The SCIP Self-administered (SA) Scales

	Self-administered (SA) Scales	Number of items
1	Anxiety	9
2	Panic	5
3	Phobia	9
4	OCD	18
5	PTSD	16
6	Depression	12
7	Mania	11
8	Hallucinations	9
9	Delusions	9
10	Alcohol	8
11	Drug	7
12	Anorexia Nervosa	9
13	Binge and Bulimia	17
14	ADHD	20
15	Intake self-administered	18

1. SCIP Generalized Anxiety Rating Scale

(Self-Administered)

Instructions: Circle the number that best describes how you have felt either during the past month OR since your last visit.

During the past month OR since your last visit…

1. Have you had excessive worry and anxiety for long periods of time (e.g., for hours each day, lasting several months), not just during panic attacks?
0 No, *or* Some anxiety, but it does not bother me. 1 Yes. . Not sure *or* Not applicable *or* Missing.
2. Have you felt restless, keyed up or on edge when anxious?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.
3. Have you felt tense in your muscles when anxious?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.
4. Have you felt tired, or easily exhausted even without work when anxious?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing. .

5. Have you had difficulty concentrating when anxious?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.
6. Have you felt irritable when anxious?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.
7. Have you had difficulty falling asleep or staying asleep when anxious?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.
8. When you experience anxiety and worry, do you feel anxious for less than half the time or more than half the time while you are awake?
0 No generalized anxiety or anxiety is non-significant. 1 Anxiety occurs less than half the time while awake, on more days than not. 2 Anxiety occurs more than half the time while awake, on more days than not. . Not sure or Not applicable or Missing.
9. In the past 12 months, how many months have you felt anxious?
0 None 1 Less than one month. 2 1-5 months. 3 6-12 months.

GENERALIZED ANXIETY SCORE:			
SEVERITY OF ANXIETY	**1**	**Mild**	**1-3**
	2	**Moderate**	**4-6**
	3	**Severe**	**7 or more**

2. SCIP PANIC SCALE
(Self-Administered)

Instructions: Please circle the number that best describes how you felt **during the past month.**

1a. Did you have a panic attack, when you suddenly become anxious and frightened for a short period of time (up to 60 minutes)?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.
1b. During that time, did you feel that your heart was racing or pounding, or did you start shaking or sweating, or did you feel you were choking?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.
2. Please write down the frequency of panic attacks you have per week in the space provided below.
3a. After a panic attack, do you worry about having another attack?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.
3***b. Do you worry about the effects of panic attacks (e.g., losing control, having a heart attack or going crazy)?***
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.

4a. Did you have to do something to end the panic attack, like leaving a store, calling someone, taking deep breaths?

0 No.

1 Yes.

. Not sure *or* Not applicable *or* Missing.

4b. Do you do anything to prevent panic attacks (like avoiding places that trigger the panic attacks)?

0 No.

1 Yes.

. Not sure *or* Not applicable *or* Missing.

5. Please circle all of the symptoms (listed in the space below) that you experience while having a panic attack.

1. Patient cannot catch breath and has feeling of being smothered.
2. Patient has chest pain or discomfort.
3. Patient has feeling of choking.
4. Patient feels heart is pounding, missing beats, or beating faster.
5. Patient feels dizzy, unsteady, light-headed, or faint.
6. Patient has numbness or tingling sensations in face or fingers.
7. Patient has dry mouth or difficulty swallowing.
8. Patient has nausea or abdominal distress.
9. Patient has trembling or shaking of hands or limbs.
10. Patient has sweating, e.g., palms.
11. Patient feels very cold.
12. Patient has hot flushes.
13. Patient has fear of dying.
14. Patient has fear of going crazy, or fear of losing emotional control.

15. Patient feels that things are not real.

16. Patient feels that people are not real.

PANIC SCALE SCORE =

3. SCIP PHOBIA SCALE
(Self-Administered)

Instructions: Please circle the number that best describes how you felt **during the past month.**

SOCIAL PHOBIA

1a. Have you been afraid and anxious when you do things in front of people, such as eating or speaking in public?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.
1b. Do you avoid social situations that involves other people or endure them with intense fear?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.
2. Have you ever experienced panic attacks because of your fear/anxiety of doing things in front of people?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.

3. <u>If you answered YES to question 2</u>, please circle all of the symptoms (listed in the space below) that you experience while having a panic attack.

1. Patient cannot catch breath and has feeling of being smothered.
2. Patient has chest pain or discomfort.
3. Patient has feeling of choking.
4. Patient feels heart is pounding, missing beats, or beating faster.
5. Patient feels dizzy, unsteady, light-headed, or faint.
6. Patient has numbness or tingling sensations in face or fingers.
7. Patient has dry mouth or difficulty swallowing.
8. Patient has nausea or abdominal distress.
9. Patient has trembling or shaking of hands or limbs.
10. Patient has sweating, e.g., palms.
11. Patient feels very cold.
12. Patient has hot flushes.
13. Patient has fear of dying.
14. Patient has fear of going crazy, or fear of losing emotional control.
15. Patient feels that things are not real.
16. Patient feels that people are not real.

