K1 a Have you ever believed that people were spying on you, or that someone was plotting against you, or trying to hurt you? NO YES
NOTE: ASK FOR EXAMPLES TO RULE OUT ACTUAL STALKING.
- b IF YES: do you currently believe these things? NO YES
- K2 a Have you ever believed that someone was reading your mind or could hear your thoughts, or that you could actually read someone's mind or hear what another person was thinking? NO YES
- b IF YES: do you currently believe these things? NO YES
- K3 a Have you ever believed that someone or some force outside of yourself put thoughts in your mind that were not your own, or made you act in a way that was not your usual self? Have you ever felt that you were possessed? NO YES
CLINICIAN: ASK FOR EXAMPLES AND DISCOUNT ANY THAT ARE NOT PSYCHOTIC.
- b IF YES: do you currently believe these things? NO YES
- K4 a Have you ever believed that you were being sent special messages through the TV, radio, internet, newspapers, books, or magazines or that a person you did not personally know was particularly interested in you? NO YES
- b IF YES: do you currently believe these things? NO YES
- K5 a Have your relatives or friends ever considered any of your beliefs odd or unusual? NO YES
INTERVIEWER: ASK FOR EXAMPLES. ONLY CODE YES IF THE EXAMPLES ARE CLEARLY DELUSIONAL IDEAS NOT EXPLORED IN QUESTIONS K1 TO K4, FOR EXAMPLE, RELIGIOUS, DEATH, DISEASE OR SOMATIC DELUSIONS, DELUSIONS OF GRANDIOSITY, JEALOUSY OR GUILT, OR OF FAILURE, INADEQUACY, RUIN, OR DESTITUTION, OR NIHILISTIC DELUSIONS.
- b IF YES: do they currently consider your beliefs strange or unusual? NO YES
- K6 a Have you ever heard things other people couldn't hear, such as voices? NO YES
- IF YES TO VOICE HALLUCINATION: Was the voice commenting on your thoughts or behavior or did you hear two or more voices talking to each other? NO YES
- b IF YES TO K6a: have you heard sounds / voices in the past month? NO YES
- IF YES TO VOICE HALLUCINATION: Was the voice commenting on your thoughts or behavior or did you hear two or more voices talking to each other? NO YES

K7 a Have you ever had visions when you were awake or have you ever seen things other people couldn't see? NO YES
 CLINICIAN: CHECK TO SEE IF THESE ARE CULTURALLY INAPPROPRIATE.

b IF YES: have you seen these things in the past month? NO YES

CLINICIAN'S JUDGMENT

K8 a DID THE PATIENT EVER IN THE PAST EXHIBIT DISORGANIZED, INCOHERENT OR DERAILED SPEECH, OR MARKED LOOSENING OF ASSOCIATIONS? NO YES

K8 b IS THE PATIENT CURRENTLY EXHIBITING INCOHERENCE, DISORGANIZED OR DERAILED SPEECH, OR MARKED LOOSENING OF ASSOCIATIONS? NO YES

K9 a DID THE PATIENT EVER IN THE PAST EXHIBIT DISORGANIZED OR CATATONIC BEHAVIOR? NO YES

K9 b IS THE PATIENT CURRENTLY EXHIBITING DISORGANIZED OR CATATONIC BEHAVIOR? NO YES

K10 a DID THE PATIENT EVER IN THE PAST HAVE NEGATIVE SYMPTOMS, E.G. SIGNIFICANT REDUCTION OF EMOTIONAL EXPRESSION OR AFFECTIVE FLATTENING, POVERTY OF SPEECH (ALOGIA) OR AN INABILITY TO INITIATE OR PERSIST IN GOAL-DIRECTED ACTIVITIES (AVOLITION)? NO YES

K10 b ARE NEGATIVE SYMPTOMS OF SCHIZOPHRENIA, E.G. SIGNIFICANT REDUCTION OF EMOTIONAL EXPRESSION OR AFFECTIVE FLATTENING, POVERTY OF SPEECH (ALOGIA) OR AN INABILITY TO INITIATE OR PERSIST IN GOAL-DIRECTED ACTIVITIES (AVOLITION), PROMINENT DURING THE INTERVIEW? NO YES

K11 a ARE 1 OR MORE « a » QUESTIONS FROM K1a TO K7a, CODED YES?
 ARE AND IS EITHER:
 MAJOR DEPRESSIVE EPISODE, (CURRENT, RECURRENT OR PAST)
 OR
 MANIC OR HYPOMANIC EPISODE, (CURRENT OR PAST) CODED YES? NO YES
 ↳ K13

HOW LONG HAS THE MOOD EPISODE LASTED? _____
 HOW LONG HAS THE PSYCHOTIC EPISODE LASTED? _____
 IF SUCH A MOOD EPISODE IS PRESENT, IT MUST BE PRESENT FOR THE MAJORITY OF THE TOTAL DURATION OF THE ACTIVE AND RESIDUAL PERIODS OF THE PSYCHOTIC SYMPTOMS. OTHERWISE CODE NO TO K11a.

