

**NATIONAL INSTITUTE ON ALCOHOL ABUSE
AND ALCOHOLISM
(NIAAA)**

**NATIONAL EPIDEMIOLOGIC SURVEY
ON ALCOHOL AND RELATED CONDITIONS –
WAVE 1**

(NESARC – WAVE 1)

**ALCOHOL USE DISORDER AND
ASSOCIATED DISABILITIES INTERVIEW
SCHEDULE – DIAGNOSTIC AND
STATISTICAL MANUAL
OF MENTAL DISORDERS –
FOURTH EDITION VERSION
(AUDADIS – IV)**

Note: This instrument has been computerized and cannot be used as a
paper and pencil instrument.

Section 1 - BACKGROUND INFORMATION

Statement A

These first few questions are about your background.

1a. (1) How old are you as of today?	_____ Age																
CHECK ITEM 1.0A Is age D or R?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 1a (4)</i>																
<i>Ask if not apparent.</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																
1a. (2) Are you 18 years old or older?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																
(3) <i>Interviewer: Enter best guess as to respondent's age.</i>	_____ Age - <i>SKIP to 1b</i>																
(4) What is your date of birth? Please give me the month, day and year. Example: 01-20-1983 12-01-1963	<table style="margin: auto; border: none;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></td> <td style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></td> <td style="width: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></td> <td style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></td> <td style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></td> <td style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></td> <td style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></td> </tr> <tr> <td style="text-align: center;">Month</td> <td style="text-align: center;">Day</td> <td></td> <td style="text-align: center;">Year</td> <td></td> <td></td> <td></td> <td></td> </tr> </table>									Month	Day		Year				
Month	Day		Year														
<i>Ask if not apparent.</i>	1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female																
1b. What is your sex?	1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female																
c. Are you of Hispanic or Latino origin?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																
(SHOW FLASHCARD 2) d. On Card 2 is a list of racial categories. Please select 1 or more categories to describe your race. <i>Mark (X) all that apply.</i>	1 <input type="checkbox"/> American Indian or Alaska Native 2 <input type="checkbox"/> Asian 3 <input type="checkbox"/> Black or African American 4 <input type="checkbox"/> Native Hawaiian or Other Pacific Islander																
(SHOW FLASHCARD 3) e. What is your origin or descent?	<table style="margin: auto; border: none;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></td> <td style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></td> </tr> </table>																
f. Were you born in the United States?	1 <input type="checkbox"/> Yes - <i>SKIP to 2a</i> 2 <input type="checkbox"/> No																
g. How many years have you lived in the United States? (Code 1 if less than 1 year.)	_____ Year(s)																
2a. Did you live with at least 1 of your biological or birth parents at any time when you were growing up, that is BEFORE you were 18 years old?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 2c</i>																
b. Did your biological father ever live in your household when you were growing up, regardless of whether he and your mother were married or not?	1 <input type="checkbox"/> Yes - <i>SKIP to 2d</i> 2 <input type="checkbox"/> No - <i>SKIP to 2g</i>																
c. When you were growing up, BEFORE the age of 18, were you raised by adoptive parents, by relatives, by foster parents or in an institution like an orphanage? <i>Mark (X) all that apply.</i>	1 <input type="checkbox"/> Adoptive parents 2 <input type="checkbox"/> Relatives 3 <input type="checkbox"/> Foster parents 4 <input type="checkbox"/> Institution 5 <input type="checkbox"/> Other																
CHECK ITEM 1.0B Is 1 marked in 2c?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 3a, page 3</i>																
2d. Did your (biological/adoptive) parents get divorced or permanently stop living together BEFORE you were 18?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 2g</i>																
e. How old were you when they first stopped living together?	_____ Age																
f. Which of your (biological/adoptive) parents did you live with most of the time after they stopped living together?	1 <input type="checkbox"/> Mother 2 <input type="checkbox"/> Father 3 <input type="checkbox"/> Both equally 4 <input type="checkbox"/> Neither parent																
g. Did you ever live with a stepparent BEFORE the age of 18, including any who may have subsequently adopted you?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 2k</i>																
h. How old were you when that stepparent started living with you? <i>(Code earliest age if more than one stepparent.)</i>	_____ Age																

Section 1 - BACKGROUND INFORMATION (Continued)

<p>2i. Did your stepparent die before you were 18?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 2k</i></p>
<p>j. How old were you when that happened? <i>(Code age at first death if more than one stepparent died.)</i></p>	<p>_____ Age</p>
<p>k. Did either of your (biological/adoptive) parents die before you were 18?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 3a</i></p>
<p>l. How old were you when that happened? <i>(Code age at first death if more than one biological/adoptive parent died.)</i></p>	<p>_____ Age</p>
<p><i>(SHOW FLASHCARD 4)</i></p> <p>3a. What is your current marital status?</p>	<p>1 <input type="checkbox"/> Married 2 <input type="checkbox"/> Living with someone as if married (not currently married or separated from another person) 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced 5 <input type="checkbox"/> Separated 6 <input type="checkbox"/> Never married - <i>SKIP to 5a</i></p>
<p>b. How many times have you been married (including your current marriage)? Do not count times when you were living with someone as if married.</p>	<p>_____ Number of times 0 <input type="checkbox"/> None - <i>SKIP to 5a</i></p>
<p>CHECK ITEM 1.1A Does number in 3b equal 1 and 3a equal 1?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to 4d</i> 2 <input type="checkbox"/> No</p>
<p>4a. How old were you when you got married (for the first time)?</p>	<p>_____ Age</p>
<p>CHECK ITEM 1.1B Does number in 3b equal 1 and 3a equal 3 or 4 or 5?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to 4c</i> 2 <input type="checkbox"/> No</p>
<p>4b. How did this marriage end - were you widowed or divorced from your first (husband/wife)?</p>	<p>1 <input type="checkbox"/> Widowed 2 <input type="checkbox"/> Divorced 3 <input type="checkbox"/> Other</p>
<p>c. How old were you when (your first/former husband/wife died/you stopped living with your first/former husband/wife)?</p>	<p>_____ Age</p>
<p>CHECK ITEM 1.1B2 Does number marked in 3a equal 1?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 5a</i></p>
<p>4d. How old were you when you and your (CURRENT) (husband/wife) got married?</p>	<p>_____ Age</p>
<p>5a. How many children HAVE you EVER had, including those who are not now living? Please include adopted or foster children and any stepchildren who may have lived with you. <i>Do not include stillbirths or abortions.</i></p>	<p>_____ Number of children 0 <input type="checkbox"/> None - <i>SKIP to 6a, page 4</i></p>
<p>b. How old were you when your (FIRST) child was born or when your (FIRST) step, adopted or foster child began to live with you? <i>Report earliest age if experienced more than 1 of these events.</i></p>	<p>_____ Age</p>
<p>c. How old were you when your LAST child was born or when your LAST step, adopted or foster child began to live with you? <i>Report latest age if experienced more than 1 of these events.</i></p>	<p>_____ Age</p>

Section 1 - BACKGROUND INFORMATION (Continued)

<p>(SHOW FLASHCARD 5)</p> <p>6a. What is the highest grade or year of school that you completed?</p>	<p>1 <input type="checkbox"/> No formal schooling - <i>SKIP to 7a</i> 2 <input type="checkbox"/> Completed grade K, 1 or 2 3 <input type="checkbox"/> Completed grade 3 or 4 4 <input type="checkbox"/> Completed grade 5 or 6 5 <input type="checkbox"/> Completed grade 7 6 <input type="checkbox"/> Completed grade 8 7 <input type="checkbox"/> Some high school (grades 9-11) 8 <input type="checkbox"/> Completed high school 9 <input type="checkbox"/> Graduate equivalency degree (GED) 10 <input type="checkbox"/> Some college (no degree) 11 <input type="checkbox"/> Completed associate or other technical 2-year degree 12 <input type="checkbox"/> Completed college (Bachelor's degree) 13 <input type="checkbox"/> Some graduate or professional studies (completed Bachelor's degree but not graduate degree) 14 <input type="checkbox"/> Completed graduate or professional degree (Master's degree or higher)</p>
<p>b. How old were you at that time?</p>	<p>_____ Age</p>
<p>(SHOW FLASHCARD 6)</p> <p>7a. Which of these statements describe your present situation?</p> <p><i>Mark (X) all that apply.</i></p> <p><i>If more than one code applies, follow skip patterns for lowest number marked.</i></p>	<p>1 <input type="checkbox"/> Working full time, that is, 35 hours or more per week 2 <input type="checkbox"/> Working part time, that is, less than 35 hours per week 3 <input type="checkbox"/> Have a job or business, but not at work because of temporary illness or injury 4 <input type="checkbox"/> Have a job or business, but on paid vacation 5 <input type="checkbox"/> Have a job or business, but absent from work without pay 6 <input type="checkbox"/> Unemployed or laid off and looking for work 7 <input type="checkbox"/> Unemployed or laid off and not looking for work 8 <input type="checkbox"/> Unemployed and permanently disabled 9 <input type="checkbox"/> Retired 10 <input type="checkbox"/> In school, full time 11 <input type="checkbox"/> In school, part time 12 <input type="checkbox"/> Currently on summer break/holiday from school 13 <input type="checkbox"/> Full-time homemaker 14 <input type="checkbox"/> Something else</p>
<p>CHECK ITEM 1.1C Is 10 or 11 checked in 7a?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to 7c</i> 2 <input type="checkbox"/> No</p>
<p>7b. Were you a full- or part-time student at any time in the last 12 months? (If necessary, ask: Was that full-time or part-time)?</p>	<p>1 <input type="checkbox"/> Yes, full-time student 2 <input type="checkbox"/> Yes, part-time student 3 <input type="checkbox"/> No - <i>SKIP to Check Item 1.1D</i></p>
<p>(SHOW FLASHCARD 7)</p> <p>c. Where did you live when you were going to school in the last 12 months?</p> <p><i>(CHECK ALL THAT APPLY)</i></p>	<p>1 <input type="checkbox"/> In parent's or relative's home 2 <input type="checkbox"/> In dormitory or residence hall 3 <input type="checkbox"/> In house or apartment on campus 4 <input type="checkbox"/> In fraternity or sorority house 5 <input type="checkbox"/> In house, apartment or room off campus 6 <input type="checkbox"/> Other</p>
<p>(SHOW FLASHCARD 7A)</p> <p>d. What was your grade level last year, that is, during the 2000 and 2001 school year?</p>	<p>1 <input type="checkbox"/> High school - any grade level 2 <input type="checkbox"/> Enrolled in graduate equivalency degree (GED) program 3 <input type="checkbox"/> 1st year undergraduate/never attended college before 4 <input type="checkbox"/> 1st year undergraduate/attended college before 5 <input type="checkbox"/> 2nd year undergraduate/sophomore 6 <input type="checkbox"/> 3rd year undergraduate/junior 7 <input type="checkbox"/> 4th year/senior 8 <input type="checkbox"/> 5th year/other undergraduate 9 <input type="checkbox"/> 1st year graduate/professional 10 <input type="checkbox"/> 2nd year graduate/professional 11 <input type="checkbox"/> 3rd year graduate/professional or beyond 12 <input type="checkbox"/> Other</p>
<p>CHECK ITEM 1.1D Is 1, 2, 3, 4 or 5 checked in 7a?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to 8d</i> 2 <input type="checkbox"/> No</p>

Section 1 - BACKGROUND INFORMATION (Continued)

<p>8a. Did you work at any time at a JOB OR BUSINESS, either full-time or part-time, even for only a few days, in the last 12 months? Include unpaid work in a family business or farm.</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to 8d</i> 2 <input type="checkbox"/> No</p>
<p>b. Have you ever worked for pay or as an unpaid worker in a family business or farm?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 10a</i></p>
<p>c. How old were you when you last worked for pay or as an unpaid worker in a family business or farm, either full-time or part-time?</p>	<p>_____ Age</p>
<p>d. How old were you when you started your FIRST full-time job, that is, when you worked at least 30 hours per week for pay or without pay in a family business or farm?</p>	<p>_____ Age OR 0 <input type="checkbox"/> Never worked 30 hours/week</p>
<p>9a. (<i>SHOW FLASHCARD 8</i>) In what kind of business or industry (is your present job/was your most recent job)?</p>	<p><input type="text"/> <input type="text"/> Kind of business/industry</p>
<p>b. (<i>SHOW FLASHCARD 8A</i>) What kind of work (do/did) you do on this job?</p>	<p><input type="text"/> <input type="text"/> Kind of work</p>
<p>c. Which of the following best describes where you (work/worked)?</p>	<p>1 <input type="checkbox"/> A private for-profit company, business, or individual 2 <input type="checkbox"/> A private not-for-profit, tax exempt, or charitable organization 3 <input type="checkbox"/> Federal government (exclude Armed Forces) 4 <input type="checkbox"/> State government 5 <input type="checkbox"/> Local government 6 <input type="checkbox"/> Armed Forces 7 <input type="checkbox"/> Unpaid in family business or farm 8 <input type="checkbox"/> Self-employed in own business, professional practice, or farm</p>
<p>(<i>SHOW FLASHCARD 9</i>) 10a. During the last 12 months, what was YOUR TOTAL PERSONAL income? Please report income from all jobs BEFORE taxes and other deductions and net income after business expenses. Include any tips, bonuses, overtime pay and commissions, as well as any income from pensions, dividends, interest, Social Security, alimony, child support, workman's compensation or any public assistance or welfare payments and any other money income received by you from ANY OTHER source shown on this card. (Round amount to nearest dollar.)</p>	<p>\$ _____</p>
<p>CHECK ITEM 1.2 Is 10a blank?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 1.2A</i></p>
<p>(<i>SHOW FLASHCARD 9A</i>) 10b. Can you tell me which category on this card best represents your TOTAL PERSONAL income in the last 12 months?</p>	<p>0 <input type="checkbox"/> \$0 (no personal income) 1 <input type="checkbox"/> \$1 to \$4,999 2 <input type="checkbox"/> \$5,000 to \$7,999 3 <input type="checkbox"/> \$8,000 to \$9,999 4 <input type="checkbox"/> \$10,000 to \$12,999 5 <input type="checkbox"/> \$13,000 to \$14,999 6 <input type="checkbox"/> \$15,000 to \$19,999 7 <input type="checkbox"/> \$20,000 to \$24,999 8 <input type="checkbox"/> \$25,000 to \$29,999 9 <input type="checkbox"/> \$30,000 to \$34,999 10 <input type="checkbox"/> \$35,000 to \$39,999 11 <input type="checkbox"/> \$40,000 to \$49,999 12 <input type="checkbox"/> \$50,000 to \$59,999 13 <input type="checkbox"/> \$60,000 to \$69,999 14 <input type="checkbox"/> \$70,000 to \$79,999 15 <input type="checkbox"/> \$80,000 to \$89,999 16 <input type="checkbox"/> \$90,000 to \$99,999 17 <input type="checkbox"/> \$100,000 or more</p>
<p>CHECK ITEM 1.2A Refer to Control Card. The number of related persons in this household is?</p>	<p>1 <input type="checkbox"/> None - <i>SKIP to Check Item 1.2C</i> 2 <input type="checkbox"/> One or more</p>

Section 1 – BACKGROUND INFORMATION (Continued)

<p><i>(SHOW FLASHCARD 10)</i></p> <p>11a. During the last 12 months, what was YOUR TOTAL COMBINED FAMILY income received from jobs, businesses, and ALL OTHER SOURCES WE JUST TALKED ABOUT? Include ONLY immediate family members living in this household and report income before taxes and other deductions or net income after business expenses for self-employed family members. Include any tips, bonuses, overtime pay or commissions.</p> <p><i>(Round amount to nearest dollar)</i></p>	<p>\$ _____</p>
<p>CHECK ITEM 1.2B Is 11a blank?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 1.2C</i></p>
<p><i>(SHOW FLASHCARD 10A)</i></p> <p>11b. Can you tell me which category on this card best represents YOUR TOTAL COMBINED FAMILY income in the last 12 months?</p>	<p>1 <input type="checkbox"/> Less than \$5,000 2 <input type="checkbox"/> \$5,000 to \$7,999 3 <input type="checkbox"/> \$8,000 to \$9,999 4 <input type="checkbox"/> \$10,000 to \$12,999 5 <input type="checkbox"/> \$13,000 to \$14,999 6 <input type="checkbox"/> \$15,000 to \$19,999 7 <input type="checkbox"/> \$20,000 to \$24,999 8 <input type="checkbox"/> \$25,000 to \$29,999 9 <input type="checkbox"/> \$30,000 to \$34,999 10 <input type="checkbox"/> \$35,000 to \$39,999 11 <input type="checkbox"/> \$40,000 to \$49,999 12 <input type="checkbox"/> \$50,000 to \$59,999 13 <input type="checkbox"/> \$60,000 to \$69,999 14 <input type="checkbox"/> \$70,000 to \$79,999 15 <input type="checkbox"/> \$80,000 to \$89,999 16 <input type="checkbox"/> \$90,000 to \$99,999 17 <input type="checkbox"/> \$100,000 to \$109,999 18 <input type="checkbox"/> \$110,000 to \$119,999 19 <input type="checkbox"/> \$120,000 to \$149,999 20 <input type="checkbox"/> \$150,000 to \$199,999 21 <input type="checkbox"/> \$200,000 or more</p>
<p>CHECK ITEM 1.2C Refer to Control Card. The number of unrelated persons in this household is?</p>	<p>1 <input type="checkbox"/> None – <i>SKIP to 13</i> 2 <input type="checkbox"/> One or more</p>
<p><i>(SHOW FLASHCARD 11)</i></p> <p>12a. During the last 12 months, what was YOUR TOTAL COMBINED HOUSEHOLD income received from jobs, business and ALL OTHER SOURCES mentioned earlier? Include income from all RELATED and UNRELATED household members before taxes and other deductions or report net income after business expenses for self-employed household members.</p> <p><i>(Round amount to nearest dollar)</i></p>	<p>\$ _____</p>
<p>CHECK ITEM 1.2D Is 12a blank?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 13</i></p>
<p><i>(SHOW FLASHCARD 11A)</i></p> <p>12b. Can you tell me which category on this card best represents YOUR TOTAL COMBINED HOUSEHOLD income in the last year?</p>	<p>1 <input type="checkbox"/> Less than \$5,000 2 <input type="checkbox"/> \$5,000 to \$7,999 3 <input type="checkbox"/> \$8,000 to \$9,999 4 <input type="checkbox"/> \$10,000 to \$12,999 5 <input type="checkbox"/> \$13,000 to \$14,999 6 <input type="checkbox"/> \$15,000 to \$19,999 7 <input type="checkbox"/> \$20,000 to \$24,999 8 <input type="checkbox"/> \$25,000 to \$29,999 9 <input type="checkbox"/> \$30,000 to \$34,999 10 <input type="checkbox"/> \$35,000 to \$39,999 11 <input type="checkbox"/> \$40,000 to \$49,999 12 <input type="checkbox"/> \$50,000 to \$59,999 13 <input type="checkbox"/> \$60,000 to \$69,999 14 <input type="checkbox"/> \$70,000 to \$79,999 15 <input type="checkbox"/> \$80,000 to \$89,999 16 <input type="checkbox"/> \$90,000 to \$99,999 17 <input type="checkbox"/> \$100,000 to \$109,999 18 <input type="checkbox"/> \$110,000 to \$119,999 19 <input type="checkbox"/> \$120,000 to \$149,999 20 <input type="checkbox"/> \$150,000 to \$199,999 21 <input type="checkbox"/> \$200,000 or more</p>