SOCIAL PHOBIA SCORE: Sum items 1-3

AGORAPHOBIA:

4a. Have you been afraid of being alone (at home or outside of the home), traveling in a car/train/plane, being in an open space (e.g., park) or being in a closed space (e.g., store), or being in crowds?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.
4b. Do you avoid these situations, or require a companion, or endure with intense fear?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.
5. Do you experience panic attacks because of your fear of being alone, traveling in a car/train/plane, being in an open space (e.g., park), being in a closed space (e.g., store), or being in crowds?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.

6. <u>If you answered YES to question 5,</u> please circle all of the symptoms (listed in the space below) that you experience while having a panic attack.

1. Patient cannot catch breath and has feeling of being smothered.
2. Patient has chest pain or discomfort.
3. Patient has feeling of choking.
4. Patient feels heart is pounding, missing beats, or beating faster.
5. Patient feels dizzy, unsteady, light-headed, or faint.
6. Patient has numbness or tingling sensations in face or fingers.
7. Patient has dry mouth or difficulty swallowing.
8. Patient has nausea or abdominal distress.
9. Patient has trembling or shaking of hands or limbs.
10. Patient has sweating, e.g., palms.
11. Patient feels very cold.
12. Patient has hot flushes.
13. Patient has fear of dying.
14. Patient has fear of going crazy, or fear of losing emotional control.
15. Patient feels that things are not real.
16. Patient feels that people are not real.

AGORAPHOBIA SCORE: Sum items 4-6

SPECIFIC PHOBIA

7a.	***Have you had strong fears of certain objects or situations (e.g., heights, animals, spiders, snakes, seeing blood, receiving injections)?***
	0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.
7b.	***Do you avoid objects or situations, or endure with intense fear?***
	0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.
8. Have you ever experienced a panic attack because of the object/situation you have a strong fear of?	
	0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.

9. <u>If you answered YES to question 8,</u> please circle all of the symptoms (listed in the space below) that you experience while having a panic attack.

1. Patient cannot catch breath and has feeling of being smothered.
2. Patient has chest pain or discomfort.
3. Patient has feeling of choking.
4. Patient feels heart is pounding, missing beats, or beating faster.
5. Patient feels dizzy, unsteady, light-headed, or faint.
6. Patient has numbness or tingling sensations in face or fingers.
7. Patient has dry mouth or difficulty swallowing.
8. Patient has nausea or abdominal distress.
9. Patient has trembling or shaking of hands or limbs.
10. Patient has sweating, e.g., palms.
11. Patient feels very cold.
12. Patient has hot flushes.
13. Patient has fear of dying.
14. Patient has fear of going crazy, or fear of losing emotional control.
15. Patient feels that things are not real.
16. Patient feels that people are not real.

SPECIFIC PHOBIA SCORE: Sum items 7-9

4. SCIP OCD Scale

(Self-Administered)

Instructions: Please circle the number that best describes how you felt **during the past week.**

OBSESSIONS:

1. "Obsessive thoughts" are thoughts or images in your mind that do not make sense and keep coming back to your mind even when you try to avoid them. ***In the past week, did you have obsessive thoughts?***
0 No. 1 Yes, for less than 1 hour/day. 2 Yes, for 1-4 hours/day. 3 Yes, for more than 4 hours/day. . Not sure *or* Not applicable *or* Missing.
2. In the past week, on approximately how many days did you have obsessive thoughts?
0 1 2 3 4 5 6 7
3. In the past week, did you have obsessive thoughts related to aggression? ***Potential examples: fears of harming oneself, fears of unintentionally hurting someone, urges to stab someone, thoughts of "losing control" and hurting a partner or significant other.***
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.
4. In the past week, did you have obsessive thoughts related to contamination, germs, or sickness? ***Potential examples: fear of contamination in public bathrooms, outdoors, or public places, fear of what might happen after touching one's own bodily secretions, fear of getting germs or viruses from others.***
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.

5. In the past week, did you have obsessive thoughts related to sex or sexuality? ***<u>Potential examples:</u> disturbing thoughts about sex, unwanted images of sexual acts toward strangers, family members or children, fear of being found with pornography.***
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.
6. In the past week, did you have obsessive thoughts related to religion? ***<u>Potential examples</u>: fear of having blasphemous or "sinful" thoughts, concerns for engaging in sinful or forbidden behavior, feeling the need to complete a certain number of prayers or "good deeds".***
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.
7. In the past week, did you have obsessive thoughts related to your health? ***<u>Potential examples:</u> worries about having an undiagnosed illness like cancer or heart disease, fear of contracting a deadly disease, images of your own death.***
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.
8. In the past week, did you have obsessive thoughts about your physical appearance*?** ***<u>Potential examples:</u> worries about the size of certain body parts (ears, nose, mouth), fears of certain body parts being disgusting to others.
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.
9. In the past week, did you have obsessive thoughts about anything else that was not mentioned yet?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.