IF NO TO K11a, CIRCLE NO IN BOTH 'MOOD DISORDER WITH PSYCHOTIC FEATURES' DIAGNOSTIC BOXES AND MOVE TO K13.

b You told me earlier that you had period(s) when you felt (depressed/high/persistently irritable).

Were the beliefs and experiences you just described (SYMPTOMS CODED YES FROM K1a TO K7a) restricted exclusively to times when you were feeling depressed/high/irritable?

IF THE PATIENT EVER HAD A PERIOD OF AT LEAST 2 WEEKS OF HAVING THESE BELIEFS OR EXPERIENCES (PSYCHOTIC SYMPTOMS) WHEN THEY WERE NOT DEPRESSED/HIGH/IRRITABLE, CODE NO TO THIS DISORDER.

IF THE ANSWER IS NO TO THIS DISORDER GROUPING, ALSO CIRCLE NO TO K12 AND MOVE TO K13

NO

YES

***MOOD DISORDER WITH
PSYCHOTIC FEATURES***

LIFETIME

K12 a ARE 1 OR MORE « b » QUESTIONS FROM K1b TO K7b CODED YES AND IS EITHER:

MAJOR DEPRESSIVE EPISODE (CURRENT)

OR

MANIC OR HYPOMANIC EPISODE (CURRENT) CODED YES?

IF THE ANSWER IS YES TO THIS DISORDER (LIFETIME OR CURRENT), CIRCLE NO TO K13 AND K14 AND MOVE TO THE NEXT MODULE.

NO

YES

***MOOD DISORDER WITH
PSYCHOTIC FEATURES***

CURRENT

K13 ARE 1 OR MORE « b » QUESTIONS FROM K1b TO K8b, CODED YES?

AND

ARE 2 OR MORE « b » QUESTIONS FROM K1b TO K10b, CODED YES?

AND DID AT LEAST TWO OF THE PSYCHOTIC SYMPTOMS OCCUR DURING THE SAME 1-MONTH PERIOD?

AND

IS "RULE OUT ORGANIC CAUSE (O2 SUMMARY)" CODED YES?

NO

YES

***PSYCHOTIC DISORDER
CURRENT***

K14 IS **K13** CODED **YES**

OR

(ARE 1 OR MORE « a » QUESTIONS FROM K1a TO K8a, CODED **YES**?)

AND

ARE 2 OR MORE « a » QUESTIONS FROM K1a TO K10a, CODED **YES**

AND DID AT LEAST TWO OF THE PSYCHOTIC SYMPTOMS OCCUR DURING THE SAME 1-MONTH PERIOD?)

AND

IS "RULE OUT ORGANIC CAUSE (**O2** SUMMARY)" CODED **YES**?

NO

YES

***PSYCHOTIC DISORDER
LIFETIME***

L. ANOREXIA NERVOSA

(➔ MEANS: GO TO THE DIAGNOSTIC BOX, CIRCLE NO, AND MOVE TO THE NEXT MODULE)

L1	a	How tall are you?	<input type="text"/>	ft	<input type="text"/>	<input type="text"/>	in.	
			<input type="text"/>	<input type="text"/>	<input type="text"/>	cm		
	b.	What was your lowest weight in the past 3 months?	<input type="text"/>	<input type="text"/>	<input type="text"/>	lb		
			<input type="text"/>	<input type="text"/>	<input type="text"/>	kg		
	c	IS PATIENT'S WEIGHT EQUAL TO OR BELOW THE THRESHOLD CORRESPONDING TO HIS / HER HEIGHT? (SEE TABLE BELOW)	➔	NO				YES

In the past 3 months:

L2		In spite of this low weight, have you tried not to gain weight or to restrict your food intake?	➔	NO	YES
L3		Have you intensely feared gaining weight or becoming fat, even though you were underweight?	➔	NO	YES
L4	a	Have you considered yourself too big / fat or that part of your body was too big / fat?		NO	YES
	b	Has your body weight or shape greatly influenced how you felt about yourself?		NO	YES
	c	Have you thought that your current low body weight was normal or excessive?		NO	YES
L5		ARE 1 OR MORE ITEMS FROM L4 CODED YES?	➔	NO	YES

IS L5 CODED YES?