Section 1 - BACKGROUND INFORMATION (Continued)

<p>13. Please tell me if YOU PERSONALLY RECEIVED any income during the last 12 months from any of the following sources:</p> <p>(1) Did YOU receive Social Security?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(2) Did YOU receive Supplemental Security Income (SSI)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(3) Did YOU receive Traditional Aid to Families with Dependent Children (TAFDC) or Employment Services Program (ESP) or Emergency Assistance Program (EA)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(4) Did YOU receive WIC Benefits (Women, Infants and Children Nutritional Program)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>14a. Did YOU receive food stamps during the last 12 months?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 14c</i></p>
<p>b. How much did you receive in food stamps during the last 12 months?</p>	<p>\$ _____</p>
<p>c. Are you currently covered by:</p>	
<p>(1) Medicare?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(2) Medicaid or (local name)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(3) CHAMPUS, CHAMPVA, the VA, or other military health care?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(4) Health insurance obtained privately or through a current or former employer or union?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 16</i></p>
<p>16. In general, would you say your health is excellent, very good, good, fair or poor?</p>	<p>1 <input type="checkbox"/> Excellent 2 <input type="checkbox"/> Very good 3 <input type="checkbox"/> Good 4 <input type="checkbox"/> Fair 5 <input type="checkbox"/> Poor</p>
<p><i>(SHOW FLASHCARD 11B)</i></p>	
<p>17. The following questions are about activities you might do during a typical day. Please tell me if your health now limits you in these activities and if so, how much.</p> <p>(1) Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf.</p>	<p>1 <input type="checkbox"/> Yes, limited a lot 2 <input type="checkbox"/> Yes, limited a little 3 <input type="checkbox"/> No, not limited at all</p>
<p>(2) Climbing several flights of stairs.</p>	<p>1 <input type="checkbox"/> Yes, limited a lot 2 <input type="checkbox"/> Yes, limited a little 3 <input type="checkbox"/> No, not limited at all</p>

Section 1 - BACKGROUND INFORMATION (Continued)

<i>(SHOW FLASHCARD 11C)</i>	
<p>18. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as the result of your physical health?</p> <p>(1) Accomplished less than you would like.</p> <hr/> <p>(2) Were limited in the kind of work or other activities.</p>	<p>1 <input type="checkbox"/> All of the time 2 <input type="checkbox"/> Most of the time 3 <input type="checkbox"/> Some of the time 4 <input type="checkbox"/> A little of the time 5 <input type="checkbox"/> None of the time</p> <p>1 <input type="checkbox"/> All of the time 2 <input type="checkbox"/> Most of the time 3 <input type="checkbox"/> Some of the time 4 <input type="checkbox"/> A little of the time 5 <input type="checkbox"/> None of the time</p>
<i>(SHOW FLASHCARD 11C)</i>	
<p>19. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as the result of any emotional problems such as feeling depressed or anxious?</p> <p>(1) Accomplished less than you would like.</p> <hr/> <p>(2) Didn't do work or other activities as carefully as usual.</p>	<p>1 <input type="checkbox"/> All of the time 2 <input type="checkbox"/> Most of the time 3 <input type="checkbox"/> Some of the time 4 <input type="checkbox"/> A little of the time 5 <input type="checkbox"/> None of the time</p> <p>1 <input type="checkbox"/> All of the time 2 <input type="checkbox"/> Most of the time 3 <input type="checkbox"/> Some of the time 4 <input type="checkbox"/> A little of the time 5 <input type="checkbox"/> None of the time</p>
<i>(SHOW FLASHCARD 11D)</i>	
<p>20. During the past 4 weeks, how much did pain interfere with your normal work including both work outside the home and housework?</p>	<p>1 <input type="checkbox"/> Not at all 2 <input type="checkbox"/> A little bit 3 <input type="checkbox"/> Moderately 4 <input type="checkbox"/> Quite a bit 5 <input type="checkbox"/> Extremely</p>
<i>(SHOW FLASHCARD 11C)</i>	
<p>21. The next few questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks...</p> <p>(1) Have you felt calm and peaceful?</p> <hr/> <p>(2) Did you have a lot of energy?</p> <hr/> <p>(3) Have you felt downhearted and depressed?</p>	<p>1 <input type="checkbox"/> All of the time 2 <input type="checkbox"/> Most of the time 3 <input type="checkbox"/> Some of the time 4 <input type="checkbox"/> A little of the time 5 <input type="checkbox"/> None of the time</p> <p>1 <input type="checkbox"/> All of the time 2 <input type="checkbox"/> Most of the time 3 <input type="checkbox"/> Some of the time 4 <input type="checkbox"/> A little of the time 5 <input type="checkbox"/> None of the time</p> <p>1 <input type="checkbox"/> All of the time 2 <input type="checkbox"/> Most of the time 3 <input type="checkbox"/> Some of the time 4 <input type="checkbox"/> A little of the time 5 <input type="checkbox"/> None of the time</p>
<i>(SHOW FLASHCARD 11C)</i>	
<p>22. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities like visiting with friends, relatives, and so forth?</p>	<p>1 <input type="checkbox"/> All of the time 2 <input type="checkbox"/> Most of the time 3 <input type="checkbox"/> Some of the time 4 <input type="checkbox"/> A little of the time 5 <input type="checkbox"/> None of the time</p>

Section 1 - BACKGROUND INFORMATION (Continued)

23. Can you please tell me if you have had any of the following experiences in the last 12 months?

In the last 12 months. . .
(Repeat phrase frequently)

- | | |
|---|---|
| (1) Did any of your family members or close friends die? | 1 <input type="checkbox"/> Yes
2 <input type="checkbox"/> No |
| (2) Did any of your family members or close friends have a serious illness or injury? | 1 <input type="checkbox"/> Yes
2 <input type="checkbox"/> No |
| (3) Did you move or have anyone new come to live with you? | 1 <input type="checkbox"/> Yes
2 <input type="checkbox"/> No |
| (4) Were you fired or laid off from a job? | 1 <input type="checkbox"/> Yes
2 <input type="checkbox"/> No |
| (5) Were you unemployed and looking for a job for more than a month? | 1 <input type="checkbox"/> Yes
2 <input type="checkbox"/> No |
| (6) Have you had trouble with your boss or a coworker? | 1 <input type="checkbox"/> Yes
2 <input type="checkbox"/> No |
| (7) Did you change jobs, job responsibilities or work hours? | 1 <input type="checkbox"/> Yes
2 <input type="checkbox"/> No |
| (8) Did you get separated or divorced or break off a steady relationship? | 1 <input type="checkbox"/> Yes
2 <input type="checkbox"/> No |
| (9) Have you had serious problems with a neighbor, friend or relative? | 1 <input type="checkbox"/> Yes
2 <input type="checkbox"/> No |
| (10) Have you experienced a major financial crisis, declared bankruptcy or more than once been unable to pay your bills on time? | 1 <input type="checkbox"/> Yes
2 <input type="checkbox"/> No |
| (11) Did you or a family member have trouble with the police, get arrested or get sent to jail? | 1 <input type="checkbox"/> Yes
2 <input type="checkbox"/> No |
| (12) Were you or a family member the victim of any type of crime? | 1 <input type="checkbox"/> Yes
2 <input type="checkbox"/> No |

24. Please tell me your height and weight as these are important factors for this survey.

Height
 Feet
 Inches

Weight
 Pounds

Section 2A - ALCOHOL CONSUMPTION



The next questions are about drinking alcohol. This includes coolers; beer; wine; champagne; liquor such as whiskey, rum, gin, vodka, bourbon, scotch, or liqueurs; and also any other type of alcohol.

<p>1. In your entire life, have you had at least 1 drink of any kind of alcohol, not counting small tastes or sips?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 2.0 and mark as lifetime abstainer</i></p>
<p>2. During the last 12 months, did you have a total of at least 12 drinks of any kind of alcohol?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to Check Item 2.0 and mark as current drinker</i> 2 <input type="checkbox"/> No</p>
<p>3. During the last 12 months, did you have at least 1 drink of any kind of alcohol?</p>	<p>1 <input type="checkbox"/> Yes - <i>GO to Check Item 2.0 and mark as current drinker</i> 2 <input type="checkbox"/> No - <i>GO to Check Item 2.0 and mark as ex-drinker</i></p>
<p>CHECK ITEM 2.0 <i>Mark (X) one and ONLY one.</i></p>	<p>1 <input type="checkbox"/> Current drinker - <i>Go to Statement C</i> 2 <input type="checkbox"/> Ex-drinker - <i>SKIP to 15, page 17</i> 3 <input type="checkbox"/> Lifetime abstainer - <i>SKIP to Section 2D, page 29</i></p>




The next few questions are about drinking coolers, beer, wine, and liquor during the last 12 months, that is, since last (Month one year ago). First, I'd like to ask you about coolers.

<p>4a. During the last 12 months, did you drink any premixed alcoholic coolers? By coolers, I mean wine, malt or liquor-based coolers or any prepackaged cocktails with alcohol and mixer already combined in the container.</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Statement D, page 10</i></p>
<p><i>(SHOW FLASHCARD 12)</i></p> <p>b. During the last 12 months, about how often did you drink any coolers?</p>	<p>1 <input type="checkbox"/> Every day 2 <input type="checkbox"/> Nearly every day 3 <input type="checkbox"/> 3 to 4 times a week 4 <input type="checkbox"/> 2 times a week 5 <input type="checkbox"/> Once a week 6 <input type="checkbox"/> 2 to 3 times a month 7 <input type="checkbox"/> Once a month 8 <input type="checkbox"/> 7 to 11 times in the last year 9 <input type="checkbox"/> 3 to 6 times in the last year 10 <input type="checkbox"/> 1 or 2 times in the last year</p>
<p><i>(SHOW FLASHCARD 13)</i></p> <p>c. What was the size of the TYPICAL bottle, can or glass of cooler that you USUALLY drank during the last 12 months?</p>	<p>1 <input type="checkbox"/> 8-ounce (small) bottle or can 2 <input type="checkbox"/> 12-ounce (regular) bottle or can 3 <input type="checkbox"/> 16-ounce (large) bottle or can 4 <input type="checkbox"/> 3-ounce glass 5 <input type="checkbox"/> 4-ounce glass 6 <input type="checkbox"/> 5-ounce glass 7 <input type="checkbox"/> 6-ounce glass 8 <input type="checkbox"/> 7-ounce glass 9 <input type="checkbox"/> 8-ounce glass 10 <input type="checkbox"/> 9-ounce glass 11 <input type="checkbox"/> 12-ounce glass 12 <input type="checkbox"/> 15-ounce glass 13 <input type="checkbox"/> 18-ounce glass 14 <input type="checkbox"/> Other - <i>Specify</i></p> <p><input type="text"/> <input type="text"/> _____ Code Size and type of container</p>
<p>d. How many (units reported in 4c) of cooler did you USUALLY drink on days when you drank coolers?</p>	<p>_____ Number</p>
<p>e. During the last 12 months, what was the LARGEST number of (units reported in 4c) of cooler that you drank in a single day?</p>	<p>_____ Number</p>

Section 2A - ALCOHOL CONSUMPTION (Continued)

<p>(SHOW FLASHCARD 12)</p> <p>4f. About how often during the last 12 months did you drink (largest number and units reported in 4e, page 9) in a single day?</p>	<p>1 <input type="checkbox"/> Every day 2 <input type="checkbox"/> Nearly every day 3 <input type="checkbox"/> 3 to 4 times a week 4 <input type="checkbox"/> 2 times a week 5 <input type="checkbox"/> Once a week 6 <input type="checkbox"/> 2 to 3 times a month 7 <input type="checkbox"/> Once a month 8 <input type="checkbox"/> 7 to 11 times in the last year 9 <input type="checkbox"/> 3 to 6 times in the last year 10 <input type="checkbox"/> 1 or 2 times in the last year</p>
<p>(SHOW FLASHCARD 14)</p> <p>g. About how often during the last 12 months did you drink FIVE OR MORE (units reported in 4e, page 9) of cooler in a single day?</p>	<p>1 <input type="checkbox"/> Every day 2 <input type="checkbox"/> Nearly every day 3 <input type="checkbox"/> 3 to 4 times a week 4 <input type="checkbox"/> 2 times a week 5 <input type="checkbox"/> Once a week 6 <input type="checkbox"/> 2 to 3 times a month 7 <input type="checkbox"/> Once a month 8 <input type="checkbox"/> 7 to 11 times in the last year 9 <input type="checkbox"/> 3 to 6 times in the last year 10 <input type="checkbox"/> 1 or 2 times in the last year 11 <input type="checkbox"/> Never in the last year</p>
<p>h. During the last 12 months, did you USUALLY drink wine coolers, malt-based coolers, liquor-based coolers or prepackaged cocktails?</p> <p><i>Mark (X) one and ONLY one.</i></p>	<p>1 <input type="checkbox"/> Wine coolers 2 <input type="checkbox"/> Malt-based coolers 3 <input type="checkbox"/> Liquor-based coolers 4 <input type="checkbox"/> Prepackaged cocktails/mixed drinks</p>
<p>i. During the last 12 months, did you USUALLY drink coolers in your own home, in the homes of friends or relatives or in public places such as bars, restaurants or sports arenas?</p> <p><i>Mark (X) one and ONLY one.</i></p>	<p>1 <input type="checkbox"/> In own home 2 <input type="checkbox"/> In homes of friends or relatives 3 <input type="checkbox"/> In public places</p>

Statement D  Now I'd like to ask you about drinking beer.

<p>5a. During the last 12 months, did you drink any beer, light beer or malt liquor? Do not count nonalcoholic beers.</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Statement E, page 11</i></p>
<p>(SHOW FLASHCARD 12)</p> <p>b. During the last 12 months, about how often did you drink any beer or malt liquor?</p>	<p>1 <input type="checkbox"/> Every day 2 <input type="checkbox"/> Nearly every day 3 <input type="checkbox"/> 3 to 4 times a week 4 <input type="checkbox"/> 2 times a week 5 <input type="checkbox"/> Once a week 6 <input type="checkbox"/> 2 to 3 times a month 7 <input type="checkbox"/> Once a month 8 <input type="checkbox"/> 7 to 11 times in the last year 9 <input type="checkbox"/> 3 to 6 times in the last year 10 <input type="checkbox"/> 1 or 2 times in the last year</p>

Section 2A - ALCOHOL CONSUMPTION (Continued)

<p>(SHOW FLASHCARD 15)</p> <p>5c. What was the size of the TYPICAL can, bottle, or glass of beer or malt liquor that you USUALLY drank during the last 12 months?</p>	<p>1 <input type="checkbox"/> 7 or 8-ounce (pony size) can, bottle or glass 2 <input type="checkbox"/> 10-ounce (small) can, bottle or glass 3 <input type="checkbox"/> 12-ounce (regular size) can, bottle or glass 4 <input type="checkbox"/> 16-ounce (large) can, bottle or glass 5 <input type="checkbox"/> 22 to 25-ounce (extra large) can, bottle or glass 6 <input type="checkbox"/> 40 to 45-ounce (jumbo) can or bottle 7 <input type="checkbox"/> Mug 8 <input type="checkbox"/> Pint 9 <input type="checkbox"/> Pitcher 10 <input type="checkbox"/> Other - <i>Specify</i></p> <p><input type="text"/> <input type="text"/> _____ Code Size and type of container</p>
<p>d. How many (units reported in 5c) of beer or malt liquor did you USUALLY drink on days when you drank beer?</p>	<p>_____ Number</p>
<p>e. During the last 12 months, what was the LARGEST number of (units reported in 5c) of beer or malt liquor that you drank in a single day?</p>	<p>_____ Number</p>
<p>(SHOW FLASHCARD 12)</p> <p>f. About how often during the last 12 months did you drink (largest number and units reported in 5e) of beer or malt liquor in a single day?</p>	<p>1 <input type="checkbox"/> Every day 2 <input type="checkbox"/> Nearly every day 3 <input type="checkbox"/> 3 to 4 times a week 4 <input type="checkbox"/> 2 times a week 5 <input type="checkbox"/> Once a week 6 <input type="checkbox"/> 2 to 3 times a month 7 <input type="checkbox"/> Once a month 8 <input type="checkbox"/> 7 to 11 times in the last year 9 <input type="checkbox"/> 3 to 6 times in the last year 10 <input type="checkbox"/> 1 or 2 times in the last year</p>
<p>(SHOW FLASHCARD 14)</p> <p>g. About how often during the last 12 months did you drink FIVE OR MORE (units reported in 5e) of beer or malt liquor in a single day?</p>	<p>1 <input type="checkbox"/> Every day 2 <input type="checkbox"/> Nearly every day 3 <input type="checkbox"/> 3 to 4 times a week 4 <input type="checkbox"/> 2 times a week 5 <input type="checkbox"/> Once a week 6 <input type="checkbox"/> 2 to 3 times a month 7 <input type="checkbox"/> Once a month 8 <input type="checkbox"/> 7 to 11 times in the last year 9 <input type="checkbox"/> 3 to 6 times in the last year 10 <input type="checkbox"/> 1 or 2 times in the last year 11 <input type="checkbox"/> Never in the last year</p>
<p>h. During the last 12 months, did you USUALLY drink regular beer, malt liquor, lite or reduced calorie beer, or ice beer?</p> <p><i>Mark (X) one and ONLY one.</i></p>	<p>1 <input type="checkbox"/> Regular beer 2 <input type="checkbox"/> Malt liquor 3 <input type="checkbox"/> Lite or reduced calorie beer 4 <input type="checkbox"/> Ice beer</p>
<p>i. During the last 12 months, did you USUALLY drink beer or malt liquor in your own home, in the homes of friends or relatives or in public places such as bars, restaurants or sports arenas?</p> <p><i>Mark (X) one and ONLY one.</i></p>	<p>1 <input type="checkbox"/> In own home 2 <input type="checkbox"/> In homes of friends or relatives 3 <input type="checkbox"/> In public places</p>
<p>Statement E Now I'd like to ask you about drinking wine.</p>	
<p>6a. During the last 12 months, did you drink any type of wine, including champagne, sparkling wine, or fortified wines such as sherry, port or sake? Do not count wine coolers.</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Statement F, page 13</i></p>

Section 2A - ALCOHOL CONSUMPTION (Continued)

(SHOW FLASHCARD 12)

6b. During the last 12 months, about how often did you drink any type of wine?

