

Name: _____

Age: _____

Date: _____

This form asks you about emotions, moods, thoughts, and behaviors. For each question, circle **YES** in the column next to that question, if it describes how you have been acting, feeling, or thinking. If the item does not apply to you, circle **NO** in the column next to that question.

PLEASE ANSWER EVERY QUESTION.

YES	NO	QUESTION	DURING THE PAST 2 WEEKS
Yes	No	1	...did you feel sad or depressed?
Yes	No	2	...did you feel sad or depressed for most of the day, nearly every day?
Yes	No	3	...did you get less joy or pleasure from almost all of the things you normally enjoy?
Yes	No	4	...were you less interested in almost all of the activities you are usually interested in?
Yes	No	5	...was your appetite significantly <i>smaller</i> than usual nearly every day?
Yes	No	6	...was your appetite significantly <i>greater</i> than usual nearly every day?
Yes	No	7	...did you sleep at least 1 to 2 hours <i>less</i> than usual nearly every day?
Yes	No	8	...did you sleep at least 1 to 2 hours <i>more</i> than usual nearly every day?
Yes	No	9	...did you feel very jumpy and physically restless, and have a lot of trouble sitting calmly in a chair, nearly every day?
Yes	No	10	...did you feel tired out nearly every day?
Yes	No	11	...did you frequently feel guilty about things you have done?
Yes	No	12	...did you put yourself down and have negative thoughts about yourself nearly every day?
Yes	No	13	...did you feel like a failure nearly every day?
Yes	No	14	...did you have problems concentrating nearly every day?
Yes	No	15	...was decision making more difficult than normal nearly every day?
Yes	No	16	...did you frequently think of dying in passive ways like going to sleep and not waking up?
Yes	No	17	...did you wish you were dead?
Yes	No	18	...did you think you were better off dead?
Yes	No	19	...did you have thoughts of suicide, even though you would not really do it?
Yes	No	20	...did you seriously consider taking your life?
Yes	No	21	...did you think about a specific way to take your life?

Yes	No	22	...Have you <i>ever experienced</i> a traumatic event such as combat, rape, assault, sexual abuse, or any other extremely upsetting event?
Yes	No	23	...Have you <i>ever witnessed</i> a traumatic event such as rape, assault, someone dying in an accident, or any other extremely upsetting incident?
YES	NO	QUESTION	<u>DURING THE PAST 2 WEEKS</u>
Yes	No	24	...did thoughts about a traumatic event frequently pop into your mind?
Yes	No	25	...did you frequently get upset because you were thinking about a traumatic event?
Yes	No	26	...were you frequently bothered by memories or dreams of a traumatic event?
Yes	No	27	...did reminders of a traumatic event cause you to feel intense distress?
Yes	No	28	...did you try to block out thoughts or feelings related to a traumatic event?
Yes	No	29	...did you try to avoid activities, places, or people that reminded you of a traumatic event?
Yes	No	30	...did you have flashbacks, where it felt like you were reliving a traumatic event?
Yes	No	31	...did reminders of a traumatic event make you shake, break out into a sweat, or have a racing heart?
Yes	No	32	...did you feel distant and cutoff from other people because of having experienced a traumatic event?
Yes	No	33	...did you feel emotionally numb because of having experienced a traumatic event?
Yes	No	34	...did you give up on goals for the future because of having experienced a traumatic event?
Yes	No	35	...did you keep your guard up because of having experienced a traumatic event?
Yes	No	36	...were you jumpy and easily startled because of having experienced a traumatic event?