NO	YES
ANOREXIA NERVOSA CURRENT	

HEIGHT / WEIGHT TABLE CORRESPONDING TO A BMI THRESHOLD OF 17.0 KG/M²

Height/Weight	4'9	4'10	4'11	5'0	5'1	5'2	5'3	5'4	5'5	5'6	5'7	5'8	5'9	5'10
ft/in	4'9	4'10	4'11	5'0	5'1	5'2	5'3	5'4	5'5	5'6	5'7	5'8	5'9	5'10
lb	79	82	84	87	90	93	96	99	102	106	109	112	115	119
cm	145	147	150	152	155	158	160	163	165	168	170	173	175	178
kg	36	37	38.5	39.5	41	42.5	43.5	45.5	46.5	48	49	51	52	54

Height/Weight	5'11	6'0	6'1	6'2	6'3
ft/in	5'11	6'0	6'1	6'2	6'3
lb	122	125	129	133	136
cm	180	183	185	188	191
kg	55	57	58.5	60	62

The weight thresholds above are calculated using a body mass index (BMI) equal to or below 17.0 kg/m² for the patient's height using the Center of Disease Control & Prevention BMI Calculator. This is the threshold guideline below which a person is deemed underweight by the DSM-5 for Anorexia Nervosa.

M. BULIMIA NERVOSA

(➡ MEANS: GO TO THE DIAGNOSTIC BOXES, CIRCLE **NO** IN ALL DIAGNOSTIC BOXES, AND MOVE TO THE NEXT MODULE)

M1	In the past three months, did you have eating binges or times when you ate a very large amount of food within a 2-hour period?	NO	YES ↳ M3
M2	During these binges, did you feel that your eating was out of control?	NO	YES

➡

M3 Did you do anything to compensate for, or to prevent a weight gain, like vomiting, fasting, exercising or taking laxatives, enemas, diuretics (fluid pills), or other medications? Did you do this as often as once a week?

NO YES

CODE YES TO M3 ONLY IF THE ANSWER TO BOTH THESE M3 QUESTIONS IS YES.

M3a Number of Episodes of Inappropriate Compensatory Behaviors per Week? _____

Number of Days of Inappropriate Compensatory Behaviors per Week? _____

➡

M4 In the last 3 months, did you have eating binges as often as once a week?

NO YES

➡

M5 Does your body weight or shape greatly influence how you feel about yourself?

NO YES

M6 DO THE PATIENT'S SYMPTOMS MEET CRITERIA FOR ANOREXIA NERVOSA?

NO YES

↓
Skip to M8

M7 Do these binges occur only when you are under (_____ lb/kg)?

NO YES

INTERVIEWER: WRITE IN THE ABOVE PARENTHESIS THE THRESHOLD WEIGHT FOR THIS PATIENT'S HEIGHT FROM THE HEIGHT / WEIGHT TABLE IN THE ANOREXIA NERVOSA MODULE.

M8 IS **M5** CODED **YES** AND IS EITHER **M6** OR **M7** CODED **NO**?

NO	YES
BULIMIA NERVOSA	
CURRENT	

IS **M7** CODED **YES**?

NO	YES
ANOREXIA NERVOSA	
<i>Binge Eating/Purging Type</i>	
CURRENT	

DO THE PATIENT'S SYMPTOMS MEET CRITERIA FOR ANOREXIA NERVOSA?

AND

ARE M2 AND M3 CODED NO?

NO	YES
ANOREXIA NERVOSA <i>Restricting Type</i> CURRENT	

SPECIFIERS OF EATING DISORDER:

MILD = 1-3 EPISODES OF INAPPROPRIATE COMPENSATORY BEHAVIORS

MODERATE = 4-7 EPISODES OF INAPPROPRIATE COMPENSATORY BEHAVIORS

SEVERE = 8-13 EPISODES OF INAPPROPRIATE COMPENSATORY BEHAVIORS

EXTREME = 14 OR MORE EPISODES OF INAPPROPRIATE COMPENSATORY BEHAVIORS

SPECIFY IF:	
MILD	<input type="checkbox"/>
MODERATE	<input type="checkbox"/>
SEVERE	<input type="checkbox"/>
EXTREME	<input type="checkbox"/>

MB. BINGE EATING DISORDER

(➡ MEANS: GO TO THE DIAGNOSTIC BOX, CIRCLE NO IN THE DIAGNOSTIC BOX, AND MOVE TO THE NEXT MODULE)