- 1 Every day
- 2 Nearly every day
- 3 3 to 4 times a week
- 4 2 times a week
- 5 Once a week
- 6 2 to 3 times a month
- 7 Once a month
- 8 7 to 11 times in the last year
- 9 3 to 6 times in the last year
- 10 1 or 2 times in the last year

(SHOW FLASHCARD 16)

c. What was the size of the TYPICAL glass or bottle of wine that you USUALLY drank during the last 12 months? Please do not include the amount of any soda or ice that may have been added.

- 1 3-ounce glass
- 2 4-ounce glass
- 3 5-ounce glass
- 4 6-ounce glass
- 5 7-ounce glass
- 6 8-ounce glass
- 7 9-ounce glass
- 8 12-ounce glass
- 9 15-ounce glass
- 10 18-ounce glass
- 11 187 ml. individual serving bottle (usually sold in 4-packs)
- 12 375 ml. bottle (half bottle of wine) or ½ carafe
- 13 750 ml. bottle (regular size wine bottle) or full carafe
- 14 Other - *Specify*

Code

Size and type of container

d. How many (units reported in 6c) of wine did you USUALLY drink on days when you drank wine?

_____ Number

e. During the last 12 months, what was the LARGEST number of (units reported in 6c) of wine that you drank in a single day?

_____ Number

(SHOW FLASHCARD 12)

f. About how often during the last 12 months did you drink (largest number and units reported in 6e) of wine in a single day?

- 1 Every day
- 2 Nearly every day
- 3 3 to 4 times a week
- 4 2 times a week
- 5 Once a week
- 6 2 to 3 times a month
- 7 Once a month
- 8 7 to 11 times in the last year
- 9 3 to 6 times in the last year
- 10 1 or 2 times in the last year

(SHOW FLASHCARD 14)

g. About how often during the last 12 months did you drink FIVE OR MORE (units reported in 6e) of wine in a single day?

- 1 Every day
- 2 Nearly every day
- 3 3 to 4 times a week
- 4 2 times a week
- 5 Once a week
- 6 2 to 3 times a month
- 7 Once a month
- 8 7 to 11 times in the last year
- 9 3 to 6 times in the last year
- 10 1 or 2 times in the last year
- 11 Never in the last year

h. During the last 12 months, did you USUALLY drink wine in your own home, in the homes of friends or relatives or in public places such as bars, restaurants or sports arenas?

- 1 In own home
- 2 In homes of friends or relatives
- 3 In public places

Mark (X) one and ONLY one.

Section 2A - ALCOHOL CONSUMPTION (Continued)

6i. During the last 12 months, did you **USUALLY** drink regular wine, champagne or sparkling wine, fortified wine such as sherry, port or sake, or low-alcohol fruit-flavored wine?

Mark (X) one and ONLY one.

- 1 Regular wine
- 2 Champagne or sparkling wine
- 3 Fortified wine (including sherry, port, sake)
- 4 Low-alcohol fruit-flavored wine

Statement F

The next questions are about drinking liquor, such as whiskey, rum, gin, vodka, bourbon, scotch, or liqueurs.

7a. During the last 12 months, did you drink any liquor, including mixed drinks and liqueurs? Do not count liquor-based coolers or premixed cocktails that you may have told me about earlier.

- 1 Yes
- 2 No - *SKIP to Statement G, page 14*

(SHOW FLASHCARD 12)

b. During the last 12 months, about how often did you drink any liquor?

- 1 Every day
- 2 Nearly every day
- 3 3 to 4 times a week
- 4 2 times a week
- 5 Once a week
- 6 2 to 3 times a month
- 7 Once a month
- 8 7 to 11 times in the last year
- 9 3 to 6 times in the last year
- 10 1 or 2 times in the last year

(SHOW FLASHCARD 17)

c. How much liquor did you **USUALLY** have in a drink? Please do not include the amount of any soda, water, ice, cola, or juice that may have been added to your drink.

- 1 1 shot or ounce
- 2 1 jigger
- 3 Mini-bottle (type sold on airplanes)
- 4 1½ shots or ounces
- 5 2 shots or ounces (double)
- 6 2 jiggers
- 7 3 shots or ounces (triple)
- 8 3 jiggers
- 9 4 shots or ounces
- 10 4 jiggers
- 11 ½ pint
- 12 Pint
- 13 Quart
- 14 Fifth
- 15 ½ gallon
- 16 Other - *Specify*

Code

Size and type of container

d. How many (drinks of this size/units reported in 7c) of liquor did you **USUALLY** drink on days when you drank liquor?

_____ Number

e. During the last 12 months, what was the **LARGEST** number of (drinks of this size/units reported in 7c) of liquor that you drank in a single day?

_____ Number

f. *(SHOW FLASHCARD 12)*

About how often during the last 12 months did you drink (largest number and units reported in 7e) of liquor in a single day?

- 1 Every day
- 2 Nearly every day
- 3 3 to 4 times a week
- 4 2 times a week
- 5 Once a week
- 6 2 to 3 times a month
- 7 Once a month
- 8 7 to 11 times in the last year
- 9 3 to 6 times in the last year
- 10 1 or 2 times in the last year

Section 2A - ALCOHOL CONSUMPTION (Continued)

<p>7g. (SHOW FLASHCARD 14)</p> <p>About how often during the last 12 months did you drink FIVE OR MORE (units reported in 7e, page 13) of liquor in a single day?</p>	<p>1 <input type="checkbox"/> Every day 2 <input type="checkbox"/> Nearly every day 3 <input type="checkbox"/> 3 to 4 times a week 4 <input type="checkbox"/> 2 times a week 5 <input type="checkbox"/> Once a week 6 <input type="checkbox"/> 2 to 3 times a month 7 <input type="checkbox"/> Once a month 8 <input type="checkbox"/> 7 to 11 times in the last year 9 <input type="checkbox"/> 3 to 6 times in the last year 10 <input type="checkbox"/> 1 or 2 times in the last year 11 <input type="checkbox"/> Never in the last year</p>
<p>h. During the last 12 months, did you USUALLY drink 80-proof liquor or brandy, 100-proof liquor or liqueurs or cordials?</p> <p><i>Mark (X) one and ONLY one.</i></p>	<p>1 <input type="checkbox"/> 80-proof liquor/brandy 2 <input type="checkbox"/> 100-proof liquor 3 <input type="checkbox"/> Liqueurs or cordials</p>
<p>i. During the last 12 months, did you USUALLY drink liquor in your own home, in the homes of friends or relatives or in public places such as bars, restaurants or sports arenas?</p> <p><i>Mark (X) one and ONLY one.</i></p>	<p>1 <input type="checkbox"/> In own home 2 <input type="checkbox"/> In homes of friends or relatives 3 <input type="checkbox"/> In public places</p>

Statement G

These next questions are about ANY alcoholic beverages that you drank during the last 12 months, that is, about all types of alcoholic drinks combined, including any types we may not have mentioned.

<p>(SHOW FLASHCARD 12)</p> <p>8a. During the last 12 months, about how often did you drink ANY alcoholic beverage?</p>	<p>1 <input type="checkbox"/> Every day 2 <input type="checkbox"/> Nearly every day 3 <input type="checkbox"/> 3 to 4 times a week 4 <input type="checkbox"/> 2 times a week 5 <input type="checkbox"/> Once a week 6 <input type="checkbox"/> 2 to 3 times a month 7 <input type="checkbox"/> Once a month 8 <input type="checkbox"/> 7 to 11 times in the last year 9 <input type="checkbox"/> 3 to 6 times in the last year 10 <input type="checkbox"/> 1 or 2 times in the last year</p>
<p>b. Counting all types of alcohol combined, how many drinks did you USUALLY have on days when you drank during the last 12 months?</p>	<p>_____ Number</p>
<p>c. During the last 12 months, what was the LARGEST number of drinks that you drank in a single day?</p>	<p>_____ Number</p>
<p>(SHOW FLASHCARD 12)</p> <p>d. About how often during the last 12 months did you drink (number of drinks reported in 8a) in a single day?</p>	<p>1 <input type="checkbox"/> Every day 2 <input type="checkbox"/> Nearly every day 3 <input type="checkbox"/> 3 to 4 times a week 4 <input type="checkbox"/> 2 times a week 5 <input type="checkbox"/> Once a week 6 <input type="checkbox"/> 2 to 3 times a month 7 <input type="checkbox"/> Once a month 8 <input type="checkbox"/> 7 to 11 times in the last year 9 <input type="checkbox"/> 3 to 6 times in the last year 10 <input type="checkbox"/> 1 or 2 times in the last year</p>
<p>(SHOW FLASHCARD 14)</p> <p>e. During the last 12 months, about how often did you drink FIVE OR MORE drinks in a single day?</p>	<p>1 <input type="checkbox"/> Every day 2 <input type="checkbox"/> Nearly every day 3 <input type="checkbox"/> 3 to 4 times a week 4 <input type="checkbox"/> 2 times a week 5 <input type="checkbox"/> Once a week 6 <input type="checkbox"/> 2 to 3 times a month 7 <input type="checkbox"/> Once a month 8 <input type="checkbox"/> 7 to 11 times in the last year 9 <input type="checkbox"/> 3 to 6 times in the last year 10 <input type="checkbox"/> 1 or 2 times in the last year 11 <input type="checkbox"/> Never in the last year</p>

Section 2A - ALCOHOL CONSUMPTION (Continued)

CHECK ITEM 2.5	What is the sex of respondent?	1 <input type="checkbox"/> Male - <i>SKIP to 10</i> 2 <input type="checkbox"/> Female
	(SHOW FLASHCARD 14) 9. During the last 12 months, about how often did you drink FOUR OR MORE drinks in a single day?	1 <input type="checkbox"/> Every day 2 <input type="checkbox"/> Nearly every day 3 <input type="checkbox"/> 3 to 4 times a week 4 <input type="checkbox"/> 2 times a week 5 <input type="checkbox"/> Once a week 6 <input type="checkbox"/> 2 to 3 times a month 7 <input type="checkbox"/> Once a month 8 <input type="checkbox"/> 7 to 11 times in the last year 9 <input type="checkbox"/> 3 to 6 times in the last year 10 <input type="checkbox"/> 1 or 2 times in the last year 11 <input type="checkbox"/> Never in the last year
	(SHOW FLASHCARD 14) 10. During the last 12 months, about how often did you drink enough to feel intoxicated or drunk, that is, when your speech was slurred, you felt unsteady on your feet, or you had blurred vision?	1 <input type="checkbox"/> Every day 2 <input type="checkbox"/> Nearly every day 3 <input type="checkbox"/> 3 to 4 times a week 4 <input type="checkbox"/> 2 times a week 5 <input type="checkbox"/> Once a week 6 <input type="checkbox"/> 2 to 3 times a month 7 <input type="checkbox"/> Once a month 8 <input type="checkbox"/> 7 to 11 times in the last year 9 <input type="checkbox"/> 3 to 6 times in the last year 10 <input type="checkbox"/> 1 or 2 times in the last year 11 <input type="checkbox"/> Never in the last year
	11. How many drinks can you hold WITHOUT feeling intoxicated or drunk?	_____ Number
	(SHOW FLASHCARD 14) 12. During the last 12 months, how often did you . . . a. Drink before 3 p.m. on any day of the week?	1 <input type="checkbox"/> Every day 2 <input type="checkbox"/> Nearly every day 3 <input type="checkbox"/> 3 to 4 times a week 4 <input type="checkbox"/> 2 times a week 5 <input type="checkbox"/> Once a week 6 <input type="checkbox"/> 2 to 3 times a month 7 <input type="checkbox"/> Once a month 8 <input type="checkbox"/> 7 to 11 times in the last year 9 <input type="checkbox"/> 3 to 6 times in the last year 10 <input type="checkbox"/> 1 or 2 times in the last year 11 <input type="checkbox"/> Never in the last year
	b. Drink after midnight on any day of the week?	1 <input type="checkbox"/> Every day 2 <input type="checkbox"/> Nearly every day 3 <input type="checkbox"/> 3 to 4 times a week 4 <input type="checkbox"/> 2 times a week 5 <input type="checkbox"/> Once a week 6 <input type="checkbox"/> 2 to 3 times a month 7 <input type="checkbox"/> Once a month 8 <input type="checkbox"/> 7 to 11 times in the last year 9 <input type="checkbox"/> 3 to 6 times in the last year 10 <input type="checkbox"/> 1 or 2 times in the last year 11 <input type="checkbox"/> Never in the last year
	c. Drink when you were at home alone?	1 <input type="checkbox"/> Every day 2 <input type="checkbox"/> Nearly every day 3 <input type="checkbox"/> 3 to 4 times a week 4 <input type="checkbox"/> 2 times a week 5 <input type="checkbox"/> Once a week 6 <input type="checkbox"/> 2 to 3 times a month 7 <input type="checkbox"/> Once a month 8 <input type="checkbox"/> 7 to 11 times in the last year 9 <input type="checkbox"/> 3 to 6 times in the last year 10 <input type="checkbox"/> 1 or 2 times in the last year 11 <input type="checkbox"/> Never in the last year

Section 2A - ALCOHOL CONSUMPTION (Continued)

(SHOW FLASHCARD 14)

12. During the last 12 months, how often did you . . .

d. Drink in public places such as bars, restaurants or arenas?

- 1 Every day
- 2 Nearly every day
- 3 3 to 4 times a week
- 4 2 times a week
- 5 Once a week
- 6 2 to 3 times a month
- 7 Once a month
- 8 7 to 11 times in the last year
- 9 3 to 6 times in the last year
- 10 1 or 2 times in the last year
- 11 Never in the last year

e. Drink at two or more separate times during the same day, for example if you drank at lunch, stopped drinking during the afternoon and drank again in the evening?

- 1 Every day
- 2 Nearly every day
- 3 3 to 4 times a week
- 4 2 times a week
- 5 Once a week
- 6 2 to 3 times a month
- 7 Once a month
- 8 7 to 11 times in the last year
- 9 3 to 6 times in the last year
- 10 1 or 2 times in the last year
- 11 Never in the last year

f. Drive a car or another motor vehicle such as a motorcycle, boat, jet ski, or skimobile after having had 3 or more drinks?

- 1 Every day
- 2 Nearly every day
- 3 3 to 4 times a week
- 4 2 times a week
- 5 Once a week
- 6 2 to 3 times a month
- 7 Once a month
- 8 7 to 11 times in the last year
- 9 3 to 6 times in the last year
- 10 1 or 2 times in the last year
- 11 Never in the last year

14. You just told me how much and how often you drank in the last 12 months. For how many years have you been drinking about this amount with this frequency?
Round up to nearest whole year.

_____ Year(s)

15. How long has it been since you last had a drink of any kind of beer, wine, liquor or cooler?

_____ Hour(s) ago
OR
_____ Day(s) ago
OR
_____ Week(s) ago
OR
_____ Month(s) ago
OR
_____ Year(s) ago

16a. About how old were you when you first started drinking, not counting small tastes or sips of alcohol?

_____ Age

b. About how old were you when you first started drinking at least once a week?

_____ Age
0 Never drank at least once a week

17. Has there ever been a period of at least one year when you drank more heavily than in the past 12 months?

- 1 Yes
- 2 No - *SKIP to Check Item 2.5A, page 17*

18. Was there ever any one year period during your life when you had a total of at least 12 drinks of any kind of alcohol?