OBSESSION SCORE			
SEVERITY OF OBSESSION	**1**	**Mild**	**1-3**
	2	**Moderate**	**4-8**
	3	**Severe**	**9 or more**

COMPULSIONS:

1a. ***"Compulsive behaviors" are things you feel you must do over and over, such as washing your hands even if they are clean, checking doors and windows more than once, or repeating mental acts such as counting or praying.***

In the past week, did you have compulsive behaviors?

0 No.

1 Yes, for less than 1 hour/day.

2 Yes, for 1-4 hours/day.

3 Yes, for more than 4 hours/day.

. Not sure *or* Not applicable *or* Missing.

1b. Do you get very anxious or tense if you did not repeat the behaviors?

0 No.

1 Yes.

. Not sure *or* Not applicable *or* Missing.

2. In the past week, on approximately how many days did you engage in a compulsive behavior?

0 1 2 3 4 5 6 7

3. In the past week, did you check things over and over again?

<u>Potential examples:</u> checking door locks, switches, or appliances many times before leaving the house, checking one's appearance for an excessive amount of time before leaving the house.

0 No.

1 Yes.

. Not sure *or* Not applicable *or* Missing.

4. In the past week, did you clean or wash things over and over again?

<u>Potential examples:</u> excessively changing your clothes, excessive handwashing, tooth brushing, showering, scrubbing surfaces.

0 No.

1 Yes.

. Not sure *or* Not applicable *or* Missing.

5. In the past week, did you repeat things many times? ***<u>Potential examples</u>: re-reading text out of concerns that one "missed something", re-writing or re-tracing words, re-entering buildings or living spaces, re-tying one's shoes.***
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.
6. In the past week, did you arrange and rearrange things, order and reorder items over and over again? ***<u>Potential examples:</u> re-arranging one's pantry or refrigerator, spending excessive amounts of time organizing one's desk or workspace.***
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.
7. In the past week, did you feel the need to collect and/or hoard things? ***<u>Potential examples:</u> picking up, collecting or buying useless things, owning an excessive amount of items and being unable to donate or get rid of them.***
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.
8. In the past week, did you engage in any repetitive counting or rituals in your mind? ***<u>Potential examples:</u> repetitively counting certain numbers or avoiding certain "bad" numbers, repeating certain words, counting senseless things (e.g., ceiling tiles), reciting prayers or statements.***
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.
9. In the past week, did you engage in any other repetitive behaviors that were not yet mentioned in order to manage or avoid distress?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.

COMPULSIONS SCORE/SEVERITY OF COMPULSION

1	**Mild**	**1-3**
2	**Moderate**	**4-8**
3	**Severe**	**9 or more**

5. SCIP PTSD Rating Scale
(Self-Administered)

Instructions: Please circle the number that best describes how you felt **during the past month.**

1a. Have you ever witnessed or experienced a traumatic event that involved actual or threatened death or serious injury to you or someone else (e.g., physical or sexual abuse, rape, terrorist attack, natural disaster, war…)?
0 I have not experienced any traumatic events. 1 I have experienced **one traumatic event.** 2 I have experienced **several traumatic events.** . Not sure *or* Not applicable *or* Missing.
1b. Did you feel intense fear and helplessness?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.
2. Did you have recurrent upsetting memories (distressing recollection) of the event?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.
3. Did you have recurrent upsetting dreams or nightmares of the event?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.
4. Did you have a sense or feeling that the event was happening again, the sense of reliving the event (flashbacks)?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.

5. Did you try to avoid thoughts and feelings associated with the event?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.
6. Did you try to avoid things that reminded you of the event (such as certain people, certain places, or some activities)?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.
7. Did you have difficulty remembering some or all important aspects of the event?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.
8. Did you spend less time or show less interest in activities with friends/family or hobbies that you used to enjoy due to the event?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.
9. Did you feel distant, cut off, or isolated from other people due to the event?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.
10a. Did you feel emotionally numb?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.

10b. Did you have trouble experiencing feelings (happiness, love feelings) due to the event?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.
11. Did you have difficulty falling or staying asleep due to the event?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.
12. Did you have periods of irritability or sudden outbursts of anger due to the event?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.
13. Did you have difficulty concentrating due to the event?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.
14. Did you feel very alert or watchful of things going on around you even when there was no need to be?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.
15a. Did you feel easily startled?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.

15b. Were you easily scared or did you make a sudden movement or jump when you heard noises or if you were caught by surprise?	
0	No.
1	Yes.
.	Not sure *or* Not applicable *or* Missing.
16. Did you have any other symptoms due to the event that are troubling you?	
0	No.
1	Yes (please specify in the space provided below):

PTSD SCORE:			
SEVERITY OF PTSD:	**1**	**Mild**	**1-3**
	2	**Moderate**	**4-8**
	3	**Severe**	**9 or more**

6. SCIP Depression Rating Scale
(Self-administered)

Instructions: Circle the number that best describes how you have felt either during the past month OR since your last visit.