MB1	DO THE PATIENT'S SYMPTOMS MEET CRITERIA FOR ANOREXIA NERVOSA?	NO	➡ YES
MB2	DO THE PATIENT'S SYMPTOMS MEET CRITERIA FOR BULIMIA NERVOSA?	NO	➡ YES
MB3	M2 IS CODED YES	➡ NO	YES

MB4	M3 IS CODED YES	NO	➡ YES
-----	-----------------	----	-------

MB5	M4 IS CODED YES	➡ NO	YES
-----	-----------------	------	-----

In the last 3 months during the binging did you:

MB6a	Eat more rapidly than normal?	NO	YES
------	-------------------------------	----	-----

MB6b	Eat until you felt uncomfortably full?	NO	YES
------	--	----	-----

MB6c	Eat large amounts of food when you were not hungry?	NO	YES
------	---	----	-----

MB6d	Eat alone because you felt embarrassed about how much you were eating?	NO	YES
------	--	----	-----

MB6e	Feel guilty, depressed or disgusted with yourself after binging?	NO	YES
------	--	----	-----

	ARE 3 OR MORE MB6 QUESTIONS CODED YES?	➡ NO	YES
--	---	------	-----

MB7 Does your bingeing distress you a lot?

➔
NO YES

MB8 Number of Binge Eating Episodes per Week? _____

Number of Binge Eating Days per Week? _____

IS MB7 CODED YES?

NO	YES
<i>BINGE-EATING DISORDER</i>	
CURRENT	

SPECIFIERS OF EATING DISORDER:

MILD = 1-3 EPISODES OF BINGE EATING PER WEEK
MODERATE = 4-7 EPISODES OF BINGE EATING PER WEEK
SEVERE = 8-13 EPISODES OF BINGE EATING PER WEEK
EXTREME = 14 OR MORE EPISODES OF BINGE EATING PER WEEK

SPECIFY IF:	
MILD	<input type="checkbox"/>
MODERATE	<input type="checkbox"/>
SEVERE	<input type="checkbox"/>
EXTREME	<input type="checkbox"/>

N. GENERALIZED ANXIETY DISORDER

(➔ MEANS: GO TO THE DIAGNOSTIC BOX, CIRCLE NO, AND MOVE TO THE NEXT MODULE)

N1	a	Were you excessively anxious or worried about several routine things, over the past 6 months? IN ENGLISH, IF THE PATIENT IS UNCLEAR ABOUT WHAT YOU MEAN, PROBE BY ASKING (Do others think that you are a worrier or a “worry wart”?) AND GET EXAMPLES.	➔ NO	YES
	b	Are these anxieties and worries present most days?	➔ NO	YES
		ARE THE PATIENT’S ANXIETY AND WORRIES RESTRICTED EXCLUSIVELY TO, OR BETTER EXPLAINED BY, ANY DISORDER PRIOR TO THIS POINT?	NO	➔ YES

N2	Do you find it difficult to control the worries?	➔ NO	YES
----	--	---------	-----

N3 FOR THE FOLLOWING, CODE **NO** IF THE SYMPTOMS ARE CONFINED TO FEATURES OF ANY DISORDER EXPLORED PRIOR TO THIS POINT.

When you were anxious over the past 6 months, did you, most of the time:

a	Feel restless, keyed up or on edge?	NO	YES
b	Have muscle tension?	NO	YES
c	Feel tired, weak or exhausted easily?	NO	YES
d	Have difficulty concentrating or find your mind going blank?	NO	YES
e	Feel irritable?	NO	YES
f	Have difficulty sleeping (difficulty falling asleep, waking up in the middle of the night, early morning waking or sleeping excessively)?	NO	YES

ARE **3** OR MORE **N3** ANSWERS CODED **YES**? ➔
NO YES

N4 Do these anxieties and worries significantly disrupt your ability to work, to function socially or in your relationships or in other important areas of your life or cause you significant distress?

AND IS “RULE OUT ORGANIC CAUSE (**O2** SUMMARY)” CODED **YES**?