- 1 Yes
- 2 No

Section 2A - ALCOHOL CONSUMPTION (Continued)

<p>19. Thinking about the period in your life when you drank the most, about how old were you when that period began?</p>	<p align="center">_____ Age</p>
<p>20. About how many years did that period last?</p>	<p align="center">_____ Year(s)</p>
<p><i>(SHOW FLASHCARD 18)</i></p> <p>21a. During that period when you drank the most, about how often did you drink?</p>	<p>1 <input type="checkbox"/> Every day 2 <input type="checkbox"/> Nearly every day 3 <input type="checkbox"/> 3 to 4 times a week 4 <input type="checkbox"/> 2 times a week 5 <input type="checkbox"/> Once a week 6 <input type="checkbox"/> 2 to 3 times a month 7 <input type="checkbox"/> Once a month 8 <input type="checkbox"/> 7 to 11 times a year 9 <input type="checkbox"/> 3 to 6 times a year 10 <input type="checkbox"/> 1 or 2 times a year</p>
<p>b. Counting all types of alcohol combined, how many drinks did you USUALLY have on days when you drank during that period?</p>	<p align="center">_____ Number</p>
<p>c. During that period when you drank the most, what was the LARGEST number of drinks that you drank in a single day?</p>	<p align="center">_____ Number</p>
<p><i>(SHOW FLASHCARD 18)</i></p> <p>d. About how often during that period did you drink (number of drinks reported in 21c) in a single day?</p>	<p>1 <input type="checkbox"/> Every day 2 <input type="checkbox"/> Nearly every day 3 <input type="checkbox"/> 3 to 4 times a week 4 <input type="checkbox"/> 2 times a week 5 <input type="checkbox"/> Once a week 6 <input type="checkbox"/> 2 to 3 times a month 7 <input type="checkbox"/> Once a month 8 <input type="checkbox"/> 7 to 11 times a year 9 <input type="checkbox"/> 3 to 6 times a year 10 <input type="checkbox"/> 1 or 2 times a year</p>
<p><i>(SHOW FLASHCARD 19)</i></p> <p>22. During that period when you drank the most, about how often did you drink FIVE OR MORE drinks in a single day?</p>	<p>1 <input type="checkbox"/> Every day 2 <input type="checkbox"/> Nearly every day 3 <input type="checkbox"/> 3 to 4 times a week 4 <input type="checkbox"/> 2 times a week 5 <input type="checkbox"/> Once a week 6 <input type="checkbox"/> 2 to 3 times a month 7 <input type="checkbox"/> Once a month 8 <input type="checkbox"/> 7 to 11 times a last year 9 <input type="checkbox"/> 3 to 6 times a year 10 <input type="checkbox"/> 1 or 2 times a year 11 <input type="checkbox"/> Never</p>
<p>23. During that period, what was the MAIN type of alcohol you drank: coolers, beer, wine or liquor?</p> <p><i>Mark (X) one and ONLY one.</i></p>	<p>1 <input type="checkbox"/> Coolers 2 <input type="checkbox"/> Beer 3 <input type="checkbox"/> Wine 4 <input type="checkbox"/> Liquor</p>
<p>CHECK ITEM 2.5A <i>Refer to Check Item 2.0.</i></p> <p>Is respondent a current drinker or ex-drinker?</p>	<p>1 <input type="checkbox"/> Current drinker - <i>Go to 1a, page 19, and ask columns a – e as appropriate</i> 2 <input type="checkbox"/> Ex-drinker – <i>Go to 1a, page 19, and ask column a only</i></p>

Section 2A - ALCOHOL CONSUMPTION (Continued)

NOTES

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Section 2B - ALCOHOL EXPERIENCES

1a. I'm going to read you a list of experiences that many people have reported in connection with their drinking. As I read each experience, please tell me if this has EVER happened to you. In your ENTIRE LIFE, did you EVER ... (PAUSE) (Repeat phrase frequently)		b. Did this happen in the last 12 months?
(1) Find that your usual number of drinks had much less effect on you than it once did?	1 <input type="checkbox"/> Yes _____ 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> Yes _____ 2 <input type="checkbox"/> No - Mark "Yes" in column c
(2) Find that you had to drink much more than you once did to get the effect you wanted?	1 <input type="checkbox"/> Yes _____ 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> Yes _____ 2 <input type="checkbox"/> No - Mark "Yes" in column c
(3) Drink as much as a fifth of liquor in one day, that would be about 20 drinks, or 3 bottles of wine, or as much as 3 six-packs of beer in a single day?	1 <input type="checkbox"/> Yes _____ 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> Yes _____ 2 <input type="checkbox"/> No - Mark "Yes" in column c
(4) Increase your drinking because the amount you used to drink didn't give you the same effect anymore?	1 <input type="checkbox"/> Yes _____ 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> Yes _____ 2 <input type="checkbox"/> No - Mark "Yes" in column c
(5) More than once want to stop or cut down on your drinking?	1 <input type="checkbox"/> Yes _____ 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> Yes _____ 2 <input type="checkbox"/> No - Mark "Yes" in column c
(6) More than once TRY to stop or cut down on your drinking but found you couldn't do it?	1 <input type="checkbox"/> Yes _____ 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> Yes _____ 2 <input type="checkbox"/> No - Mark "Yes" in column c
(7) Have a period when you ended up drinking more than you meant to?	1 <input type="checkbox"/> Yes _____ 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> Yes _____ 2 <input type="checkbox"/> No - Mark "Yes" in column c
(8) Have a period when you kept on drinking for longer than you had intended to?	1 <input type="checkbox"/> Yes _____ 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> Yes _____ 2 <input type="checkbox"/> No - Mark "Yes" in column c
(9) The next few questions are about the bad aftereffects of drinking that people may have when the effects of alcohol are wearing off. This includes the morning after drinking or in the first few days after stopping or cutting down. Did you EVER...		
(a) Have trouble falling asleep or staying asleep (when the effects of alcohol were wearing off)?	1 <input type="checkbox"/> Yes _____ 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> Yes _____ 2 <input type="checkbox"/> No - Mark "Yes" in column c
(b) Find yourself shaking (when the effects of alcohol were wearing off)?	1 <input type="checkbox"/> Yes _____ 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> Yes _____ 2 <input type="checkbox"/> No - Mark "Yes" in column c
(c) Feel anxious or nervous (when the effects of alcohol were wearing off)?	1 <input type="checkbox"/> Yes _____ 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> Yes _____ 2 <input type="checkbox"/> No - Mark "Yes" in column c
(d) Feel sick to your stomach or vomit (when the effects of alcohol were wearing off)?	1 <input type="checkbox"/> Yes _____ 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> Yes _____ 2 <input type="checkbox"/> No - Mark "Yes" in column c
(e) Feel more restless than is usual for you (when the effects of alcohol were wearing off)?	1 <input type="checkbox"/> Yes _____ 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> Yes _____ 2 <input type="checkbox"/> No - Mark "Yes" in column c
(f) Find yourself sweating or your heart beating fast (when the effects of alcohol were wearing off)?	1 <input type="checkbox"/> Yes _____ 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> Yes _____ 2 <input type="checkbox"/> No - Mark "Yes" in column c
(g) See, feel, or hear things that weren't really there (when the effects of alcohol were wearing off)?	1 <input type="checkbox"/> Yes _____ 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> Yes _____ 2 <input type="checkbox"/> No - Mark "Yes" in column c
(h) Have fits or seizures (when the effects of alcohol were wearing off)?	1 <input type="checkbox"/> Yes _____ 2 <input type="checkbox"/> No - Go to next experience, page 21	1 <input type="checkbox"/> Yes _____ 2 <input type="checkbox"/> No - Mark "Yes" in column c

Section 2B - ALCOHOL EXPERIENCES (Continued)

c. Did this happen before 12 months ago, that is before last (Month one year ago)?	d.	e.
1 <input type="checkbox"/> Yes - Mark Box A1 2 <input type="checkbox"/> No - Go to next experience	<p align="center">A1</p> 1 <input type="checkbox"/> Had to drink much more to get an effect or drank an equivalent of a fifth of liquor	
1 <input type="checkbox"/> Yes - Mark Box A1 2 <input type="checkbox"/> No - Go to next experience		
1 <input type="checkbox"/> Yes - Mark Box A1 2 <input type="checkbox"/> No - Go to next experience		
1 <input type="checkbox"/> Yes - Mark Box A1 2 <input type="checkbox"/> No - Go to next experience		
1 <input type="checkbox"/> Yes - Mark Box A2 2 <input type="checkbox"/> No - Go to next experience		
1 <input type="checkbox"/> Yes - Mark Box A2 2 <input type="checkbox"/> No - Go to next experience		
1 <input type="checkbox"/> Yes - Mark Box A3 2 <input type="checkbox"/> No - Go to next experience	<p align="center">A3</p> 1 <input type="checkbox"/> Drank more or longer than you meant to	
1 <input type="checkbox"/> Yes - Mark Box A3 2 <input type="checkbox"/> No - Go to next experience		
1 <input type="checkbox"/> Yes - Mark Box A4-1 2 <input type="checkbox"/> No - Go to next experience	<p align="center">A4-1</p> 1 <input type="checkbox"/> Had bad aftereffects after drinking, cutting down or stopping	
1 <input type="checkbox"/> Yes - Mark Box A4-1 2 <input type="checkbox"/> No - Go to next experience		
1 <input type="checkbox"/> Yes - Mark Box A4-1 2 <input type="checkbox"/> No - Go to next experience		
1 <input type="checkbox"/> Yes - Mark Box A4-1 2 <input type="checkbox"/> No - Go to next experience		
1 <input type="checkbox"/> Yes - Mark Box A4-1 2 <input type="checkbox"/> No - Go to next experience		
1 <input type="checkbox"/> Yes - Mark Box A4-1 2 <input type="checkbox"/> No - Go to next experience		
1 <input type="checkbox"/> Yes - Mark Box A4-1 2 <input type="checkbox"/> No - Go to next experience		
1 <input type="checkbox"/> Yes - Mark Box A4-1 2 <input type="checkbox"/> No - Go to next experience, page 21		

Section 2B - ALCOHOL EXPERIENCES (Continued)

1a. In your entire life, did you EVER... (PAUSE) (Repeat phrase frequently)	b. Did this happen in the last 12 months?	
(i) Have very bad headaches (when the effects of alcohol were wearing off)?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>SKIP to Check Item 2.6</i>	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark "Yes" in column c</i>
CHECK ITEM 2.6 Are at least 2 items marked in column b, 9(a) - 9(i)?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 2.7</i>	
(j) You just mentioned that you experienced some bad physical aftereffects of drinking in the last 12 months. Were any of these bad aftereffects uncomfortable or upsetting to you or did they cause problems in your life - like at work or school or with family or friends?		1 <input type="checkbox"/> Yes } <i>Go to Check</i> 2 <input type="checkbox"/> No } <i>Item 2.7</i>
CHECK ITEM 2.7 Are at least 2 items marked in column c, 9(a) - 9(i)?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to (10)</i>	
(k) You just mentioned that you experienced some bad physical aftereffects of drinking BEFORE 12 months ago. Were any of these bad aftereffects uncomfortable or upsetting to you or did they cause problems in your life - like at work or school or with family and friends?		
(10) Take a drink or use any drug or medicine, other than aspirin, Advil or Tylenol, to GET OVER any of the bad aftereffects of drinking?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark "Yes" in column c</i>
(11) Take a drink or use any drug or medicine, other than aspirin, Advil or Tylenol, to KEEP FROM having any of these bad aftereffects of drinking?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark "Yes" in column c</i>
(12) Have a period when you spent a lot of time drinking?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark "Yes" in column c</i>
(13) Have a period when you spent a lot of time being sick or getting over the bad aftereffects of drinking?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark "Yes" in column c</i>
(14) Give up or cut down on activities that were important to you in order to drink - like work, school, or associating with friends or relatives?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark "Yes" in column c</i>
(15) Give up or cut down on activities that you were interested in or that gave you pleasure in order to drink?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark "Yes" in column c</i>
(16) Continue to drink even though you knew it was making you feel depressed, uninterested in things, or suspicious or distrustful of other people?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark "Yes" in column c</i>
(17) Continue to drink even though you knew it was causing you a health problem or making a health problem worse?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark "Yes" in column c</i>
(18) Continue to drink even though you had experienced a prior blackout, that is, awakened the next day not being able to remember some of the things you did while drinking or after drinking?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark "Yes" in column c</i>
(19) Have a period when your drinking or being sick from drinking often interfered with taking care of your home or family?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience, page 23</i>	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark "Yes" in column c</i>

Section 2B - ALCOHOL EXPERIENCES (Continued)

<p>c. Did this happen before 12 months ago, that is before last (Month one year ago)?</p>	<p>d.</p>	<p>e.</p>
<p>1 <input type="checkbox"/> Yes - Mark Box A4-1 2 <input type="checkbox"/> No - Go to Check Item 2.6</p>	<p align="center">A4-1 1 <input type="checkbox"/> Had bad aftereffects after stopping or cutting down on your drinking</p>	
<p>1 <input type="checkbox"/> Yes } Go to next 2 <input type="checkbox"/> No } experience</p>		
<p>1 <input type="checkbox"/> Yes - Mark Box A4-2 2 <input type="checkbox"/> No - Go to next experience</p>	<p align="center">A4-2 1 <input type="checkbox"/> Took a drink, medicine or drug to get over or avoid the bad aftereffects of drinking</p>	
<p>1 <input type="checkbox"/> Yes - Mark Box A4-2 2 <input type="checkbox"/> No - Go to next experience</p>		
<p>1 <input type="checkbox"/> Yes - Mark Box A5 2 <input type="checkbox"/> No - Go to next experience</p>	<p align="center">A5 1 <input type="checkbox"/> Spent a lot of time drinking or getting over being sick from drinking</p>	
<p>1 <input type="checkbox"/> Yes - Mark Box A5 2 <input type="checkbox"/> No - Go to next experience</p>		
<p>1 <input type="checkbox"/> Yes - Mark Box A6 2 <input type="checkbox"/> No - Go to next experience</p>	<p align="center">A6 1 <input type="checkbox"/> Gave up or cut down on activities that were important to you in order to drink</p>	
<p>1 <input type="checkbox"/> Yes - Mark Box A6 2 <input type="checkbox"/> No - Go to next experience</p>		
<p>1 <input type="checkbox"/> Yes - Mark Box A7 2 <input type="checkbox"/> No - Go to next experience</p>	<p align="center">A7 1 <input type="checkbox"/> Drank even though it affected your mood or health</p>	
<p>1 <input type="checkbox"/> Yes - Mark Box A7 2 <input type="checkbox"/> No - Go to next experience</p>		
<p>1 <input type="checkbox"/> Yes - Mark Box A7 2 <input type="checkbox"/> No - Go to next experience</p>		
<p>1 <input type="checkbox"/> Yes - Mark Box B1 2 <input type="checkbox"/> No - Go to next experience, page 23</p>		<p align="center">B1 1 <input type="checkbox"/> Were drunk or hung over when you were supposed to be doing something important</p>

Section 2B - ALCOHOL EXPERIENCES (Continued)

1a. In your entire life, did you EVER... (PAUSE) (Repeat phrase frequently)	b. Did this happen in the last 12 months?	
(20) Have job or school troubles because of your drinking or being sick from drinking - like missing too much work, not doing your work well, being demoted or losing a job, or being suspended, expelled or dropping out of school?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Mark "Yes" in column c
(21) More than once drive a car or other vehicle WHILE you were drinking?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Mark "Yes" in column c
(22) More than once ride in a car or other vehicle as a passenger WHILE the driver was drinking?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Mark "Yes" in column c
(23) More than once drive a car, motorcycle, truck, boat, or other vehicle after having too much to drink?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Mark "Yes" in column c
(24) Get into situations while drinking or after drinking that increased your chances of getting hurt - like swimming, using machinery, or walking in a dangerous area or around heavy traffic?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Mark "Yes" in column c
(25) Continue to drink even though you knew it was causing you trouble with your family or friends?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Mark "Yes" in column c
(26) Get into physical fights while drinking or right after drinking?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Mark "Yes" in column c
(27) Get arrested, held at a police station, or have any other legal problems because of your drinking?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Mark "Yes" in column c
(28) Find that you could drink much LESS than you once did to get the effect you wanted?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Mark "Yes" in column c
(29) Ride in a car as a passenger while you were drinking?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Go to Check Item 2.8, Page 25	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Mark "Yes" in column c

Section 2B - ALCOHOL EXPERIENCES (Continued)

c. Did this happen before 12 months ago, that is before last (Month one year ago)?	d.	e.		
1 <input type="checkbox"/> Yes - Mark Box B1 2 <input type="checkbox"/> No - Go to next experience		<p align="center">B1</p> 1 <input type="checkbox"/> Were drunk or hung over when you were supposed to be doing something important		
1 <input type="checkbox"/> Yes } Go to next 2 <input type="checkbox"/> No } experience		<p align="center">B2</p> 1 <input type="checkbox"/> Were in a situation while drinking or after drinking where you could have been hurt		
1 <input type="checkbox"/> Yes - Mark Box B2 2 <input type="checkbox"/> No - Go to next experience		<p align="center">B3</p> 1 <input type="checkbox"/> Drank even though it affected your relationships with other people		
1 <input type="checkbox"/> Yes - Mark Box B2 2 <input type="checkbox"/> No - Go to next experience		<p align="center">B4</p> 1 <input type="checkbox"/> Got arrested or had legal problems as the result of your drinking		
1 <input type="checkbox"/> Yes - Mark Box B2 2 <input type="checkbox"/> No - Go to next experience			<p align="center">B3</p> 1 <input type="checkbox"/> Drank even though it affected your relationships with other people	
1 <input type="checkbox"/> Yes - Mark Box B3 2 <input type="checkbox"/> No - Go to next experience			<p align="center">B4</p> 1 <input type="checkbox"/> Got arrested or had legal problems as the result of your drinking	
1 <input type="checkbox"/> Yes - Mark Box B3 2 <input type="checkbox"/> No - Go to next experience				<p align="center">B3</p> 1 <input type="checkbox"/> Drank even though it affected your relationships with other people
1 <input type="checkbox"/> Yes - Mark Box B4 2 <input type="checkbox"/> No - Go to next experience				
1 <input type="checkbox"/> Yes } Go to next 2 <input type="checkbox"/> No } Experience			<p align="center">B3</p> 1 <input type="checkbox"/> Drank even though it affected your relationships with other people	
1 <input type="checkbox"/> Yes } Go to Check Item 2.8, 2 <input type="checkbox"/> No } page 25				<p align="center">B4</p> 1 <input type="checkbox"/> Got arrested or had legal problems as the result of your drinking