YES	NO	QUESTION	DURING THE PAST 2 WEEKS
Yes	No	37	...did you often go on eating binges (eating a <i>very large</i> amount of food very quickly over a short period of time)?
Yes	No	38	...did you often feel you could not control how much you were eating during an eating binge?
Yes	No	39	...did you go on eating binges during which you ate so much that you felt uncomfortably full?
Yes	No	40	...did you go on eating binges during which you ate a large amount of food even when you didn't feel hungry?
Yes	No	41	...did you eat alone during an eating binge because you were embarrassed by how much you were eating?
Yes	No	42	...did you go on eating binges and then feel disgusted with yourself afterwards?
Yes	No	43	...were you very upset with yourself because you were going on eating binges?
Yes	No	44	...to prevent gaining weight from an eating binge did you go on strict diets or exercise excessively?
Yes	No	45	...to prevent weight gain from an eating binge did you force yourself to vomit or use laxatives or water pills?
Yes	No	46	...was your weight, or the shape of your body, one of the most important things that affected your opinion of yourself?

YES	NO	QUESTION	DURING THE PAST 2 WEEKS
Yes	No	47	...did you worry obsessively about dirt, germs, or chemicals?
Yes	No	48	...did you worry obsessively that something bad would happen because you forgot to do something important – like locking the door, turning off the stove, or pulling out the electrical cords of appliances?
Yes	No	49	...were there things you felt compelled to do over and over (for at least ½ hour per day) that you could not stop doing when you tried?
Yes	No	50	...were there things you felt compelled to do over and over even though they interfered with getting other things done?
Yes	No	51	...did you wash and clean yourself or things around you obsessively and excessively?
Yes	No	52	...did you obsessively and excessively check things or repeat actions over and over again?
Yes	No	53	...did you count things obsessively and excessively?

YES	NO	QUESTION	DURING THE PAST 2 WEEKS
Yes	No	54	...did you get very scared because your heart was beating fast?
Yes	No	55	...did you get very scared because you were short of breath?
Yes	No	56	...did you get very scared because you were feeling shaky or faint?
Yes	No	57	...did you get sudden attacks of intense anxiety or fear that came on from out of the blue, for no reason at all?
Yes	No	58	...did you get sudden attacks of very intense anxiety or fear during which you thought something terrible might happen, such as your dying, going crazy; or losing control?
Yes	No	59	...did you have sudden, unexpected attacks of anxiety during which you had three or more of the following symptoms: heart racing or pounding, sweating, shakiness, shortness of breath, nausea, dizziness, or feeling faint?
Yes	No	60	...did you worry a lot about having unexpected anxiety attacks?
Yes	No	61	...did you have anxiety attacks that caused you to avoid certain situations or to change your behavior or normal routine?

YES	NO	QUESTION	DURING THE PAST 2 WEEKS
Yes	No	62	...did things happen that you knew were true, but that other people told you were your imagination?
Yes	No	63	...were you convinced that other people were watching you, talking about you, or spying on you?
Yes	No	64	...did you think that you were in danger because someone was plotting to hurt you?
Yes	No	65	...did you think that you had special powers other people didn't have?
Yes	No	66	...did you think that some outside force or power was controlling you body or mind?
Yes	No	67	...did you hear voices that other people didn't hear, or see things that other people didn't see?

YES	NO	QUESTION	DURING THE PAST 2 WEEKS
Yes	No	68	...did you regularly avoid any situations because you were afraid they'd cause you to have an anxiety attack?
		69	...did any of the following make you feel fearful, anxious, or nervous because you were afraid you'd have an anxiety attack in the situation?
Yes	No	a.	going outside far away from home
Yes	No	b.	being in crowded places
Yes	No	c.	standing in long lines
Yes	No	d.	being on a bridge or in a tunnel
Yes	No	e.	traveling in a bus, train, or plane
Yes	No	f.	driving or riding in a car
Yes	No	g.	being home alone
Yes	No	h.	being in wide-open spaces (like a park)
Yes	No	70	...did you almost always get very anxious as soon as you were in any of the above situations?
Yes	No	71	...did you avoid any of the above situations because they made you feel anxious or fearful?