During the past month OR since your last visit…

1. Have you felt sad, depressed or in low spirits?	
0	No.
1	Yes, some of the time.
2	Yes, most of the time.
.	Not sure *or* Not applicable *or* Missing.
2. Did you lose interest in things, or not enjoy things you normally would?	
0	No.
1	Yes, some of the time.
2	Yes, most of the time.
.	Not sure *or* Not applicable *or* Missing.
3. Did you feel hopeless about the future?	
0	No.
1	Yes, some of the time.
2	Yes, most of the time.
.	Not sure *or* Not applicable *or* Missing.
4. Did you have trouble concentrating to complete a task, read an article, or watch a show?	
0	No.
1	Yes, some of the time.
2	Yes, most of the time.
.	Not sure *or* Not applicable *or* Missing.

5. Did you talk or move very slowly?	
0	No.
1	Yes, some of the time.
2	Yes, most of the time.
.	Not sure *or* Not applicable *or* Missing.
6. Did you feel worthless or like a failure?	
0	No.
1	Yes, some of the time.
2	Yes, most of the time.
.	Not sure *or* Not applicable *or* Missing.
7. Did you feel very guilty or ashamed for something you have done or thought?	
0	No.
1	Yes, some of the time.
2	Yes, most of the time.
.	Not sure *or* Not applicable *or* Missing.
8. Any other depressive symptoms (for example, appetite changes, sleep changes, or losing interest in sex)?	
0	No.
1	Yes.
.	Not sure *or* Not applicable *or* Missing.
9. Did you have thoughts of killing yourself?	
0	No.
1	Yes.
.	Not sure *or* Not applicable *or* Missing.

10. Did you intend to carry out the suicidal thoughts in the past month?	
0	No.
1	Yes.
.	Not sure *or* Not applicable *or* Missing.
11. Did you make a specific plan to kill yourself in the past month?	
0	No.
1	Yes.
.	Not sure *or* Not applicable *or* Missing.
12. Did you make a suicide attempt in the past month?	
0	No, I did not make a suicide attempt in the past month.
1	Yes, one suicide attempt in the past month.
2	Yes, two or more suicide attempts in the past month.
.	Not sure *or* Not applicable *or* Missing.

DEPRESSION SCORE =			
SEVERITY OF DEPRESSION	**1**	**Mild**	**1- 4**
	2	**Moderate**	**5-8**
	3	**Severe**	**9 or more**

7. SCIP Mania Rating Scale

(Self-administered)

Instructions: Circle the number that best describes how you have felt either during the past month OR since your last visit.

During the past month OR since your last visit…

1. Did you feel extremely happy, elated, or on top of the world?
0 No. 1 Yes, some of the time. 2 Yes, most of the time. . Not sure *or* Not applicable *or* Missing.
2. Did you feel irritable without a reason (for example, shouting at people, starting an argument, or becoming aggressive)?
0 No. 1 Yes, some of the time. 2 Yes, most of the time. . Not sure *or* Not applicable *or* Missing.
3. Did you experience quick changes in mood or mood swings (depressed and happy or depressed and irritable) on the same day?
0 No. 1 Yes, some of the time. 2 Yes, most of the time. . Not sure *or* Not applicable *or* Missing.
4. Did you have racing thoughts going through your mind?
0 No. 1 Yes, some of the time. 2 Yes, most of the time. . Not sure *or* Not applicable *or* Missing.

5. Did you notice that you were speaking very quickly, or that other people told you that you were speaking very fast?
0 No. 1 Yes, some of the time. 2 Yes, most of the time. . Not sure *or* Not applicable *or* Missing.
6. Did you have too much energy and start more projects than usual at work, school, or socially?
0 No. 1 Yes, some of the time. 2 Yes, most of the time. . Not sure *or* Not applicable *or* Missing.
7. Did you feel rested after sleeping 4 hours or less (in a 24-hour period including naps)?
0 No. 1 Yes, some days. . Not sure *or* Not applicable *or* Missing.
8. Were you easily distracted by noises?
0 No. 1 Yes, some of the time. 2 Yes, most of the time. . Not sure *or* Not applicable *or* Missing.
9. Did you feel very self-confident, or that you have special abilities others do not have?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.
10. Did you spend a lot of money, even if you couldn't afford it?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.

11. Did you engage in a risky behavior that is out of character for you (for example, being hypersexual, aggressive driving, illegal drug use, or gambling)?	
0	No.
1	Yes.
.	Not sure *or* Not applicable *or* Missing.

MANIA SCORE			
SEVERITY OF MANIA	**1**	**Mild**	**1-3**
	2	**Moderate**	**4-8**
	3	**Severe**	**9 or more**

8. SCIP Hallucinations Rating Scale

(Self-administered)

Instructions: Circle the number that best describes how you have felt either during the past month OR since your last visit.

During the past month OR since your last visit…

1. Do you hear noises (for example music or whispering sounds) or voices talking to you when there is no one around? Do voices sometimes give you commands to do things?
0 No. 1 Yes, but without voices telling me to do things. 2 Yes, with voices telling me do things. . Not sure *or* Not applicable *or* Missing.
2. How often did you hear these sounds or voices (hallucinations)?
0 Never. 1 1-4 days out of the last month. 2 5-15 days out of the last month. 3 More than 15 days out of the last month. . Not sure *or* Not applicable *or* Missing.
3. How long do these sounds or voices (hallucinations) last on days when you hear them (on average)?
0 I don't hear these sounds or voices. 1 Less than 1 hour per day. 2 1-4 hours per day. 3 More than 4 hours per day. . Not sure *or* Not applicable *or* Missing.
4. Do you think that your thoughts are so loud that someone close to you can hear what you are thinking?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.