Section 2B - ALCOHOL EXPERIENCES (Continued)

CHECK ITEM 2.8	Are there AT LEAST 3 BOXES marked for A1 - A7 in 1, column d, pages 20 - 22?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 2.10</i>
2a.	You mentioned that before 12 months ago, you... (Read ALL summary statements marked in Boxes A1 - A7 in 1, column d). Before last (Month one year ago), was there EVER a period when SOME of these experiences were happening around the same time ON AND OFF FOR A FEW MONTHS OR LONGER?	1 <input type="checkbox"/> Yes - <i>SKIP to 2d</i> 2 <input type="checkbox"/> No
b.	Before last (Month one year ago), was there EVER a period when SOME of these experiences were happening around the same time MOST DAYS FOR AT LEAST A MONTH?	1 <input type="checkbox"/> Yes - <i>SKIP to 2d</i> 2 <input type="checkbox"/> No
c.	Before last (Month one year ago), was there EVER a period when SOME of these experiences happened within the same 1-year period?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 2.10</i>
d.	About how old were you the FIRST time SOME of these experiences BEGAN to happen around the same time?	_____ Age
e.	In your ENTIRE LIFE , how many separate periods like this did you have when SOME of these experiences were happening around the same time? By separate periods, I mean times that were separated by at least 1 year when you EITHER STOPPED drinking entirely (<i>PAUSE</i>) OR you didn't have any of the experiences you mentioned with alcohol at all.	_____ Number
CHECK ITEM 2.8A	Is number entered in 2e, 2 or more or unknown?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 2h</i>
2f.	What was the LONGEST period you had when SOME of these experiences were happening around the same time?	_____ Month(s) OR _____ Year(s)
g.	How old were you the MOST RECENT time SOME of these experiences BEGAN to happen around the same time?	_____ Age - <i>SKIP to Check Item 2.9</i>
h.	How long did this period last when SOME of these experiences were happening around the same time?	_____ Month(s) OR _____ Year(s)
CHECK ITEM 2.9	Is at least 1 item marked in 1, column b, items (1) - (27), pages 19 - 23?	1 <input type="checkbox"/> Yes - <i>SKIP to Check Item 2.10</i> 2 <input type="checkbox"/> No
2i.	About how old were you when you FINALLY STOPPED having ANY of these experiences with alcohol? By finally stopped, I mean they never started happening again.	_____ Age
CHECK ITEM 2.10	Is at least 1 Box marked for B1 - B4 in 1, column e, pages 22 - 24?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Section 2C, page 27</i>
3a.	Now I'd like to know a little more about a (SMALL/ SMALLER) GROUP of drinking experiences that you had in the past, that is, before 12 months ago. You mentioned that before 12 months ago, you... (Read summary statement(s) marked in Boxes B1 - B4 in 1, column e, pages 22 - 24). About how old were you the first time AT LEAST ONE of these experiences BEGAN to happen?	_____ Age

Section 2B - ALCOHOL EXPERIENCES (Continued)

<p>3b. In your ENTIRE LIFE, how many separate periods like this did you have when any of these experiences were happening?</p> <p>By separate periods, I mean times that were separated by at least 1 year when you EITHER STOPPED drinking entirely (PAUSE) OR you didn't have any of this SMALLER GROUP of experiences you mentioned with alcohol at all.</p>	<p>_____ Number</p>
<p>CHECK ITEM 2.10A Is number entered in 3b, 2 or more or unknown?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 3e</i></p>
<p>3c. What was the LONGEST period you had like this?</p> <p>_____</p>	<p>_____ Month(s) OR _____ Year(s)</p>
<p>d. How old were you the MOST RECENT time this BEGAN to happen?</p> <p>_____</p>	<p>_____ Age - <i>SKIP to Check Item 2.11</i></p>
<p>e. How long did this period last?</p>	<p>_____ Month(s) OR _____ Year(s)</p>
<p>CHECK ITEM 2.11 Is at least 1 item marked in 1, column b, items 19 - 21, 23 - 27, pages 21 - 23?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to Section 2C, page 27</i> 2 <input type="checkbox"/> No</p>
<p>3f. About how old were you when you FINALLY STOPPED having ANY of these experiences with alcohol? By finally stopped, I mean they never started happening again.</p>	<p>_____ Age</p>

Section 2C - TREATMENT UTILIZATION

<p>1. Have you ever gone anywhere or seen anyone for a reason that was related in any way to your drinking - a physician, counselor, Alcoholics Anonymous, or any other community agency or professional?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 4a, page 28</i></p>	
<p>2a. I am going to read you a list of community agencies and professionals. For each one, please tell me if you have ever gone there for any reason related to your drinking.</p> <p>In your entire life, did you EVER go to (a/an) ... <i>(Repeat phrase frequently)</i></p>	<p>b. Did you go there during the last 12 months ONLY, before the last 12 months ONLY or during both time periods?</p>	
<p>(1) Alcoholics Anonymous, Narcotics or Cocaine Anonymous meeting, or any 12-step meeting?</p>	<p>1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to Next Agency</i></p>	<p>1 <input type="checkbox"/> Last 12 months only 2 <input type="checkbox"/> Before the last 12 months only 3 <input type="checkbox"/> Both time periods</p>
<p>(2) Family services or other social service agency?</p>	<p>1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to Next Agency</i></p>	<p>1 <input type="checkbox"/> Last 12 months only 2 <input type="checkbox"/> Before the last 12 months only 3 <input type="checkbox"/> Both time periods</p>
<p>(3) Alcohol or drug detoxification ward or clinic?</p>	<p>1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to Next Agency</i></p>	<p>1 <input type="checkbox"/> Last 12 months only 2 <input type="checkbox"/> Before the last 12 months only 3 <input type="checkbox"/> Both time periods</p>
<p>(4) Inpatient ward of a psychiatric or general hospital or community mental health program?</p>	<p>1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to Next Agency</i></p>	<p>1 <input type="checkbox"/> Last 12 months only 2 <input type="checkbox"/> Before the last 12 months only 3 <input type="checkbox"/> Both time periods</p>
<p>(5) Outpatient clinic, including outreach programs and day or partial patient programs?</p>	<p>1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to Next Agency</i></p>	<p>1 <input type="checkbox"/> Last 12 months only 2 <input type="checkbox"/> Before the last 12 months only 3 <input type="checkbox"/> Both time periods</p>
<p>(6) Alcohol or drug rehabilitation program?</p>	<p>1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to Next Agency</i></p>	<p>1 <input type="checkbox"/> Last 12 months only 2 <input type="checkbox"/> Before the last 12 months only 3 <input type="checkbox"/> Both time periods</p>
<p>(7) Emergency room for any reason related to your drinking?</p>	<p>1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to Next Agency</i></p>	<p>1 <input type="checkbox"/> Last 12 months only 2 <input type="checkbox"/> Before the last 12 months only 3 <input type="checkbox"/> Both time periods</p>
<p>(8) Halfway house, including therapeutic communities?</p>	<p>1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to Next Agency</i></p>	<p>1 <input type="checkbox"/> Last 12 months only 2 <input type="checkbox"/> Before the last 12 months only 3 <input type="checkbox"/> Both time periods</p>
<p>(9) Crisis Center for any reason related to your drinking?</p>	<p>1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to Next Agency</i></p>	<p>1 <input type="checkbox"/> Last 12 months only 2 <input type="checkbox"/> Before the last 12 months only 3 <input type="checkbox"/> Both time periods</p>
<p>(10) Employee Assistance Program (EAP)?</p>	<p>1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to Next Agency</i></p>	<p>1 <input type="checkbox"/> Last 12 months only 2 <input type="checkbox"/> Before the last 12 months only 3 <input type="checkbox"/> Both time periods</p>
<p>(11) Clergyman, priest, or rabbi for any reason related to your drinking?</p>	<p>1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to Next Agency</i></p>	<p>1 <input type="checkbox"/> Last 12 months only 2 <input type="checkbox"/> Before the last 12 months only 3 <input type="checkbox"/> Both time periods</p>
<p>(12) Private physician, psychiatrist, psychologist, social worker, or any other professional?</p>	<p>1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to Next Agency</i></p>	<p>1 <input type="checkbox"/> Last 12 months only 2 <input type="checkbox"/> Before the last 12 months only 3 <input type="checkbox"/> Both time periods</p>
<p>(13) Any other agency or professional?</p>	<p>1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to 3a, page 28</i></p>	<p>1 <input type="checkbox"/> Last 12 months only 2 <input type="checkbox"/> Before the last 12 months only 3 <input type="checkbox"/> Both time periods</p>

Section 2C - TREATMENT UTILIZATION (Continued)

<p>3a. How old were you the FIRST time you went anywhere or saw anyone for help with your drinking?</p>	<p>_____ Age</p>
<p>b. How old were you the MOST RECENT time you went anywhere or saw anyone for help with your drinking?</p>	<p>_____ Age OR 0 <input type="checkbox"/> Happened only once</p>
<p>4a. Was there ever a time when you thought you should see a doctor, counselor, or other health professional or seek any other help for your drinking, but you didn't go?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Section 2D, page 29</i></p>
<p>b. Did this happen during the last 12 months?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 4d</i></p>
<p>c. Did this happen before 12 months ago, that is, before last (Month one year ago)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(<i>SHOW FLASHCARD 20</i>)</p> <p>d. What were your reasons for not getting help? (<i>Check all that apply.</i>)</p>	<p>1 <input type="checkbox"/> Wanted to go, but health insurance didn't cover 2 <input type="checkbox"/> Didn't think anyone could help 3 <input type="checkbox"/> Didn't know any place to go for help 4 <input type="checkbox"/> Couldn't afford to pay the bill 5 <input type="checkbox"/> Didn't have any way to get there 6 <input type="checkbox"/> Didn't have time 7 <input type="checkbox"/> Thought the problem would get better by itself 8 <input type="checkbox"/> Was too embarrassed to discuss it with anyone 9 <input type="checkbox"/> Was afraid of what my boss, friends, family, or others would think 10 <input type="checkbox"/> Thought it was something I should be strong enough to handle alone 11 <input type="checkbox"/> Was afraid they would put me into the hospital 12 <input type="checkbox"/> Was afraid of the treatment they would give me 13 <input type="checkbox"/> Hated answering personal questions 14 <input type="checkbox"/> The hours were inconvenient 15 <input type="checkbox"/> A member of my family objected 16 <input type="checkbox"/> My family thought I should go but I didn't think it was necessary 17 <input type="checkbox"/> Can't speak English very well 18 <input type="checkbox"/> Was afraid I would lose my job 19 <input type="checkbox"/> Couldn't arrange for child care 20 <input type="checkbox"/> Had to wait too long to get into a program 21 <input type="checkbox"/> Wanted to keep drinking or got drunk 22 <input type="checkbox"/> Didn't think drinking problem was serious enough 23 <input type="checkbox"/> Didn't want to go 24 <input type="checkbox"/> Stopped drinking on my own 25 <input type="checkbox"/> Friends or family helped me stop drinking 26 <input type="checkbox"/> Tried getting help before and it didn't work 27 <input type="checkbox"/> Other reason</p>

Section 2D - FAMILY HISTORY

Statement H

Now I would like to ask you some questions about whether any of your relatives, regardless of whether or not they are now living, have **EVER** been alcoholics or problem drinkers. By alcoholic or problem drinker, I mean a person who has physical or emotional problems because of drinking (*PAUSE*); problems with a spouse, family, or friends because of drinking (*PAUSE*); problems at work or school because of drinking (*PAUSE*); problems with the police because of drinking - like drunk driving (*PAUSE*) or a person who seems to spend a lot of time drinking or being hungover. (*Repeat definition frequently.*)

1. Has your blood or natural father been an alcoholic or problem drinker at ANY time in his life?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 99 <input type="checkbox"/> DK
2. Has your blood or natural mother been an alcoholic or problem drinker at ANY time in her life?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 99 <input type="checkbox"/> DK
3a. How many full brothers have you had who lived to be at least 10 years old, including those who are still living? By full brothers, I mean brothers who have the same natural mother AND the same natural father as you do.	_____ Number 0 <input type="checkbox"/> None } <i>SKIP to 4a</i> 99 <input type="checkbox"/> DK }
CHECK ITEM 2.12 Is number marked in 3a equal to 1?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 3c</i>
3b. Was your full brother an alcoholic or problem drinker at ANY time in his life? _____	1 <input type="checkbox"/> Yes } <i>SKIP to 4a</i> 2 <input type="checkbox"/> No } 99 <input type="checkbox"/> DK }
c. How many of your full brothers are now, or were in the past, alcoholics or problem drinkers?	_____ Number
4a. How many full sisters have you had who lived to be at least 10 years old, including those who are still living? By full sisters, I mean sisters who have the same natural mother AND the same natural father as you do.	_____ Number 0 <input type="checkbox"/> None } <i>SKIP to 5a</i> 99 <input type="checkbox"/> DK }
CHECK ITEM 2.13 Is number marked in 4a equal to 1?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No- <i>SKIP to 4c</i>
4b. Was your full sister an alcoholic or problem drinker at ANY time in her life? _____	1 <input type="checkbox"/> Yes } <i>SKIP to 5a</i> 2 <input type="checkbox"/> No } 99 <input type="checkbox"/> DK }
c. How many of your full sisters are now, or were in the past, alcoholics or problem drinkers?	_____ Number
5a. How many natural sons have you had who lived to be at least 10 years old, including those who are still living? By natural, I mean those who you (biologically fathered/gave birth to.)	_____ Number 0 <input type="checkbox"/> None } <i>SKIP to 6a, page 30</i> 99 <input type="checkbox"/> DK }
CHECK ITEM 2.14 Is number marked in 5a equal to 1?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 5c</i>
5b. Was your natural son an alcoholic or problem drinker at ANY time in his life? _____	1 <input type="checkbox"/> Yes } <i>SKIP to 6a, page 30</i> 2 <input type="checkbox"/> No } 99 <input type="checkbox"/> DK }
c. How many of your natural sons are now, or were in the past, alcoholics or problem drinkers?	_____ Number

Section 2D - FAMILY HISTORY (Continued)

<p>6a. How many natural daughters have you had who lived to be at least 10 years old, including those who are still living? By natural daughters, I mean those who you (biologically fathered/gave birth to).</p>	<p>_____ Number</p> <p>0 <input type="checkbox"/> None } 99 <input type="checkbox"/> DK } <i>SKIP to 7a</i></p>
<p>CHECK ITEM 2.15 Is number marked in 6a equal to 1?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No – <i>SKIP to 7c</i></p>
<p>6b. Was your natural daughter an alcoholic or problem drinker at ANY time in her life?</p>	<p>1 <input type="checkbox"/> Yes } 2 <input type="checkbox"/> No } <i>SKIP to 7a</i> 99 <input type="checkbox"/> DK }</p>
<p>c. How many of your natural daughters are now, or were in the past, alcoholics or problem drinkers?</p>	<p>_____ Number</p>
<p>7a. How many full brothers did your natural father have who lived to be at least 10 years old, including those who are still alive? By full brothers, I mean those who had the SAME TWO natural or blood parents as your father.</p>	<p>_____ Number</p> <p>0 <input type="checkbox"/> None } 99 <input type="checkbox"/> DK } <i>SKIP to 8a</i></p>
<p>CHECK ITEM 2.16 Is number marked in 7a equal to 1?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No – <i>SKIP to 7c</i></p>
<p>7b. Was your natural father’s full brother an alcoholic or problem drinker at ANY time in his life?</p>	<p>1 <input type="checkbox"/> Yes } 2 <input type="checkbox"/> No } <i>SKIP to 8a</i> 99 <input type="checkbox"/> DK }</p>
<p>c. How many of your natural father’s full brothers are now, or were in the past, alcoholics or problem drinkers?</p>	<p>_____ Number</p>
<p>8a. How many full sisters did your natural father have who lived to be at least 10 years old, including those who are still living? By full sisters, I mean those who had the SAME TWO natural or blood parents as your father.</p>	<p>_____ Number</p> <p>0 <input type="checkbox"/> None } 99 <input type="checkbox"/> DK } <i>SKIP to 9a</i></p>
<p>CHECK ITEM 2.17 Is number marked in 8a equal to 1?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No – <i>SKIP to 8c</i></p>
<p>8b. Was your natural father’s full sister an alcoholic or problem drinker at ANY time in her life?</p>	<p>1 <input type="checkbox"/> Yes } 2 <input type="checkbox"/> No } <i>SKIP to 9a</i> 99 <input type="checkbox"/> DK }</p>
<p>c. How many of your natural father’s full sisters are now, or were in the past, alcoholics or problem drinkers?</p>	<p>_____ Number</p>
<p>9a. How many full brothers did your natural mother have who lived to be at least 10 years old, including those who are still living? By full brothers, I mean those who had the SAME TWO natural or blood parents as your mother.</p>	<p>_____ Number</p> <p>0 <input type="checkbox"/> None } 99 <input type="checkbox"/> DK } <i>SKIP to 10a</i></p>
<p>CHECK ITEM 2.18 Is number marked in 9a equal to 1?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 9c</i></p>
<p>9b. Was your natural mother’s full brother an alcoholic or problem drinker at ANY time in his life?</p>	<p>1 <input type="checkbox"/> Yes } 2 <input type="checkbox"/> No } <i>SKIP to 10a</i> 99 <input type="checkbox"/> DK }</p>
<p>c. How many of your natural mother’s full brothers are now, or were in the past, alcoholics or problem drinkers?</p>	<p>_____ Number</p>
<p>10a. How many full sisters did your natural mother have who lived to be at least 10 years old, including those who are still living? By full sisters, I mean those who had the SAME TWO natural or blood parents as your mother.</p>	<p>_____ Number</p> <p>0 <input type="checkbox"/> None } 99 <input type="checkbox"/> DK } <i>SKIP to 11, page 31</i></p>

Section 2D - FAMILY HISTORY (Continued)