YES	NO	QUESTION	DURING THE PAST 2 WEEKS
Yes	No	72	...did you worry a lot about embarrassing yourself in front of others?
Yes	No	73	...did you worry a lot that you might do something to make people think that you were stupid or foolish?
Yes	No	74	...did you feel very nervous in situations where people might pay attention to you?
Yes	No	75	...were you extremely nervous in social situations?
Yes	No	76	...did you regularly avoid any situations because you were afraid you'd do or say something to embarrass yourself?
		77	...did you worry a lot about doing or saying something to embarrass yourself in any of the following situations?
Yes	No	a.	public speaking
Yes	No	b.	eating in front of other people
Yes	No	c.	using public restrooms
Yes	No	d.	writing in front of others
Yes	No	e.	saying something stupid when you were with a group of people
Yes	No	f.	asking a question when in a group of people
Yes	No	g.	business meetings
Yes	No	h.	parties or other social gatherings
Yes	No	78	...did you almost always get very anxious as soon as you were in any of the above situations?
Yes	No	79	...did you avoid any of the above situations because they made you feel anxious or fearful?

YES	NO	QUESTION	DURING THE PAST 2 WEEKS
Yes	No	80	...did you think that you were drinking too much?
Yes	No	81	...did anyone in your family think or say that you were drinking too much, or that you had an alcohol problem?
Yes	No	82	...did friends, a doctor, or anyone else think or say that you were drinking too much?
Yes	No	83	...did you think about cutting down or limiting your drinking?
Yes	No	84	...did you think that you had an alcohol problem?
Yes	No	85	...because of your drinking did you have problems in your marriage; at your job; with your friends or family; doing household chores; or in any other important area of your life?

YES	NO	QUESTION	DURING THE PAST 2 WEEKS
Yes	No	86	...did you think that you were using drugs too much?
Yes	No	87	...did anyone in your family think or say that you were using drugs too much, or that you had a drug problem?
Yes	No	88	...did friends, a doctor, or anyone else think or say that you were using drugs too much?
Yes	No	89	...did you think about cutting down or limiting your drug use?
Yes	No	90	...did you think that you had a drug problem?
Yes	No	91	...because of your drug use did you have problems in your marriage; at your job; with your friends or family; doing household chores; or in any other important area of your life?

YES	NO	QUESTION	DURING THE PAST 2 WEEKS
Yes	No	92	...were you a nervous person on most days?
Yes	No	93	...did you worry a lot that bad things might happen to you or someone close to you?
Yes	No	94	...did you worry about things that other people said you shouldn't worry about?
Yes	No	95	...were you worried or anxious about a number of things in your daily life on most days?
Yes	No	96	...did you often feel restless or on edge because you were worrying?
Yes	No	97	...did you often have problems falling asleep because you were worrying about things?
Yes	No	98	...did you often feel tension in your muscles because of anxiety or stress?
Yes	No	99	...did you often have difficulty concentrating because your mind was on your worries?
Yes	No	100	...were you often snappy or irritable because you were worrying or feeling stressed out?
Yes	No	101	...was it hard for you to control or stop your worrying on most days?

YES	NO	QUESTION	DURING THE PAST 2 WEEKS
Yes	No	102	...have you had a lot of stomach and intestinal problems such as nausea, vomiting, excessive gas, stomach bloating, or diarrhea?
Yes	No	103	...have you been bothered by aches and pains in many different parts of your body?
Yes	No	104	Do you get sick more than most people?
Yes	No	105	Has your physical health been poor <i>most of your life</i> ?
Yes	No	106	Are your doctors <i>usually</i> unable to find a physical cause for your physical symptoms?

YES	NO	QUESTION	DURING THE PAST 2 WEEKS
Yes	No	107	...did you often worry that you might have a serious physical illness?
Yes	No	108	...was it hard to stop worrying that you have a serious physical illness?
Yes	No	109	...did your doctor say you didn't have a serious illness but it was still hard to stop thinking about it?
Yes	No	110	...did you worry so much about having a serious illness that it interfered with your activities or it caused you problems?
Yes	No	111	...did you visit the doctor a lot because you were worried that you had a serious physical illness?