NO	YES
GENERALIZED ANXIETY DISORDER CURRENT	

O. RULE OUT MEDICAL, ORGANIC OR DRUG CAUSES FOR ALL DISORDERS

IF THE PATIENT CODES POSITIVE FOR ANY CURRENT DISORDER ASK:

Just before these symptoms began:

O1a Were you taking any drugs or medicines or in withdrawal from any of these? No Yes Uncertain

O1b Did you have any medical illness? No Yes Uncertain

O2 IF O1a OR O1b IS CODED YES, IN THE CLINICIAN’S JUDGMENT IS EITHER LIKELY TO BE A DIRECT CAUSE OF THE PATIENT’S DISORDER? IF NECESSARY, ASK ADDITIONAL OPEN-ENDED QUESTIONS. No Yes Uncertain

O2 SUMMARY: AN “ORGANIC” / MEDICAL / DRUG RELATED CAUSE BEEN RULED OUT No Yes Uncertain

IF **O2** IS YES, THEN **O2** SUMMARY IS NO. IF **O2** IS NO, THEN **O2** SUMMARY IS YES. OTHERWISE IT IS UNCERTAIN.

P. ANTISOCIAL PERSONALITY DISORDER

(➡ MEANS: GO TO THE DIAGNOSTIC BOX AND CIRCLE NO)

P1 Before you were 15 years old, did you:

- | | | | |
|---|--|----|-----|
| a | repeatedly skip school or run away from home overnight or stayed out at night against your parent's rules? | NO | YES |
| b | repeatedly lie, cheat, "con" others, or steal or break into someone's house or car? | NO | YES |
| c | start fights or bully, threaten, or intimidate others? | NO | YES |
| d | deliberately destroy things or start fires? | NO | YES |
| e | deliberately hurt animals or people? | NO | YES |
| f | force someone into sexual activity? | NO | YES |
| | ARE 2 OR MORE P1 ANSWERS CODED YES? | NO | YES |

DO NOT CODE YES TO THE BEHAVIORS BELOW IF THEY ARE EXCLUSIVELY POLITICALLY OR RELIGIOUSLY MOTIVATED.

P2 Since you were 15 years old, have you:

- | | | | |
|---|--|----|-----|
| a | done things that are illegal or would be grounds to get arrested, even if you didn't get caught (for example destroying property, shoplifting, stealing, selling drugs, or committing a felony)? | NO | YES |
| b | often lied or "conned" other people to get money or pleasure, or lied just for fun? | NO | YES |
| c | been impulsive and didn't care about planning ahead? | NO | YES |
| d | been in physical fights repeatedly or assaulted others (including physical fights with your spouse or children)? | NO | YES |
| e | exposed others or yourself to danger without caring? | NO | YES |
| f | repeatedly behaved in a way that others would consider irresponsible, like failing to pay for things you owed, deliberately being impulsive or deliberately not working to support yourself? | NO | YES |
| g | felt no guilt after hurting, mistreating, lying to, or stealing from others, or after damaging property? | NO | YES |

ARE 3 OR MORE P2 QUESTIONS CODED YES?

NO	YES
ANTISOCIAL PERSONALITY DISORDER LIFETIME	

THIS CONCLUDES THE INTERVIEW

MOOD DISORDERS: DIAGNOSTIC ALGORITHM

Consult Modules: A Major Depressive Episode
 C (Hypo)manic Episode
 K Psychotic Disorders

MODULE K:

1a	IS K11b CODED YES?	NO	YES
1b	IS K12a CODED YES?	NO	YES

MODULES A and C:

			Current	Past
2	a	CIRCLE YES IF A DELUSIONAL IDEA IS IDENTIFIED IN A3e OR ANY PSYCHOTIC FEATURE IN K1 THROUGH K7	YES	YES
	b	CIRCLE YES IF A DELUSIONAL IDEA IS IDENTIFIED IN C3a OR ANY PSYCHOTIC FEATURE IN K1 THROUGH K7	YES	YES

c Is Major Depressive Episode coded YES (current or past)?
and
 is Manic Episode coded NO (current and past)?
and
 is Hypomanic Episode coded NO (current and past)?
and
 is "Rule out Organic Cause (O2 Summary)" coded YES?

Specify:

- If the depressive episode is **current** or **past** or both
- **With Psychotic Features** Current: If 1b or 2a (current) = YES
 With Psychotic Features Past: If 1a or 2a (past) = YES

MAJOR DEPRESSIVE DISORDER

	current	past
MDD	<input type="checkbox"/>	<input type="checkbox"/>
With Psychotic Features		
Current	<input type="checkbox"/>	
Past		<input type="checkbox"/>

d Is a Manic Episode coded YES (current or past)?