5. Do you hear two or more voices that argue about what you are doing or thinking?	
0	No.
1	Yes.
.	Not sure *or* Not applicable *or* Missing.
6. Do you hear a voice or voices commenting on what you are doing or thinking?	
0	No.
1	Yes.
.	Not sure *or* Not applicable *or* Missing.
7. Do people sometimes say that they observe you talking to yourself or talking to unseen?	
0	No.
1	Yes.
.	Not sure *or* Not applicable *or* Missing.
8. Do you see things other people cannot see (for example, shadows, objects or people)?	
0	No.
1	Yes.
.	Not sure *or* Not applicable *or* Missing.
9. Do you notice unusual smells you cannot explain? ***Do you experience strange tastes in your mouth?*** ***Do you feel strange sensations on your body?***	
0	No.
1	Yes.
.	Not sure *or* Not applicable *or* Missing.

HALLUCINATIONS SCORE:			
SEVERITY OF HALLUCINATIONS	**1**	**Mild**	**1-3**
	2	**Moderate**	**4-8**
	3	**Severe**	**9 or more**

9. SCIP Delusions Rating Scale

(Self-administered)

Instructions: Circle the number that best describes how you have felt either **during the past month OR since your last visit.**

During the past month OR since your last visit.

1. Do you feel or have a bodily sensation (e.g., something is crawling under your skin) and think it is caused by an outside person or force?	
0	No.
1	Yes.
.	Not sure *or* Not applicable *or* Missing.
2. Do you think that thoughts in your mind are not your own thoughts and that they were inserted into your mind by an outside person or force?	
0	No.
1	Yes.
.	Not sure *or* Not applicable *or* Missing.
3. Do you think that your thoughts have been taken out of your mind by an outside person or force?	
0	No.
1	Yes.
.	Not sure *or* Not applicable *or* Missing.
4. Do you think that your thoughts are broadcast so that people are able to know what you are thinking, even if they are in different places?	
0	No.
1	Yes.
.	Not sure *or* Not applicable *or* Missing.
5. Do you think that someone or some group of people are after you, spying on you, or even trying to harm you?	
0	No.
1	Yes, some of the time.
2	Yes, most of the time.
.	Not sure *or* Not applicable *or* Missing.

6. Do you think there is a plot or a conspiracy against you by an outside person or force or agency (e.g., a person, FBI, CIA)?
0 No. 1 Yes, some of the time. 2 Yes, most of the time. . Not sure *or* Not applicable *or* Missing.
7. Do you think the TV, the radio, or the newspaper are sending special messages that are intended specifically for you?
0 No. 1 Yes, some of the time. 2 Yes, most of the time. . Not sure *or* Not applicable *or* Missing.
8. Do you have other thoughts or beliefs that other people say they are not real?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.
9. Do you have other thoughts or beliefs that other people say they are very strange or bizarre?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.

DELUSIONS SCORE =			
SEVERITY OF DELUSIONS	**1**	**Mild**	**1-3**
	2	**Moderate**	**4-5**
	3	**Severe**	**6 or more**

10. SCIP Alcohol Use Rating Scale (Self-Administered)

Over the past year, how often do you drink alcohol (please circle one)?

0 Never or monthly or less.

1 2-4 times a month.

2 2-4 times a week.

3 5 or more times a week.

On a typical day when you drink alcohol, how many drinks do you usually have (please circle one)?

0 1-2 drinks a day.

1 3-5 drinks a day.

2 6 or more drinks a day.

When was the last time you had a drink containing alcohol (please write your answer in the space provided below)?

Instructions: For the remaining questions, please circle the number that best describes how you felt **during the past year.**

1a. Did you use a lot more alcohol than you previously used to get the same effect (compared when you first started to drink)?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.
1b. Did you notice that the same amount of alcohol you take now has less effect than before (compared when you first started to drink)?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.

2. When you stopped or cut down on alcohol use, did you have withdrawal symptoms (e.g., shakes, hand tremors, sweating, seizure)?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.
3. Did alcohol use result in failure to fulfill major role obligations (work, school or home)?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.
4. Did alcohol cause any social or interpersonal problems (e.g., work problems, school problems, relationship problems, family problems, legal problems, physical fights)?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.
5. Did you continue to use alcohol even though you had problems?
0 No, *or* I did not have any problems. 1 Yes, I continued to use alcohol even though alcohol caused problems. . Not sure *or* Not applicable *or* Missing.
6. Did you use alcohol in a situation, in which it was physically hazardous (e.g., driving a car or operating machinery)?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.
7. Did you have a blackout after drinking so much alcohol that the next day you could not remember what you said or did?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.