CHECK ITEM 2.19	Is number marked in 10a equal to 1?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 10c</i>
10b.	Was your natural mother's full sister an alcoholic or problem drinker at ANY time in her life? <hr/>	1 <input type="checkbox"/> Yes } 2 <input type="checkbox"/> No } <i>SKIP to 11</i> 99 <input type="checkbox"/> DK }
c.	How many of your natural mother's full sisters are now, or were in the past, alcoholics or problem drinkers?	_____ Number
11.	Was your natural grandfather on your father's side an alcoholic or problem drinker at ANY time in his life? By natural grandfather on your father's side, I mean your father's natural or blood father.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 99 <input type="checkbox"/> DK
12.	Was your natural grandmother on your father's side an alcoholic or problem drinker at ANY time in her life? By natural grandmother on your father's side, I mean your father's natural or blood mother.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 99 <input type="checkbox"/> DK
13a.	Was your natural grandfather on your mother's side an alcoholic or problem drinker at ANY time in his life? By natural grandfather on your mother's side, I mean your mother's natural or blood father.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 99 <input type="checkbox"/> DK
b.	Was your natural grandmother on your mother's side an alcoholic or problem drinker at ANY time in her life? By natural grandmother on your mother's side, I mean your mother's natural or blood mother.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 99 <input type="checkbox"/> DK
CHECK ITEM 2.19A	Is "1" marked in 2c, Section 1, page 2?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 2.20A</i>
14a.	Was your adoptive father an alcoholic or problem drinker at ANY time in his life?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
b.	Was your adoptive mother an alcoholic or problem drinker at ANY time in her life?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
CHECK ITEM 2.20A	<i>Refer to 3a and 3b, Section 1, page 3.</i> Is respondent never married? (3a=6 or 3b=0)	1 <input type="checkbox"/> Yes - <i>SKIP to 18, page 32</i> 2 <input type="checkbox"/> No
15.	Were you EVER married to an alcoholic or problem drinker?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 2.20C, page 32</i>
CHECK ITEM 2.20B	<i>Refer to 3a, Section 1, page 3.</i> Is respondent currently married? (Code 1)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 2.20C, page 32</i>
16.	Is that your current (husband/wife)?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 18, page 32</i>
17.	Would you say that (he/she) is an alcoholic or problem drinker at this time?	1 <input type="checkbox"/> Yes } 2 <input type="checkbox"/> No } <i>SKIP to 18, page 32</i>

Section 2D - FAMILY HISTORY (Continued)

CHECK ITEM 2.20C	<i>Refer to 3a, Section 1, page 3.</i> Is respondent currently living with someone as if married? (Code 2)	1 <input type="checkbox"/> Yes - <i>SKIP to 19</i> 2 <input type="checkbox"/> No
18. Did you EVER live with someone as if you were married?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Section 3A, page 33</i>	
19. Did you EVER live as if married with someone who was an alcoholic or problem drinker?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Section 3A, page 33</i>	
CHECK ITEM 2.21	<i>Refer to 3a, Section 1, page 3.</i> Is respondent currently living with someone as if married? (Code 2)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Section 3A, page 33</i>
20. Is that the person you live with now?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Section 3A, page 33</i>	
21. Would you say that (he/she) is an alcoholic or problem drinker at this time?	1 <input type="checkbox"/> Yes } 2 <input type="checkbox"/> No } <i>Go to Section 3A, page 33</i>	

Section 3A - TOBACCO USE

Statement I

Now I'd like to ask you about your experiences with tobacco.

1a. In your ENTIRE LIFE, have you ever . . . Smoked at least 100 cigarettes?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
b. Smoked at least 50 cigars?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
c. Smoked a pipe at least 50 times?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
d. Used snuff, such as Skoal, Skoal Bandit or Copenhagen at least 20 times?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
e. Used chewing tobacco, such as Redman, Levi Garrett or Beechnut at least 20 times?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No

CHECK ITEM 3.1 Is at least 1 category marked in a - e above?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Section 3B, page 39</i>
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For each tobacco category reported in 1, MARK EACH TOBACCO CATEGORY CODE BOX and ask 2 through 7 for each tobacco category marked.	1 <input type="checkbox"/> Cigarettes	2 <input type="checkbox"/> Cigars	3 <input type="checkbox"/> Pipe	4 <input type="checkbox"/> Snuff	5 <input type="checkbox"/> Chewing Tobacco
	_____ Age	_____ Age	_____ Age	_____ Age	_____ Age

2a. (About how old were you when you smoked your first FULL (cigarette/cigar/pipe bowl of tobacco)?/About how old were you when you first used snuff/chewing tobacco?)	_____ Age	_____ Age	_____ Age	_____ Age	_____ Age
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3a. When was the MOST RECENT time you (smoked a/used) (Name of tobacco category)? If DK, then ask: Was it within the past year?	_____ Hour(s) ago OR _____ Day(s) ago OR _____ Week(s) ago OR _____ Month(s) ago OR _____ Year(s) ago	_____ Hour(s) ago OR _____ Day(s) ago OR _____ Week(s) ago OR _____ Month(s) ago OR _____ Year(s) ago	_____ Hour(s) ago OR _____ Day(s) ago OR _____ Week(s) ago OR _____ Month(s) ago OR _____ Year(s) ago	_____ Hour(s) ago OR _____ Day(s) ago OR _____ Week(s) ago OR _____ Month(s) ago OR _____ Year(s) ago	_____ Hour(s) ago OR _____ Day(s) ago OR _____ Week(s) ago OR _____ Month(s) ago OR _____ Year(s) ago
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CHECK ITEM 3.2 Did respondent (smoke/use) (tobacco product) in the last year? <i>Refer to 3a, if necessary.</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
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3b. (SHOW FLASHCARD 21) About how often did you USUALLY (smoke/use) (Name of tobacco category) (in the past year/in the year right before you stopped)?	1 <input type="checkbox"/> Every day - SKIP to 5 2 <input type="checkbox"/> 5 to 6 days a week 3 <input type="checkbox"/> 3 to 4 days a week 4 <input type="checkbox"/> 1 to 2 days a week 5 <input type="checkbox"/> 2 to 3 days a month 6 <input type="checkbox"/> Once a month or less	1 <input type="checkbox"/> Every day - SKIP to 5 2 <input type="checkbox"/> 5 to 6 days a week 3 <input type="checkbox"/> 3 to 4 days a week 4 <input type="checkbox"/> 1 to 2 days a week 5 <input type="checkbox"/> 2 to 3 days a month 6 <input type="checkbox"/> Once a month or less	1 <input type="checkbox"/> Every day - SKIP to 5 2 <input type="checkbox"/> 5 to 6 days a week 3 <input type="checkbox"/> 3 to 4 days a week 4 <input type="checkbox"/> 1 to 2 days a week 5 <input type="checkbox"/> 2 to 3 days a month 6 <input type="checkbox"/> Once a month or less	1 <input type="checkbox"/> Every day - SKIP to 5 2 <input type="checkbox"/> 5 to 6 days a week 3 <input type="checkbox"/> 3 to 4 days a week 4 <input type="checkbox"/> 1 to 2 days a week 5 <input type="checkbox"/> 2 to 3 days a month 6 <input type="checkbox"/> Once a month or less	1 <input type="checkbox"/> Every day - SKIP to 5 2 <input type="checkbox"/> 5 to 6 days a week 3 <input type="checkbox"/> 3 to 4 days a week 4 <input type="checkbox"/> 1 to 2 days a week 5 <input type="checkbox"/> 2 to 3 days a month 6 <input type="checkbox"/> Once a month or less
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Section 3A - TOBACCO USE (Continued)

	1 <input type="checkbox"/> Cigarettes	2 <input type="checkbox"/> Cigars	3 <input type="checkbox"/> Pipe	4 <input type="checkbox"/> Snuff	5 <input type="checkbox"/> Chewing Tobacco
3c. (On the days that you smoked (in the past year/ in the year right before you stopped), about how many (cigarettes/cigars/ pipe bowls of tobacco) did you USUALLY smoke?/ On the days that you used (snuff/chewing tobacco) (in the past year/in the year right before you stopped) about how many (pinches, dips or rubs/plugs, wads or chews) did you use?)	____ Number	____ Number	____ Number	____ Number	____ Number
d. For how long (have/did) you (smoke(d)/use(d)) this amount?	____ Day(s) OR ____ Week(s) OR ____ Month(s) OR ____ Year(s)	____ Day(s) OR ____ Week(s) OR ____ Month(s) OR ____ Year(s)	____ Day(s) OR ____ Week(s) OR ____ Month(s) OR ____ Year(s)	____ Day(s) OR ____ Week(s) OR ____ Month(s) OR ____ Year(s)	____ Day(s) OR ____ Week(s) OR ____ Month(s) OR ____ Year(s)
4. Did you ever (smoke/use) (Name of tobacco category) every day?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - SKIP to Check Item 3.3	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - SKIP to Check Item 3.3	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - SKIP to Check Item 3.3	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - SKIP to Check Item 3.3	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - SKIP to 8a, page 35
5. About how old were you when you FIRST started (smoking/using) (Name of tobacco category) every day?	____ Age	____ Age	____ Age	____ Age	____ Age
6. Thinking back over the entire period when you were (smoking/using snuff/ chewing tobacco) every day, about how many (cigarettes/cigars/pipe bowls of tobacco/pinches, dips or rubs/plugs, wads or chews) did you USUALLY (smoke/use) in a single day?	____ Number	____ Number	____ Number	____ Number	____ Number
7. For how long (have/did) you (smoke(d)/use(d)) this amount every day?	____ Day(s) OR ____ Week(s) OR ____ Month(s) OR ____ Year(s)	____ Day(s) OR ____ Week(s) OR ____ Month(s) OR ____ Year(s)	____ Day(s) OR ____ Week(s) OR ____ Month(s) OR ____ Year(s)	____ Day(s) OR ____ Week(s) OR ____ Month(s) OR ____ Year(s)	____ Day(s) OR ____ Week(s) OR ____ Month(s) OR ____ Year(s)
CHECK ITEM 3.3 Is another tobacco category marked?	1 <input type="checkbox"/> Yes - Fill 2-7 in designated column for next tobacco category 2 <input type="checkbox"/> No - Go to Check Item 3.3A	1 <input type="checkbox"/> Yes - Fill 2-7 in designated column for next tobacco category 2 <input type="checkbox"/> No - Go to Check Item 3.3A	1 <input type="checkbox"/> Yes - Fill 2-7 in designated column for next tobacco category 2 <input type="checkbox"/> No - Go to Check Item 3.3A	1 <input type="checkbox"/> Yes - Fill 2-7 in designated column for next tobacco category 2 <input type="checkbox"/> No - Go to Check Item 3.3A	
CHECK ITEM 3.3A Are all columns in Check Item 3.2 marked "No"?	1 <input type="checkbox"/> Yes - Ask 8a and c only 2 <input type="checkbox"/> No - Ask 8a, b and c as appropriate				

Section 3A - TOBACCO USE (Continued)

8a. The next few questions are about experiences that many people have had with using tobacco, including cigarettes, cigars, a pipe, snuff or chewing tobacco. As I read each experience, please tell me if it has EVER happened to you as a result of using ANY of these types of tobacco.

b. Did this happen in the last 12 months?

c. Did this happen before 12 months ago, that is before last (*Month one year ago*)?

In your ENTIRE LIFE, did you EVER ... (PAUSE)
(Repeat phrase frequently)

<p>(1) More than once want to stop or cut down on your tobacco use?</p>	<p>1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i></p>	<p>1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark "Yes" in column c</i></p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(2) Give up or cut down on activities that you were interested in or that gave you pleasure because tobacco use was not permitted at the activity?</p>	<p>1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i></p>	<p>1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark "Yes" in column c</i></p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(3) Give up or cut down on activities that were important to you - like associating with friends or relatives or attending social activities because tobacco use was not permitted at the activity?</p>	<p>1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i></p>	<p>1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark "Yes" in column c</i></p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(4) Continue to use tobacco even though you knew it was causing you a health problem or making a health problem worse?</p>	<p>1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i></p>	<p>1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark "Yes" in column c</i></p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(5) Find yourself (chain smoking/using one pinch or plug of snuff or chewing tobacco right after another)?</p>	<p>1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i></p>	<p>1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark "Yes" in column c</i></p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(6) More than once try to stop or cut down on your tobacco use but found you couldn't do it?</p>	<p>1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i></p>	<p>1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark "Yes" in column c</i></p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(7) Many people experience problems on occasions when they stop or cut down on their tobacco use. After stopping or cutting down on your tobacco use, did you EVER...</p>			
<p>(a) Feel depressed?</p>	<p>1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i></p>	<p>1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark "Yes" in column c</i></p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(b) Have difficulty falling asleep or staying asleep?</p>	<p>1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i></p>	<p>1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark "Yes" in column c</i></p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(c) Have difficulty concentrating?</p>	<p>1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience, page 36</i></p>	<p>1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark "Yes" in column c</i></p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>

Section 3A - TOBACCO USE (Continued)

8a. In your ENTIRE LIFE, did you EVER ... (PAUSE) <i>(Repeat phrase frequently)</i>		b. Did this happen in the last 12 months?	c. Did this happen before 12 months ago, that is before last (Month one year ago)?
(d) Eat more than usual or gain weight?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark "Yes" in column c</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(e) Become easily irritated, angry, or frustrated?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark "Yes" in column c</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(f) Feel anxious or nervous?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark "Yes" in column c</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(g) Feel your heart beating more slowly than usual?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark "Yes" in column c</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(h) Feel more restless than usual?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to Check Item 3.4</i>	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark "Yes" in column c</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
CHECK ITEM 3.4	Are at least 2 items marked "Yes" in column b, 7(a) - 7(h)?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 3.5</i>	
(i) You just mentioned that you had some experiences after stopping or cutting down on your tobacco use in the last 12 months. Were any of these experiences very uncomfortable or upsetting to you or did they cause problems in your life - like at work or school or with family or friends?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
(j) Did you use tobacco in the last 12 months to keep from having any of these experiences?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
CHECK ITEM 3.5	Are at least 2 items marked "Yes" in column c, 7(a) - 7(h)?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to (8), page 37</i>	
(k) You just mentioned that you had some experiences after stopping or cutting down on your tobacco use BEFORE 12 months ago. Were any of these experiences very uncomfortable or upsetting to you or did they cause problems in your life - like at work or school or with family or friends?			1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No

Section 3A - TOBACCO USE (Continued)

<p>8a. In your ENTIRE LIFE, did you EVER ... (PAUSE) <i>(Repeat phrase frequently)</i></p>	<p>b. Did this happen in the last 12 months?</p>	<p>c. Did this happen before 12 months ago, that is before last (Month one year ago)?</p>	
<p>(1) Did you use tobacco to keep from having any of these experiences before 12 months ago?</p>		<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>	
<p>(8) Wake up in the middle of the night to use tobacco?</p>	<p>1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i></p>	<p>1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark "Yes" in column c</i></p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(9) Often use tobacco just after getting up or shortly after getting up in the morning?</p>	<p>1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i></p>	<p>1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark "Yes" in column c</i></p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(10) Find yourself using tobacco JUST AFTER being in a situation where tobacco use was not permitted - like after being on a plane, at a meeting, or shopping at the mall?</p>	<p>1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i></p>	<p>1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark "Yes" in column c</i></p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(11) Find that you had to use much more tobacco than you once did to get the effect you wanted?</p>	<p>1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i></p>	<p>1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark "Yes" in column c</i></p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(12) Increase your use of tobacco by at least 50 percent?</p>	<p>1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i></p>	<p>1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark "Yes" in column c</i></p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(13) Have a period when you often used tobacco more than you intended to?</p>	<p>1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i></p>	<p>1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark "Yes" in column c</i></p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(14) Continue to use tobacco even though it made you nervous, jittery, anxious or depressed?</p>	<p>1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to Check Item 3.6</i></p>	<p>1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark "Yes" in column c</i></p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 3.6 Is more than 1 item marked in 1(a) - (e), page 33?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 3.8</i></p>		
<p>CHECK ITEM 3.7 Are at least 3 Boxes marked in 8, column b, pages 35 - 36?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 3.8</i></p>		
<p>9. What type or types of tobacco were you using when you had some of these experiences with tobacco you mentioned in the last 12 months? <i>Mark (X) all that apply.</i></p>	<p>1 <input type="checkbox"/> Cigarettes 2 <input type="checkbox"/> Cigars 3 <input type="checkbox"/> Pipe 4 <input type="checkbox"/> Snuff 5 <input type="checkbox"/> Chewing tobacco</p>		
<p>CHECK ITEM 3.8 Are at least 3 Boxes marked "Yes" in 8, column c, pages 35 - 36?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Section 3B, page 39</i></p>		
<p>10a. You just mentioned some experiences with using tobacco that happened in the past, that is, before 12 months ago. Now I'd like to know if some of the experiences you mentioned happened around the same time in the past. Before last (Month one year ago), was there EVER a period when SOME of these experiences were happening around the same time most days FOR AT LEAST A MONTH?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to 10d, page 38</i> 2 <input type="checkbox"/> No</p>		

Section 3A - TOBACCO USE (Continued)

<p>10b. Before last (<i>Month one year ago</i>), was there EVER a period when SOME of these experiences were happening around the same time ON AND OFF FOR A FEW MONTHS OR LONGER?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to 10d</i> 2 <input type="checkbox"/> No</p>
<p>c. Before last (<i>Month one year ago</i>), was there EVER a time when some of these experiences happened within the same 1-year period?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Section 3B, page 39</i></p>
<p>d. About old were you the FIRST time SOME of these experiences BEGAN to happen at around the same time?</p>	<p>_____ Age</p>
<p>e. In your entire LIFE, how many separate periods like this did you have when some of these experiences were happening around the same time?</p> <p>By separate periods, I mean times that were separated by at least 1 year when you STOPPED using tobacco entirely OR you didn't have any of the experiences you mentioned with tobacco at all?</p>	<p>_____ Number</p>
<p>CHECK ITEM 3.9A Is number entered in 10e, 2 or more or unknown?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 10h</i></p>
<p>10f. What was the longest period you had when SOME of these experiences were happening around the same time?</p>	<p>_____ Month(s) OR _____ Year(s)</p>
<p>g. How old were you the MOST RECENT time SOME of these experiences BEGAN to happen at around the same time?</p>	<p>_____ Age - <i>SKIP to Check Item 3.9B</i></p>
<p>h. How long did this period last when SOME of these experiences were happening around the same time?</p>	<p>_____ Month(s) OR _____ Year(s)</p>
<p>CHECK ITEM 3.9B Is at least 1 item marked in 8, column b, pages 35 - 36?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to Check Item 3.9C</i> 2 <input type="checkbox"/> No</p>
<p>10i. About how old were you when you FINALLY STOPPED having any of these experiences with tobacco? By finally stopped, I mean they never started happening again.</p>	<p>_____ Age</p>
<p>CHECK ITEM 3.9C Is "Yes" marked in Check Item 3.6?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Section 3B, page 39</i></p>
<p>11. What type or types of tobacco were you using when you had some of the experiences you mentioned with tobacco BEFORE 12 months ago?</p> <p><i>Mark (X) all that apply.</i></p>	<p>1 <input type="checkbox"/> Cigarettes 2 <input type="checkbox"/> Cigars 3 <input type="checkbox"/> Pipe 4 <input type="checkbox"/> Snuff 5 <input type="checkbox"/> Chewing tobacco</p>

Section 3B - MEDICINE USE

Statement J

Now I'd like to ask you about your experiences with medicines and other kinds of drugs that you may have used **ON YOUR OWN** - that is, either **WITHOUT** a doctor's prescription (*PAUSE*); in **GREATER** amounts, **MORE OFTEN**, or **LONGER** than prescribed (*PAUSE*); or for a reason other than a doctor said you should use them. People use these medicines and drugs **ON THEIR OWN** to feel more alert, to relax or quiet their nerves, to feel better, to enjoy themselves, or to get high or just to see how they would work.