Specify:

- If the Bipolar I Disorder is **current** or **past** or both
- With **Single Manic Episode**: If Manic episode (current or past) = YES and MDE (current and past) = NO
- **With Psychotic Features** Current: If 1b or 2a (current) or 2b (current) = YES
With Psychotic Features Past: If 1a or 2a (past) or 2b (past) = YES
- If the **most recent episode** is manic, depressed, or hypomanic or unspecified (all mutually exclusive)
- **Most Recent Episode Unspecified** if the Past Manic Episode is coded YES

AND

(If any current C3 symptoms are coded YES and current C3 Summary is coded NO)

OR

(If current C3 Summary is coded YES

AND

If current Manic Episode diagnostic box is coded NO current)

BIPOLAR I DISORDER		
	current	past
Bipolar I Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Single Manic Episode	<input type="checkbox"/>	<input type="checkbox"/>
With Psychotic Features		
Current	<input type="checkbox"/>	
Past		<input type="checkbox"/>
Most Recent Episode		
Manic	<input type="checkbox"/>	
Depressed	<input type="checkbox"/>	
Hypomanic	<input type="checkbox"/>	
Unspecified	<input type="checkbox"/>	
Most Recent Episode		
Mild	<input type="checkbox"/>	
Moderate	<input type="checkbox"/>	
Severe	<input type="checkbox"/>	

e Is Major Depressive Episode coded YES (current or past)
and
Is Hypomanic Episode coded YES (current or past)
and
Is Manic Episode coded NO (current and past)?

Specify:

- If the Bipolar Disorder is **current** or **past** or both
- If the most recent mood episode is **hypomanic** or **depressed** (mutually exclusive)
- **Most Recent Episode Unspecified** if the Past Manic / Hypomanic Episode is coded YES

AND

(If any current C3 symptoms are coded YES and current C3 Summary is coded NO)

OR

(If current C3 Summary is coded YES

AND

If current Hypomanic Episode diagnostic box is coded NO current)

BIPOLAR II DISORDER		
	current	past
Bipolar II Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Most Recent Episode		
Hypomanic	<input type="checkbox"/>	
Depressed	<input type="checkbox"/>	
Hypomanic	<input type="checkbox"/>	
Unspecified	<input type="checkbox"/>	
Most Recent Episode		
Mild	<input type="checkbox"/>	
Moderate	<input type="checkbox"/>	
Severe	<input type="checkbox"/>	

- f Is MDE coded NO (current and past)
 - and**
 - Is Manic Episode coded NO (current and past)
 - and**
 - Is C4b coded YES for the appropriate time frame
 - and**
 - Is C8b coded YES?

or

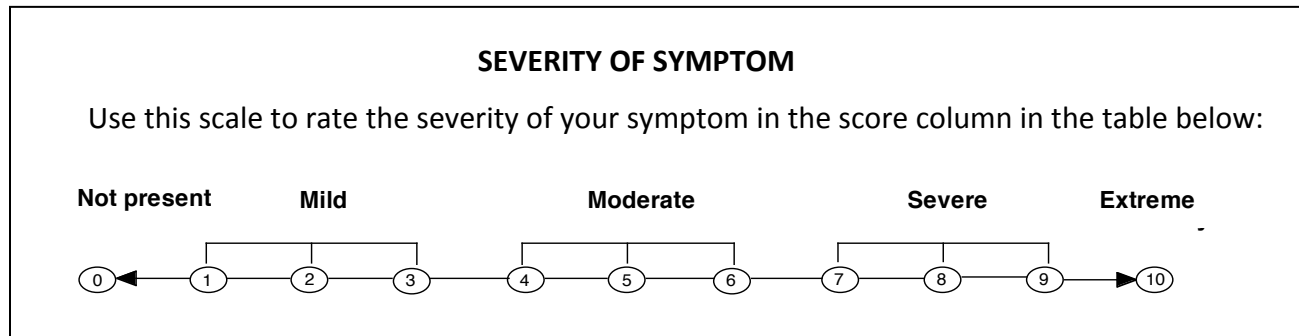
- Is Manic Episode coded NO (current and past)
 - and**
 - Is Hypomanic Episode coded NO (current and past)
 - and**
 - Is C4a coded YES for the appropriate time frame
 - and**
 - Is C8c coded YES?

Specify if the Bipolar Disorder Unspecified is **current** or **past** or both.