8. Did you have any other problems due to alcohol use?	
0	No.
1	Yes (please specify in the space provided below):

ALCOHOL USE SCORE =			
SEVERITY OF ALCOHOL USE SCORE	**1**	**Mild**	**1-3**
	2	**Moderate**	**4-5**
	3	**Severe**	**6 or more**

11. SCIP Drug Use Rating Scale
(Self-Administered)

Please write in the provided space below the name of the drug causing you the most problems, or that is the focus of the visit today:

Over the past year, how often did you use the drug (please circle one)?

0 Never or monthly or less.

1 2-4 times a month.

2 2-4 times a week.

3 5 or more times a week.

When was the last time you used the drug (please write your answer in the space below)?

Instructions: For the remaining questions, please circle the number that best describes how you felt **during the past year.**

1a. Did you use a lot more of the drug than you previously used to get the same effect (compared when you first started to use the drug)?

0 No.

1 Yes.

. Not sure *or* Not applicable *or* Missing.

1b. Did you notice that the same amount of the drug you take now has less effect than before (compared when you first started to use the drug)?

0 No.

1 Yes.

. Not sure *or* Not applicable *or* Missing.

2. When you stopped or cut down on the drug use, did you have withdrawal symptoms?

0 No.

1 Yes.

. Not sure *or* Not applicable *or* Missing.

3. Did the drug use result in failure to fulfill major role obligations at work, school or home?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.
4. Did the drug cause any social or interpersonal problems (e.g., work problems, school problems, relationship problems, family problems, legal problems, physical fights)?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.
5. ***Did you continue to use the drug even though you had problems?***
0 No, *or* the drug use did not cause me any problems. 1 Yes. . Not sure *or* Not applicable *or* Missing.
6. Did you use the drug in a situation, in which it was physically hazardous (e.g., driving a car or operating machinery)?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.
7. Did you have any other problems due to drug use?
0 No. 1 Yes (please specify in the space provided below):

SEVERITY OF DRUG ABUSE	**1**	**Mild**	**1-3**
	2	**Moderate**	**4-5**
	3	**Severe**	**6 or more**

12. SCIP Anorexia Nervosa Scale
(Self-Administered)

Instructions: Please fill in the information requested for the following questions.

A. How tall are you? ____feet _____ inches

B. How much do you weigh now? ____lbs.

C. What has been your highest weight ever (when not pregnant)? ____lbs.

When was that? _____

D. What has been your lowest weight ever (when not physically ill)? ____lbs.

When was that? _____

1a. Have you ever been very thin and could not maintain a minimal normal weight?	
0	No.
1	Yes.
.	Not sure *or* Not applicable *or* Missing.
1b. Have people ever said you weighed much less than normal?	
0	No.
1	Yes.
.	Not sure *or* Not applicable *or* Missing.

Instructions: For the remaining questions, please circle the number that best describes how you felt **during the past three months.**

2. Do you feel that your weight and shape are very important and affect how you feel about yourself to the point that you do not worry about the health risks of being so little?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.
3. Do you have an intense fear of gaining weight or becoming fat, even though you are underweight?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.
4. Do you try to lose weight by fasting (not eating anything at all for at least 24 hours)?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.
5. Do you try to lose weight by exercising too much (more than one hour a day for at least one week)?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.
6. Do you try to lose weight by using diet pills?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.

7. Do you try to lose weight by inducing vomiting?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.
8. Do you try to lose weight by taking laxatives or using enemas?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.
9. Do you try to lose weight by taking diuretics or by other methods?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.

ANOREXIA NERVOSA SCORE = sum of items 1 through 9

13. SCIP Binge and Bulimia Scales (Self-Administered)

Instructions: Please fill in the information requested for the following questions.

A. How tall are you? ____feet _____ inches

B. How much do you weigh now? ____lbs.

C. What has been your highest weight ever (when not pregnant)? ____lbs.

When was that? _____

D. What has been your lowest weight ever (when not physically ill)? ____lbs.

When was that? _____

Binge Eating

1. Do you have episodes of binge eating (eating within one or two-hour period what most people would consider an unusually large amount of food)?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.
2. Please circle the number that best represents the <u>frequency</u> in which you binge eat (on average):
0 None. 1 1-3 times per month. 2 at least once per week for the past 3 months. . Not sure *or* Not applicable *or* Missing.

3. During the episodes of binge eating, did you feel that you had lost control and could not stop eating?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.
4. During the episodes of binge eating, did you eat much more rapidly than usual?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.
5. During the episodes of binge eating, did you eat until you felt uncomfortably full?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.
6. During the episodes of binge eating, did you eat a large amount of food when you did not feel physically hungry?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.
7. During the episodes of binge eating, did you eat alone because you were embarrassed by how much you were eating?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.
8. During the episodes of binge eating, did you feel disgusted with yourself, depressed or guilty by your overeating?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.

9. During the episodes of binge eating, did you feel quite upset or very distressed by your overeating?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.

BINGE EATING SCORE = Sum of items 1 through 9

Bulimia Nervosa

10. After binge eating episodes, did you try to lose weight by fasting (not eating anything at all for at least 24 hours)?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.
11. After binge eating episodes, did you try to lose weight by exercising too much (more than one hour a day for at least one week)?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.
12. After binge eating episodes, did you try to lose weight by using diet pills?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.
13. After binge eating episodes, did you try to lose weight by inducing vomiting?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.
14. After binge eating episodes, did you try to lose weight by taking laxatives or enemas?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.
15. After binge eating episodes, did you try to lose weight by taking diuretics or other methods?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.