(SHOW FLASHCARD 22)

1a. Have you EVER used any of these medicines or drugs?

Read list. (If "YES" to any drug category, ask: Which ones?)

Record specific drug(s) used.

- 1 Sedatives, for example, sleeping pills, bar-bit-your-ates, Seconal, Kway^l-ludes, or Khlor^l-all Hydrate - *Specify* ↓

- 2 Tranquilizers or anti-anxiety drugs, for example, Valium, Librium, muscle relaxants, or Zanax - *Specify* ↓

- 3 Painkillers, for example, Codeine, Darvon, Per^l-ko-dan, Dill-odd^l-id, or Demerol - *Specify* ↓

- 4 Stimulants, for example, Pray-lude^l-in, Benzadrine, Methadrine, uppers, or speed - *Specify* ↓

- 5 Mariwa^l-na, hash, THC, or grass - *Specify* ↓

- 6 Cocaine or crack - *Specify* ↓

- 7 Hallucinogens, for example, Ecstasy/MDMA, LSD, mescaline, Sillosy^l-bin, PCP, angel dust, or pay-o^l-tee - *Specify* ↓

- 8 Inhalants or solvents, for example, a^l-mill nitrate, nitrous oxide, glue, tol^l-u- een or gasoline - *Specify* ↓

- 9 Heroin

- 10 Any OTHER medicines, or drugs, or substances, for example, steroids, Elavil, Thorazine, or Haldol?

(SELECT MOST FREQUENTLY USED OTHER DRUG)

CHECK ITEM 3.10

Is at least one category marked in 1a?

- 1 Yes - *Classify as ever (drug) user*
- 2 No - *Classify as non (drug) user and SKIP to Section 3E, page 59*

Section 3B - MEDICINE USE (Continued)

**CHECK
ITEM 3.11**

For every drug category marked in 1a, page 39, mark the corresponding category below and ask 2a - g for each marked drug category.

2a. How old were you when you FIRST used (Name of drug category)?

b. Did you use (Name of drug category) in the last 12 months only, before the last 12 months only, or during both time periods?

c. During the last 12 months, about how often did you use (Name of drug category)?

(SHOW FLASHCARD 23)

1 <input type="checkbox"/> Sedatives	_____ Age	1 <input type="checkbox"/> Last 12 months only _____ 2 <input type="checkbox"/> Prior to last 12 months only - <i>Ask column d</i> 3 <input type="checkbox"/> Both time periods _____	<input type="checkbox"/> Code
2 <input type="checkbox"/> Tranquilizers	_____ Age	1 <input type="checkbox"/> Last 12 months only _____ 2 <input type="checkbox"/> Prior to last 12 months only - <i>Ask column d</i> 3 <input type="checkbox"/> Both time periods _____	<input type="checkbox"/> Code
3 <input type="checkbox"/> Painkillers	_____ Age	1 <input type="checkbox"/> Last 12 months only _____ 2 <input type="checkbox"/> Prior to last 12 months only - <i>Ask column d</i> 3 <input type="checkbox"/> Both time periods _____	<input type="checkbox"/> Code
4 <input type="checkbox"/> Stimulants	_____ Age	1 <input type="checkbox"/> Last 12 months only _____ 2 <input type="checkbox"/> Prior to last 12 months only - <i>Ask column d</i> 3 <input type="checkbox"/> Both time periods _____	<input type="checkbox"/> Code
5 <input type="checkbox"/> Marijuana	_____ Age	1 <input type="checkbox"/> Last 12 months only _____ 2 <input type="checkbox"/> Prior to last 12 months only - <i>Ask column d</i> 3 <input type="checkbox"/> Both time periods _____	<input type="checkbox"/> Code
6 <input type="checkbox"/> Cocaine or Crack	_____ Age	1 <input type="checkbox"/> Last 12 months only _____ 2 <input type="checkbox"/> Prior to last 12 months only - <i>Ask column d</i> 3 <input type="checkbox"/> Both time periods _____	<input type="checkbox"/> Code
7 <input type="checkbox"/> Hallucinogens	_____ Age	1 <input type="checkbox"/> Last 12 months only _____ 2 <input type="checkbox"/> Prior to last 12 months only - <i>Ask column d</i> 3 <input type="checkbox"/> Both time periods _____	<input type="checkbox"/> Code
8 <input type="checkbox"/> Inhalants/Solvents	_____ Age	1 <input type="checkbox"/> Last 12 months only _____ 2 <input type="checkbox"/> Prior to last 12 months only - <i>Ask column d</i> 3 <input type="checkbox"/> Both time periods _____	<input type="checkbox"/> Code
9 <input type="checkbox"/> Heroin	_____ Age	1 <input type="checkbox"/> Last 12 months only _____ 2 <input type="checkbox"/> Prior to last 12 months only - <i>Ask column d</i> 3 <input type="checkbox"/> Both time periods _____	<input type="checkbox"/> Code
10 <input type="checkbox"/> OTHER <i>Specify</i> ↓ _____	_____ Age	1 <input type="checkbox"/> Last 12 months only _____ 2 <input type="checkbox"/> Prior to last 12 months only - <i>Ask column d</i> 3 <input type="checkbox"/> Both time periods _____	<input type="checkbox"/> Code

Section 3B - MEDICINE (Continued)

d. When was the most recent time you used (Name of drug category)?	e. Think about the time when you were using (Name of drug category) the most. At that time about how often did you use (it/them)? (SHOW FLASHCARD 23)	f. About how old were you when you FIRST BEGAN using (Name of drug category) that frequently?	g. About how long did that period last when you were using (Name of drug category) that frequently?
____ Day(s) ago <i>OR</i> ____ Week(s) ago <i>OR</i> ____ Month(s) ago <i>OR</i> ____ Year(s) ago	<input type="text"/> <input type="text"/> Code	____ Age	____ Week(s) OR ____ Month(s) OR ____ Year(s) } <i>SKIP to next marked drug category</i>
____ Day(s) ago <i>OR</i> ____ Week(s) ago <i>OR</i> ____ Month(s) ago <i>OR</i> ____ Year(s) ago	<input type="text"/> <input type="text"/> Code	____ Age	____ Week(s) OR ____ Month(s) OR ____ Year(s) } <i>SKIP to next marked drug category</i>
____ Day(s) ago <i>OR</i> ____ Week(s) ago <i>OR</i> ____ Month(s) ago <i>OR</i> ____ Year(s) ago	<input type="text"/> <input type="text"/> Code	____ Age	____ Week(s) OR ____ Month(s) OR ____ Year(s) } <i>SKIP to next marked drug category</i>
____ Day(s) ago <i>OR</i> ____ Week(s) ago <i>OR</i> ____ Month(s) ago <i>OR</i> ____ Year(s) ago	<input type="text"/> <input type="text"/> Code	____ Age	____ Week(s) OR ____ Month(s) OR ____ Year(s) } <i>SKIP to next marked drug category</i>
____ Day(s) ago <i>OR</i> ____ Week(s) ago <i>OR</i> ____ Month(s) ago <i>OR</i> ____ Year(s) ago	<input type="text"/> <input type="text"/> Code	____ Age	____ Week(s) OR ____ Month(s) OR ____ Year(s) } <i>SKIP to next marked drug category</i>
____ Day(s) ago <i>OR</i> ____ Week(s) ago <i>OR</i> ____ Month(s) ago <i>OR</i> ____ Year(s) ago	<input type="text"/> <input type="text"/> Code	____ Age	____ Week(s) OR ____ Month(s) OR ____ Year(s) } <i>SKIP to next marked drug category</i>
____ Day(s) ago <i>OR</i> ____ Week(s) ago <i>OR</i> ____ Month(s) ago <i>OR</i> ____ Year(s) ago	<input type="text"/> <input type="text"/> Code	____ Age	____ Week(s) OR ____ Month(s) OR ____ Year(s) } <i>SKIP to next marked drug category</i>
____ Day(s) ago <i>OR</i> ____ Week(s) ago <i>OR</i> ____ Month(s) ago <i>OR</i> ____ Year(s) ago	<input type="text"/> <input type="text"/> Code	____ Age	____ Week(s) OR ____ Month(s) OR ____ Year(s) } <i>SKIP to next marked drug category</i>
____ Day(s) ago <i>OR</i> ____ Week(s) ago <i>OR</i> ____ Month(s) ago <i>OR</i> ____ Year(s) ago	<input type="text"/> <input type="text"/> Code	____ Age	____ Week(s) OR ____ Month(s) OR ____ Year(s) } <i>SKIP to next marked drug category</i>
____ Day(s) ago <i>OR</i> ____ Week(s) ago <i>OR</i> ____ Month(s) ago <i>OR</i> ____ Year(s) ago	<input type="text"/> <input type="text"/> Code	____ Age	____ Week(s) OR ____ Month(s) OR ____ Year(s) } <i>Go to Check Item 3.12, page 42</i>

Section 3B - MEDICINE USE (Continued)

CHECK ITEM 3.12	What is the time period marked in 2b for marijuana on page 40?	1 <input type="checkbox"/> Last 12 months only 2 <input type="checkbox"/> Before last 12 months only – <i>SKIP to 4</i> 3 <input type="checkbox"/> Both time periods 4 <input type="checkbox"/> Never (Blank) – <i>SKIP to Check Item 3.13</i>
	When did respondent use marijuana ?	
3.	Now I would like to know a little more about your use of marijuana. On the days that you used marijuana in the last 12 months, about how many joints did you usually smoke in a single day?	_____ Number
4.	At the time you were using marijuana the most, about how many joints did you usually smoke in a single day?	_____ Number
CHECK ITEM 3.13	Is cocaine or crack marked in 1a?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No – <i>SKIP to Check Item 3.13A</i>
	Did the respondent use cocaine or crack?	
5a.	Earlier you told me that you had used cocaine OR crack. Now please tell me, NOT COUNTING CRACK, have you ever used cocaine?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No – <i>SKIP to 9a</i>
b.	Did you use cocaine during the last 12 months ONLY, before the last 12 months ONLY or during both time periods?	1 <input type="checkbox"/> Last 12 months only 2 <input type="checkbox"/> Before last 12 months only – <i>SKIP to 7</i> 3 <input type="checkbox"/> Both time periods
6.	On the days that you used cocaine in the last 12 months, about how many grams or lines did you usually use in a single day?	_____ Gram(s) OR _____ Line(s)
7.	At the time when you were using cocaine the most, about how many grams or lines did you usually use in a single day?	_____ Gram(s) OR _____ Line(s)
8.	In which of the following ways have you used cocaine? <i>Read each response category.</i> <i>Mark (X) all that apply.</i>	1 <input type="checkbox"/> IV, through the veins? 2 <input type="checkbox"/> Injection under the skin? 3 <input type="checkbox"/> Smoking, freebasing? 4 <input type="checkbox"/> Snorting, sniffing, breathing? 5 <input type="checkbox"/> By mouth, drinking? 6 <input type="checkbox"/> Other method?
9a.	NOT COUNTING COCAINE, have you ever used crack?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No – <i>SKIP to Check Item 3.13A</i>
b.	Did you use crack during the last 12 months ONLY, before the last 12 months ONLY or during both time periods?	1 <input type="checkbox"/> Last 12 months only 2 <input type="checkbox"/> Before last 12 months only – <i>SKIP to 11</i> 3 <input type="checkbox"/> Both time periods
10.	On the days that you used crack in the last 12 months, about how many rocks did you usually use in a single day?	_____ Number
11.	At the time when you were using crack the most, about how many rocks did you usually use in a single day?	_____ Number
12.	In which of the following ways have you used crack? <i>Read each response category.</i> <i>Mark (X) all that apply.</i>	1 <input type="checkbox"/> IV, through the veins? 2 <input type="checkbox"/> Injection under the skin? 3 <input type="checkbox"/> Smoking, freebasing? 4 <input type="checkbox"/> Snorting, sniffing, breathing? 5 <input type="checkbox"/> By mouth, drinking? 6 <input type="checkbox"/> Other method?
CHECK ITEM 3.13A	Did respondent EVER use hallucinogens?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No – <i>SKIP to Check Item 3.14, page 42a</i>

Section 3B - MEDICINE USE (Continued)

<p>12m. (1) Did you EVER use ecstasy or MDMA?</p> <hr/>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 3.14</i></p>
<p>(2) Did you use ecstasy or MDMA in the last 12 months?</p> <hr/>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 3.14</i></p>
<p>(3) Did you use ecstasy or MDMA BEFORE 12 months ago, that is, BEFORE last (Month one year ago)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 3.14 Are any 1's or 3's marked in 2 column b, page 40?</p>	<p>1 <input type="checkbox"/> Yes - <i>GO to 12a, page 43, ask columns a - e as appropriate</i> 2 <input type="checkbox"/> No - <i>GO to 12a, page 43, ask columns a and e only</i></p>

Section 3C - MEDICINE EXPERIENCES

12a. Now I'm going to ask you about some experiences that people have reported in connection with their use of the medicines or drugs that we just talked about. As I read each experience, please tell me if this has ever happened to you.

b. Did this happen in the last 12 months?

In your entire life, did you EVER ... (PAUSE)
(Repeat phrase frequently)

(1) Have arguments with your spouse, boyfriend/girlfriend, family, or friends as a result of your medicine or drug use?

1 Yes \longrightarrow
2 No - Go to next experience

1 Yes \longrightarrow
2 No - Mark "Yes" in column d

(2) Get into physical fights while under the influence of a medicine or drug?

1 Yes \longrightarrow
2 No - Go to next experience

1 Yes \longrightarrow
2 No - Mark "Yes" in column d

(3) Continue to use a medicine or drug even though you knew it was causing you trouble with your family or friends?

1 Yes \longrightarrow
2 No - Go to next experience

1 Yes \longrightarrow
2 No - Mark "Yes" in column d

(4) Have job or school troubles as a result of your medicine or drug use - like missing too much work, not doing your work well, being demoted or losing a job, or being suspended, expelled or dropping out of school?

1 Yes \longrightarrow
2 No - Go to next experience

1 Yes \longrightarrow
2 No - Mark "Yes" in column d

(5) Have a period when your medicine or drug use or your being sick from your medicine or drug use often interfered with taking care of your home or family?

1 Yes \longrightarrow
2 No - Go to next experience

1 Yes \longrightarrow
2 No - Mark "Yes" in column d

(6) Accidentally injure yourself while under the influence of a medicine or drug, for example, have a bad fall or cut yourself badly, get hurt in a traffic accident, or anything like that?

1 Yes \longrightarrow
2 No - Go to next experience

1 Yes \longrightarrow
2 No - Mark "Yes" in column d

(7) More than once drive a car, motorcycle, truck, boat, or other vehicle when you were under the influence of a medicine or drug?

1 Yes \longrightarrow
2 No - Go to next experience

1 Yes \longrightarrow
2 No - Mark "Yes" in column d

(8) Find yourself under the influence of a medicine or drug or feeling its aftereffects in situations that increased your chances of getting hurt - like swimming, using machinery, or walking in a dangerous area or around heavy traffic?

1 Yes \longrightarrow
2 No - Go to next experience

1 Yes \longrightarrow
2 No - Mark "Yes" in column d

(9) Get arrested, get held at a police station or have any other legal problems because of your medicine or drug use?