BIPOLAR DISORDER UNSPECIFIED		
	current	past
Bipolar Disorder Unspecified	<input type="checkbox"/>	<input type="checkbox"/>

OPTIONAL ASSESSMENT MEASURES TO TRACK CHANGES OVER TIME

A: CROSS CUTTING MEASURES



Assessment of Symptoms That Cut Across Disorders

	Symptom Name	Score
1	Depression	
2	Anger	
3	Mania (feeling up or high or hyper or full of energy with racing thoughts)	
4	Anxiety	
5	Physical (somatic) symptoms	
6	Suicidal thoughts (having ANY thoughts of killing yourself)	
7	Hearing sounds or voices others can't hear or fearing someone can hear or read your thoughts or believing things others don't accept as true e.g. that people are spying on you or plotting against you or talking about you (Psychosis)	
8	Sleep problems	
9	Memory problems	
10	Repetitive thoughts or behaviors	
11	Feeling things around you are strange, unreal, detached or unfamiliar, or feeling outside or detached from part or all of your body (Dissociation)	
12	Ability to function at work, at home, in your life, or in your relationships (Personality functioning)	
13	Overusing alcohol or drugs	

B: DISABILITY / FUNCTIONAL IMPAIRMENT

SEVERITY OF DISABILITY / IMPAIRMENT

Use this scale to rate in the score column of the table below, how much your symptoms have disrupted your ability to function in the following areas of your life:

Not present **Mild** **Moderate** **Severe** **Extreme**

Assessment of Impairment of Functioning /Disability

	Domain Name	Score
1	Work or school work	
2	Social life or leisure activities (like hobbies or things you do for enjoyment)	
3	Family life and / or home responsibilities	
4	Ability to get along with people	
5	Personal and social relationships	
6	Ability to understand and to communicate with others	
7	Ability to take care of yourself (washing, showering, bathing, dressing properly, brushing teeth, laundry, combing / brushing hair, eating regularly)	
8	Made you disruptive or aggressive towards others	
9	Financially (ability to manage your money)	
10	Ability to get around physically	
11	Spiritual or religious life	
12	How much did your condition have an impact on other people in your family?	

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6. Individual clinicians and patients who over the years made countless suggestions to help improve the accuracy and clinical value to the MINI: JM Giddens for her advice on the MINI 7 version of the Suicidality Module, Dr. Michael Van Ameringen for assistance with the ADHD module, and Dr P Powers for her advice on the modules on Anorexia Nervosa and Bulimia.
7. A validation study of this instrument was made possible, in part, by grants from SmithKlineBeecham and the European Commission.

M.I.N.I. PLUS

The shaded modules below are additional modules available in the MINI PLUS beyond what is available in the standard MINI. The un-shaded modules below are in the standard MINI.

These MINI PLUS modules can be inserted into or used in place of the standard MINI modules, as dictated by the specific needs of any study.

MODULES	TIME FRAME		
A MAJOR DEPRESSIVE EPISODE	Current (2 weeks) Past Recurrent		
MAJOR DEPRESSIVE DISORDER	Current (2 weeks) Past Recurrent		
MDE WITH MELANCHOLIC FEATURES	Current (2 weeks)		
MDE WITH CATATONIC FEATURES	Current (2 weeks)		
MDE WITH ATYPICAL FEATURES	Current (2 weeks)		
MAJOR DEPRESSIVE DISORDER WITH PSYCHOTIC FEATURES	Current Past		
MINOR DEPRESSIVE DISORDER (DEPRESSIVE DISORDER UNSPECIFIED)	Current (2 weeks) Past Recurrent		
MOOD DISORDER DUE TO A GENERAL MEDICAL CONDITION	Current (2 weeks) Past		
SUBSTANCE INDUCED MOOD DISORDER	Current (2 weeks) Past		
AY DYSTHYMIA	Current		
B SUICIDALITY	Current (Past Month)	<input type="checkbox"/>	
SUICIDE BEHAVIOR DISORDER	Lifetime attempt	<input type="checkbox"/>	<input type="checkbox"/> Low <input type="checkbox"/> Moderate <input type="checkbox"/> High
	Current	<input type="checkbox"/>	(In Past Year)
	In early remission	<input type="checkbox"/>	(1 - 2 Years Ago)
C MANIC EPISODE	Current Past		
HYPOMANIC EPISODE	Current Past		
BIPOLAR I DISORDER	Current Past		
BIPOLAR II DISORDER	Current Past		
BIPOLAR DISORDER UNSPECIFIED	Current Past		
BIPOLAR I DISORDER WITH PSYCHOTIC FEATURES	Current Past		
MANIC EPISODE DUE TO A GENERAL MEDICAL CONDITION	Current (2 weeks) Past		
HYPOMANIC EPISODE DUE TO A GENERAL MEDICAL CONDITION	Current (2 weeks) Past		
SUBSTANCE INDUCED MANIC EPISODE	Current (2 weeks)		