16. Binge compensatory behaviors frequency:
0 None. 1 1-3 times per month. 2 At least once a week for 3 months. . Not sure *or* Not applicable *or* Missing.
17. Other eating behaviors: ***Do you have any other eating behaviors?***
0 Absent or non-significant. 1 Present. . Not sure *or* Not applicable *or* Missing.

BULIMIA NERVOSA SCORE = sum of items 1 through 17

14. SCIP Attention Deficit (Self-Administered)

Instructions: *Circle the number that best describes how you have felt either* ***during the past month OR since your last visit.***

1. Do you have difficulty paying attention and concentrating when reading an article, watching a TV show or a movie, or doing your work or school assignments?
0 No, *or* Sometimes, but it does not bother me. 1 Yes. . Not sure *or* Not applicable *or* Missing.
2. Do you have difficulty concentrating on one thing for a long time (for example, reading a book, writing a letter)?
0 No, *or* Sometimes, but it does not bother me. 1 Yes. . Not sure *or* Not applicable *or* Missing.
3. Do you avoid tasks that require a lot of concentration at work, school, or home (for example, reading a book or writing a letter)?
0 No, *or* Sometimes, but it does not bother me. 1 Yes. . Not sure *or* Not applicable *or* Missing.
4. Do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?
0 No, *or* Sometimes, but it does not bother me. 1 Yes, even when they are speaking to me directly. . Not sure *or* Not applicable *or* Missing.

5a. Do you have difficulty with tasks that require organization and keeping track of many things all at once (for example, planning and organizing your work or household chores)?
0 No, *or* Sometimes, but it does not bother me. 1 Yes. . Not sure *or* Not applicable *or* Missing.
5b. Do you have difficulty managing your time (for example, usually fail to meet deadlines)?
0 No, *or* Sometimes, but it does not bother me. 1 Yes. . Not sure *or* Not applicable *or* Missing.
6. Do you change from one activity to another without finishing anything?
0 No, *or* Sometimes, but it does not bother me. 1 Yes. . Not sure *or* Not applicable *or* Missing.
7. Are you easily distracted by activity or noise around you?
0 No, *or* Sometimes, but it does not bother me. 1 Yes. . Not sure *or* Not applicable *or* Missing.
8. Do you lose or misplace things more often than others do (for example, wallets, keys, cell phones)?
0 No, *or* Sometimes, but it does not bother me. 1 Yes. . Not sure *or* Not applicable *or* Missing.
9. Do you forget daily activities more often than others do (for example, appointments, paying bills, returning phone calls)?
0 No, *or* Sometimes, but it does not bother me. 1 Yes. . Not sure *or* Not applicable *or* Missing.

10. Do you lose track of what you are doing (for example, forget why you went to get something)?	
0	No, *or* Sometimes, but it does not bother me.
1	Yes, I lose track of what I am doing.
.	Not sure *or* Not applicable *or* Missing.

ATTENTION PROBLEMS SCORE			
SEVERITY OF ATTENTION PROBLEMS	**1**	**Mild**	**1-3**
	2	**Moderate**	**4-8**
	3	**Severe**	**9 or more**

SCIP (HYPERACTIVITY)
(Self-Administered)

Instructions: Circle the number that best describes how you have felt either **during the past month OR since your last visit.**

1. Do you have difficulty remaining seated (fidget with hands and feet, squirm or wiggle in seat) when expected to remain seated (for example, in a meeting or a church service)?
0 No, *or* Sometimes, but it does not bother me. 1 Yes. . Not sure *or* Not applicable *or* Missing.
2. Do you leave your seat in meetings or other situations (for example, during an appointment or a church service) where you are expected to remain seated?
0 No, *or* Sometimes, but it does not bother me. 1 Yes. . Not sure *or* Not applicable *or* Missing.
3. Do you feel restless, fidgety and you must get up and move around?
0 No, *or* Sometimes, but it does not bother me. 1 Yes. . Not sure *or* Not applicable *or* Missing.
4. Do you feel overly active and you must do things, like you are driven by a motor?
0 No, *or* Sometimes, but it does not bother me. 1 Yes. . Not sure *or* Not applicable *or* Missing.
5. Is it difficult for you to wait in line for your turn when the situation calls for it?
0 No, *or* Sometimes, but it does not bother me. 1 Yes. . Not sure *or* Not applicable *or* Missing.

6. Do you think you talk too much? Do others say that you talk too much?
0 No, *or* Sometimes, but it does not bother me. 1 Yes. . Not sure *or* Not applicable *or* Missing.
7a. Do you think that you are a loud and noisy person?
0 No, *or* Sometimes, but it does not bother me or others. 1 Yes. . Not sure *or* Not applicable *or* Missing.
7b. Do other people sometimes ask you to quiet down or lower your voice?
0 No, *or* Sometimes, but it does not bother me or others. 1 Yes. . Not sure *or* Not applicable *or* Missing.
8. Are you impulsive (in other words, act before you think)?
0 No, *or* Sometimes, but it does not bother me. 1 Yes. . Not sure *or* Not applicable *or* Missing.
9. Do you disturb others or intrude on others (for example, when people are talking or when people are involved in activities?)
0 No, *or* Sometimes, but it does not bother me or others. 1 Yes. . Not sure *or* Not applicable *or* Missing.