		Past
	SUBSTANCE INDUCED HYPMANIC EPISODE	Current (2 weeks) Past
	MOOD DISORDER UNSPECIFIED	Lifetime
D	PANIC DISORDER	Current (Past Month) Lifetime
	ANXIETY DISORDER WITH PANIC ATTACKS DUE TO A GENERAL MEDICAL CONDITION	Current
	SUBSTANCE INDUCED ANXIETY DISORDER WITH PANIC ATTACKS	Current
E	AGORAPHOBIA	Current
F	SOCIAL ANXIETY DISORDER (Social Phobia)	Current (Past Month) Generalized Non-Generalized
FA	SPECIFIC PHOBIA	Current
G	OBSESSIVE-COMPULSIVE DISORDER (OCD)	Current (Past Month)
	OCD DUE TO A GENERAL MEDICAL CONDITION	Current
	SUBSTANCE INDUCED OCD	Current
H	POSTTRAUMATIC STRESS DISORDER	Current (Past Month)
HL	POSTTRAUMATIC STRESS DISORDER	Lifetime
I	ALCOHOL USE DISORDER	Past 12 Months
IL	ALCOHOL USE DISORDER	Lifetime
J	SUBSTANCE DEPENDENCE (Non-alcohol) SUBSTANCE ABUSE (Non-alcohol)	Past 12 Months Past 12 Months
JL	SUBSTANCE USE DISORDER (Non-alcohol)	Lifetime
K	PSYCHOTIC DISORDERS	Lifetime Current
	MOOD DISORDER WITH PSYCHOTIC FEATURES	Lifetime
	MOOD DISORDER WITH PSYCHOTIC FEATURES	Current
	SCHIZOPHRENIA	Current Lifetime
	SCHIZOAFFECTIVE DISORDER	Current Lifetime
	SCHIZOPHRENIFORM DISORDER	Current Lifetime
	BRIEF PSYCHOTIC DISORDER	Current Lifetime
	DELUSIONAL DISORDER	Current Lifetime
	PSYCHOTIC DISORDER DUE TO A GENERAL MEDICAL CONDITION	Current Lifetime
	SUBSTANCE INDUCED PSYCHOTIC DISORDER	Current Lifetime

	PSYCHOTIC DISORDER UNSPECIFIED	Current Lifetime
L	ANOREXIA NERVOSA	Current (Past 3 Months)
	ANOREXIA NERVOSA, BINGE EATING/PURGING TYPE	Current
	ANOREXIA NERVOSA, RESTRICTING TYPE	Current
M	BULIMIA NERVOSA	Current (Past 3 Months)
	BULMIA NERVOSA, PURGING TYPE	Current
	BULMIA NERVOSA, NON-PURGING TYPE	Current
MB	BINGE-EATING DISORDER	Current (Past 3 Months)
N	GENERALIZED ANXIETY DISORDER (GAD)	Current (Past 6 Months)
	GAD DUE TO A GENERAL MEDICAL CONDITION	Current
	SUBSTANCE INDUCED GAD	Current
O	SOMATIZATION DISORDER	Current Lifetime
P	HYPOCHONDRIASIS	Current
Q	BODY DYSMORPHIC DISORDER	Current
R	PAIN DISORDER	Current
S	CONDUCT DISORDER	Current (past 12 months)
T	ATTENTION DEFICIT/ HYPERACTIVITY DISORDER	Current (Past 6 months) (Children /Adolescents)
	ADHD COMBINED	
	ADHD INATTENTIVE	
	ADHD HYPERACTIVE / IMPULSIVE	
TA	ATTENTION DEFICIT/ HYPERACTIVITY DISORDER	Current (Past 6 months) (Adults)
	ADHD COMBINED	
	ADHD INATTENTIVE	
	ADHD HYPERACTIVE / IMPULSIVE	
U	PREMENSTRUAL DYSPHORIC DISORDER	Current
V	MIXED ANXIETY DEPRESSIVE DISORDER	Current
W	ADJUSTMENT DISORDERS	Current
X	MEDICAL, ORGANIC, DRUG CAUSE RULED OUT	
Y	ANTISOCIAL PERSONALITY DISORDER	Lifetime

For Schizophrenia and psychotic disorder studies and for psychotic disorder subtyping in clinical settings, use the MINI for Psychotic Disorders instead of the standard MINI. For many clinical settings this level of psychotic disorder subtyping detail is not necessary.

For children and adolescents, use the MINI Kid or the MINI Kid Parent of the MIN Kid for Psychotic Disorders. A computerized version of the MINI is available from Medical Outcomes Systems <https://www.medical-outcomes.com>