10. Do you have tendency to blurt out the answer before another person has finished asking the question?	
0	No, *or* Sometimes, but it does not bother me.
1	Yes.
.	Not sure *or* Not applicable *or* Missing.

HYPERACTIVITY SCORE **SEVERITY OF HYPERACTIVITY**	**1**	**Mild**	**1-3**
	2	**Moderate**	**4-8**
	3	**Severe**	**9 or more**

15. SCIP SCREENING QUESTIONNAIRE

(Self-Administered)

Instructions: Circle the number that best describes how you have felt either during the past month OR since your last visit.

During the past month OR since your last visit…

1. Did you have excessive worry and anxiety for long periods of time (e.g., for hours each day, lasting several months), not just during panic attacks?
0 No, *or* Some anxiety, but it does not bother me. 1 Yes. . Not sure *or* Not applicable *or* Missing.
2. Did you have a panic attack, when you suddenly become anxious and frightened for a short period of time (up to 60 minutes)? ***During that time, did you feel that your heart was racing or pounding, did you start shaking or sweating, or did you feel you were choking?***
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.
3. "Obsessive thoughts" are thoughts or images in your mind that do not make sense and keep coming back to your mind even when you try to avoid them. ***In the past month, did you have obsessive thoughts?***
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.
4. ***"Compulsive behaviors" are things you feel you must do over and over, such as washing your hands even if they are clean, checking doors and windows more than once, or repeating mental acts such as counting or praying.*** ***In the past month, did you have compulsive behaviors?***
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.
5. Have you ever witnessed or experienced a traumatic event that involved actual or threatened death or serious injury to you or someone else (e.g., physical or sexual abuse, rape, terrorist attack, natural disaster, war…)?
0 I have not experienced any traumatic events. 1 I have experienced **one traumatic event.** 2 I have experienced **several traumatic events.** . Not sure *or* Not applicable *or* Missing.

6. Over the past month, have you re-experienced the event in a distressing way (e.g., flashbacks, nightmares, bad dreams)?
0 Absent or non-significant. 1 Present. . Not sure *or* Not applicable *or* Missing.
7. Did you feel sad, depressed or in low spirits?
0 No. 1 Yes, some of the time. 2 Yes, most of the time. . Not sure *or* Not applicable *or* Missing.
8. Did you have thoughts of killing yourself?
0 No. 1 Yes. . Not sure *or* Not applicable *or* Missing.
9. Did you feel extremely happy, elated, or on top of the world without much reason?
0 No. 1 Yes, some of the time. 2 Yes, most of the time. . Not sure *or* Not applicable *or* Missing.
10. Did you experience quick changes in mood or mood swings (depressed and happy or depressed and irritable) <u>on the same day?</u>
0 No. 1 Yes, some of the time. 2 Yes, most of the time. . Not sure *or* Not applicable *or* Missing.
11. Did you experience hearing voices or noises that other people cannot hear?
0 Absent. 1 Present. . Not sure *or* Not applicable *or* Missing.

12. Did you feel that someone is spying on you or trying to harm you or has a plot or conspiracy against you?
0 Absent or non-significant. 1 Present. . Not sure *or* Not applicable *or* Missing.
***<u>13. During the past year,</u> did alcohol cause problems for you at work or school, problems with family or friends, legal problems, or other problems such as getting in physical fights*?**
0 Absent or non-significant. 1 Present. . Not sure *or* Not applicable *or* Missing.
<u>14. During the past year</u>, did drug use (_____) cause problems for you at work or school, problems with family or friends, legal problems, or other problems such as getting in physical fights?
0 Absent or non-significant. 1 Present. . Not sure *or* Not applicable *or* Missing.
15. Have you worried about gaining weight to the point that you did things such as self-induced vomiting, using diet pills, laxatives, or heavy exercise?
0 Absent or non-significant. 1 Present. . Not sure *or* Not applicable *or* Missing.
16. Do you have episodes of binge eating (eating within one or two-hour period what most people would consider an unusually large amount of food)?
0 Absent or non-significant. 1 Present. . Not sure *or* Not applicable *or* Missing.
17. Did you have difficulty concentrating on one task for a sustained period of time (e.g., reading a book, writing a letter)?
0 Absent or non-significant. 1 I have difficulty concentrating for a long period of time. . Not sure *or* Not applicable *or* Missing.
18. Did you have difficulty remaining seated (e.g., did you find yourself fidgeting with hands and feet, squirming or wiggling in seat, etc.) during a time when you were expected to remain seated (e.g., during a meeting or a church service)?
0 Absent or non-significant. 1 I fidget with hands and feet, or wiggle in seat. . Not sure *or* Not applicable *or* Missing.