1 Yes \longrightarrow
2 No - Go to Check Item 3.15, page 45

1 Yes \longrightarrow
2 No - Mark "Yes" in column d

Section 3C - MEDICINE EXPERIENCES (Continued)

<p>c. During the last 12 months, which medicines or drugs did this happen with? <i>(SHOW FLASHCARD 22)</i></p>	<p>d. Did this happen before 12 months ago, that is before last (Month one year ago)?</p>	<p>e. Which medicines or drugs did this happen with before 12 months ago? <i>(SHOW FLASHCARD 22)</i></p>
<p>1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH</p>	<p>1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to next experience</i></p>	<p>1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH</p>
<p>1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH</p>	<p>1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to next experience</i></p>	<p>1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH</p>
<p>1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH</p>	<p>1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to next experience</i></p>	<p>1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH</p>
<p>1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH</p>	<p>1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to next experience</i></p>	<p>1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH</p>
<p>1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH</p>	<p>1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to next experience</i></p>	<p>1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH</p>
<p>1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH</p>	<p>1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to next experience</i></p>	<p>1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH</p>
<p>1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH</p>	<p>1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to next experience</i></p>	<p>1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH</p>
<p>1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH</p>	<p>1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to next experience</i></p>	<p>1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH</p>
<p>1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH</p>	<p>1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to Check Item 3.15, page 45</i></p>	<p>1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH</p>

Section 3C - MEDICINE EXPERIENCES (Continued)

<p>CHECK ITEM 3.15 Is at least 1 item marked for any drug category in 12 column e, page 44?</p> <p>1 <input type="checkbox"/> Yes </p> <p>2 <input type="checkbox"/> No - <i>SKIP to 14a, page 47</i></p> <p><i>Mark each corresponding category below and ask 13a-f for each marked category.</i></p>	<p>13a. You just mentioned (an/some) experience(s) you had with (<i>Name of drug category</i>) in the past, that is, before 12 months ago. About how old were you the FIRST time (ANY ONE of these/this) experience(s) began to happen with (<i>Name of drug category</i>)?</p>	<p>b. In your ENTIRE LIFE how many separate periods like this did you have when any of these experiences were happening with (<i>Name of drug category</i>)?</p> <p>By separate periods, I mean time that were separated by at least 1 year when you EITHER STOPPED using (<i>Name of drug category</i>) entirely (PAUSE) OR you didn't have any of the experiences you just mentioned with (<i>Name of drug category</i>)?</p>	<p>CHECK ITEM 3.16 Is number in 13b, 2 or more or unknown?</p>
<p>1 <input type="checkbox"/> Sedatives</p>	<p>_____ Age</p>	<p>_____ Number</p>	<p>1 <input type="checkbox"/> Yes </p> <p>2 <input type="checkbox"/> No - <i>SKIP to 13e</i></p>
<p>2 <input type="checkbox"/> Tranquillizers</p>	<p>_____ Age</p>	<p>_____ Number</p>	<p>1 <input type="checkbox"/> Yes </p> <p>2 <input type="checkbox"/> No - <i>SKIP to 13e</i></p>
<p>3 <input type="checkbox"/> Painkillers</p>	<p>_____ Age</p>	<p>_____ Number</p>	<p>1 <input type="checkbox"/> Yes </p> <p>2 <input type="checkbox"/> No - <i>SKIP to 13e</i></p>
<p>4 <input type="checkbox"/> Stimulants</p>	<p>_____ Age</p>	<p>_____ Number</p>	<p>1 <input type="checkbox"/> Yes </p> <p>2 <input type="checkbox"/> No - <i>SKIP to 13e</i></p>
<p>5 <input type="checkbox"/> Marijuana</p>	<p>_____ Age</p>	<p>_____ Number</p>	<p>1 <input type="checkbox"/> Yes </p> <p>2 <input type="checkbox"/> No - <i>SKIP to 13e</i></p>
<p>6 <input type="checkbox"/> Cocaine or Crack</p>	<p>_____ Age</p>	<p>_____ Number</p>	<p>1 <input type="checkbox"/> Yes </p> <p>2 <input type="checkbox"/> No - <i>SKIP to 13e</i></p>
<p>7 <input type="checkbox"/> Hallucinogens</p>	<p>_____ Age</p>	<p>_____ Number</p>	<p>1 <input type="checkbox"/> Yes </p> <p>2 <input type="checkbox"/> No - <i>SKIP to 13e</i></p>
<p>8 <input type="checkbox"/> Inhalants/Solvents</p>	<p>_____ Age</p>	<p>_____ Number</p>	<p>1 <input type="checkbox"/> Yes </p> <p>2 <input type="checkbox"/> No - <i>SKIP to 13e</i></p>
<p>9 <input type="checkbox"/> Heroin</p>	<p>_____ Age</p>	<p>_____ Number</p>	<p>1 <input type="checkbox"/> Yes </p> <p>2 <input type="checkbox"/> No - <i>SKIP to 13e</i></p>
<p>10 <input type="checkbox"/> OTHER - <i>Specify</i> ↓</p> <p>_____</p>	<p>_____ Age</p>	<p>_____ Number</p>	<p>1 <input type="checkbox"/> Yes </p> <p>2 <input type="checkbox"/> No - <i>SKIP to 13e</i></p>

Section 3C - MEDICINE EXPERIENCES (Continued)

c. What is the longest period you had like this?	d. About how old were you the MOST RECENT time this BEGAN to happen?	e. How long did this period last?	CHECK ITEM 3.17 Is at least 1 item marked in 12, column C for this drug category?	f. About how old were you when you FINALLY STOPPED having ANY of these experiences you just mentioned with (Name of drug category)? By finally stopped, I mean they never started happening again.
____ Month(s) OR ____ Year(s)	____ Age - <i>SKIP to Check Item 3.17</i>	____ Month(s) OR ____ Year(s) } <i>Go to Check Item 3.17</i>	1 <input type="checkbox"/> Yes - <i>SKIP to next marked drug category</i> 2 <input type="checkbox"/> No _____→	____ Age - <i>SKIP to next marked drug category</i>
____ Month(s) OR ____ Year(s)	____ Age - <i>SKIP to Check Item 3.17</i>	____ Month(s) OR ____ Year(s) } <i>Go to Check Item 3.17</i>	1 <input type="checkbox"/> Yes - <i>SKIP to next marked drug category</i> 2 <input type="checkbox"/> No _____→	____ Age - <i>SKIP to next marked drug category</i>
____ Month(s) OR ____ Year(s)	____ Age - <i>SKIP to Check Item 3.17</i>	____ Month(s) OR ____ Year(s) } <i>Go to Check Item 3.17</i>	1 <input type="checkbox"/> Yes - <i>SKIP to next marked drug category</i> 2 <input type="checkbox"/> No _____→	____ Age - <i>SKIP to next marked drug category</i>
____ Month(s) OR ____ Year(s)	____ Age - <i>SKIP to Check Item 3.17</i>	____ Month(s) OR ____ Year(s) } <i>Go to Check Item 3.17</i>	1 <input type="checkbox"/> Yes - <i>SKIP to next marked drug category</i> 2 <input type="checkbox"/> No _____→	____ Age - <i>SKIP to next marked drug category</i>
____ Month(s) OR ____ Year(s)	____ Age - <i>SKIP to Check Item 3.17</i>	____ Month(s) OR ____ Year(s) } <i>Go to Check Item 3.17</i>	1 <input type="checkbox"/> Yes - <i>SKIP to next marked drug category</i> 2 <input type="checkbox"/> No _____→	____ Age - <i>SKIP to next marked drug category</i>
____ Month(s) OR ____ Year(s)	____ Age - <i>SKIP to Check Item 3.17</i>	____ Month(s) OR ____ Year(s) } <i>Go to Check Item 3.17</i>	1 <input type="checkbox"/> Yes - <i>SKIP to next marked drug category</i> 2 <input type="checkbox"/> No _____→	____ Age - <i>SKIP to next marked drug category</i>
____ Month(s) OR ____ Year(s)	____ Age - <i>SKIP to Check Item 3.17</i>	____ Month(s) OR ____ Year(s) } <i>Go to Check Item 3.17</i>	1 <input type="checkbox"/> Yes - <i>SKIP to next marked drug category</i> 2 <input type="checkbox"/> No _____→	____ Age - <i>SKIP to next marked drug category</i>
____ Month(s) OR ____ Year(s)	____ Age - <i>SKIP to Check Item 3.17</i>	____ Month(s) OR ____ Year(s) } <i>Go to Check Item 3.17</i>	1 <input type="checkbox"/> Yes - <i>SKIP to next marked drug category</i> 2 <input type="checkbox"/> No _____→	____ Age - <i>SKIP to next marked drug category</i>
____ Month(s) OR ____ Year(s)	____ Age - <i>SKIP to Check Item 3.17</i>	____ Month(s) OR ____ Year(s) } <i>Go to Check Item 3.17</i>	1 <input type="checkbox"/> Yes - <i>SKIP to next marked drug category</i> 2 <input type="checkbox"/> No _____→	____ Age - <i>SKIP to next marked drug category</i>
____ Month(s) OR ____ Year(s)	____ Age - <i>SKIP to Check Item 3.17</i>	____ Month(s) OR ____ Year(s) } <i>Go to Check Item 3.17</i>	1 <input type="checkbox"/> Yes - <i>SKIP to 14a(1)</i> 2 <input type="checkbox"/> No _____→	____ Age - <i>SKIP to 14a(1)</i>

Section 3C - MEDICINE EXPERIENCES (Continued)

14a. Now I'm going to ask you about some OTHER experiences you may have had with medicines and drugs. In your ENTIRE LIFE, did you EVER . . . (PAUSE) <i>(Repeat phrase frequently)</i>	b. Did this happen in the last 12 months?	
(1) More than once want to stop or cut down on using any of these medicines or drugs?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark "Yes" in column d</i>
(2) More than once try to stop or cut down on using any of these medicines or drugs but found you couldn't do it?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark "Yes" in column d</i>
(3) Often use a medicine or drug in larger amounts or for a much longer period than you meant to?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark "Yes" in column d</i>
(4) Have a period when you spent a lot of time using a medicine or drug or getting over its bad aftereffects?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark "Yes" in column d</i>
(5) Have a period when you spent a lot of time making sure you always had enough of a medicine or drug available?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark "Yes" in column d</i>
(6) Have any of the following bad aftereffects when the effects of a medicine or drug were wearing off? This includes the morning after using it or in the first few days after stopping or cutting down on it? For example, did you EVER. . . (a) Sleep more than usual?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark "Yes" in column d</i>
(b) Feel weak or tired (when the effects of a medicine or drug were wearing off)?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark "Yes" in column d</i>
(c) Feel depressed?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark "Yes" in column d</i>
(d) Find yourself sweating or your heart beating fast (when the effects of a medicine or drug were wearing off)?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark "Yes" in column d</i>
(e) Have nausea, vomiting or a stomach ache?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark "Yes" in column d</i>
(f) Yawn a lot (when the effects of a medicine or drug were wearing off)?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i> <i>page 49</i>	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark "Yes" in column d</i>

Section 3C - MEDICINE EXPERIENCES (Continued)

c. During the last 12 months, which medicines or drugs did this happen with? <i>(SHOW FLASHCARD 22)</i>	d. Did this happen before 12 months ago, that is before last (Month one year ago)?	e. Which medicines or drugs did this happen with before 12 months ago? <i>(SHOW FLASHCARD 22)</i>
1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH
1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH
1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH
1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH
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1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH
1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH
1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH
1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH
1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH
1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to next experience, page 49</i>	1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH

Section 3C - MEDICINE EXPERIENCES (Continued)

14a. In your entire life, did you EVER ...
(Repeat phrase frequently)

b. Did this happen in the last 12 months?

(g) Have runny eyes or a runny nose?

1 Yes \longrightarrow
 2 No - *Go to next experience*

1 Yes \longrightarrow
 2 No - *Mark "Yes" in column d*

(h) Eat more than usual or gain weight (when the effects of a medicine or drug were wearing off)?

1 Yes \longrightarrow
 2 No - *Go to next experience*

1 Yes \longrightarrow
 2 No - *Mark "Yes" in column d*

(i) Feel anxious or nervous?

1 Yes \longrightarrow
 2 No - *Go to next experience*

1 Yes \longrightarrow
 2 No - *Mark "Yes" in column d*

(j) Have muscle aches or cramps or diarrhea (when the effects of a medicine or drug were wearing off)?

1 Yes \longrightarrow
 2 No - *Go to next experience*

1 Yes \longrightarrow
 2 No - *Mark "Yes" in column d*

(k) Have a fever?

1 Yes \longrightarrow
 2 No - *Go to next experience*

1 Yes \longrightarrow
 2 No - *Mark "Yes" in column d*

(l) Became so restless you fidgeted, paced or couldn't sit still (when the effects of a medicine or drug were wearing off)?

1 Yes \longrightarrow
 2 No - *Go to next experience*

1 Yes \longrightarrow
 2 No - *Mark "Yes" in column d*

(m) Move or talk much more slowly than usual?

1 Yes \longrightarrow
 2 No - *Go to next experience*

1 Yes \longrightarrow
 2 No - *Mark "Yes" in column d*

(n) Find yourself sweating, your pupils dilating or your hair standing up (when the effects of a medicine or drug were wearing off)?

1 Yes \longrightarrow
 2 No - *Go to next experience*

1 Yes \longrightarrow
 2 No - *Mark "Yes" in column d*

(o) Have unpleasant dreams that often seemed real?

1 Yes \longrightarrow
 2 No - *Go to next experience*

1 Yes \longrightarrow
 2 No - *Mark "Yes" in column d*

(p) See, feel or hear things that weren't really there (when the effects of a medicine or drug were wearing off)?

1 Yes \longrightarrow
 2 No - *Go to next experience, page 51*

1 Yes \longrightarrow
 2 No - *Mark "Yes" in column d*

Section 3C - MEDICINE EXPERIENCES (Continued)

c. During the last 12 months, which medicines or drugs did this happen with? <i>(SHOW FLASHCARD 22)</i>	d. Did this happen before 12 months ago, that is before last (Month one year ago)?	e. Which medicines or drugs did this happen with before 12 months ago? <i>(SHOW FLASHCARD 22)</i>
1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH
1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH
1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH
1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH
1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH
1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH
1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH
1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH
1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH
1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to next experience, page 51</i>	1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH

Section 3C - MEDICINE EXPERIENCES (Continued)

14a. In your entire life, did you EVER ... <i>(Repeat phrase frequently)</i>	b. Did this happen in the last 12 months?	
(q) Find yourself shaking?	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - Mark "Yes" in column d
(r) Have trouble falling asleep or staying asleep (when the effects of a medicine or drug were wearing off)?	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - Mark "Yes" in column d
(s) Have fits or seizures?	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - Mark "Yes" in column d
(t) Have very bad headaches (when the effects of a medicine or drug were wearing off)?	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - Go to Check Item 3.18	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - Mark "Yes" in column d
CHECK ITEM 3.18 Are at least 2 items marked "Yes" in column c, 6(a) - 6(t) for at least 1 medicine or drug?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - SKIP to Check Item 3.19	
(u) You just mentioned that you experienced some bad physical aftereffects of <i>(Name of drug category)</i> in the last 12 months. Were any of these bad aftereffects uncomfortable or upsetting to you or did they cause problems in your life - like at work or school or with family or friends?		
CHECK ITEM 3.19 Are at least 2 items marked "Yes" in column e, 6(a) - 6(t) for at least 1 medicine or drug?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Go to (7)	
(v) You just mentioned that you experienced some bad physical aftereffects of <i>(Name of drug category)</i> BEFORE 12 months ago. Were any of these bad aftereffects uncomfortable or upsetting to you or did they cause problems in your life - like at work or school or with family or friends?		
(7) Take more of the same or a similar medicine or drug to get over or avoid any of these bad aftereffects?	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - Mark "Yes" in column d
(8) Find that your usual amount of a medicine or drug had much less effect on you than it once did?	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - Go to next experience, page 53	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - Mark "Yes" in column d

Section 3C - MEDICINE EXPERIENCES (Continued)

c. During the last 12 months, which medicines or drugs did this happen with? <i>(SHOW FLASHCARD 22)</i>	d. Did this happen before 12 months ago, that is before last (Month one year ago)?	e. Which medicines or drugs did this happen with before 12 months ago? <i>(SHOW FLASHCARD 22)</i>
1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH
1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH
1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH
1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to Check Item 3.18</i>	1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH
1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH		
		1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH
1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH
1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to next experience page 53</i>	1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH

Section 3C - MEDICINE EXPERIENCES (Continued)

14a. In your entire life, did you EVER ... <i>(Repeat phrase frequently)</i>	b. Did this happen in the last 12 months?	
(9) Find that you had to use much more of a medicine or drug than you once did to get the effect you wanted?	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Mark "Yes" in column d</i>
(10) Give up or cut down on activities that were important to you in order to use a medicine or drug - like work, school, or associating with friends or relatives?	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Mark "Yes" in column d</i>
(11) Give up or cut down on activities that you were interested in or that gave you pleasure in order to use a medicine or drug?	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Mark "Yes" in column d</i>
(12) Continue to use a medicine or drug even though it was making you feel depressed, uninterested in things, or suspicious or distrustful of other people?	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Mark "Yes" in column d</i>
(13) Continue to use a medicine or drug even though you knew it was causing you a health problem or making a health problem worse?	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to Check Item 3.20, page 55</i>	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Mark "Yes" in column d</i>

Section 3C - MEDICINE EXPERIENCES (Continued)

c. During the last 12 months, which medicines or drugs did this happen with? <i>(SHOW FLASHCARD 22)</i>	d. Did this happen before 12 months ago, that is before last (Month one year ago)?	e. Which medicines or drugs did this happen with before 12 months ago? <i>(SHOW FLASHCARD 22)</i>
1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH
1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH
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1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH
1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to Check Item 3.20, page 55</i>	1 <input type="checkbox"/> SED 2 <input type="checkbox"/> TRAN 3 <input type="checkbox"/> PAIN 4 <input type="checkbox"/> STIM 5 <input type="checkbox"/> MAR 6 <input type="checkbox"/> COC 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH

Section 3C - MEDICINE EXPERIENCES (Continued)

**CHECK
ITEM 3.20**

Are at least 3
Boxes marked
in 14, column e,
for any drug
category, pages
48 - 54?

- 1 Yes
2 No - SKIP to Section
3D, page

Mark each corresponding
category below and ask 15 a-g
for each marked category.

15a. You just mentioned some other experiences you had with (*Name of drug category*) in the past, that is, before 12 months ago. Before last (*Month one year ago*) was there ever a period when SOME of these experiences with (*Name of drug category*) were happening around the same time most days for at least a month (PAUSE), on and off for a few months or longer (PAUSE) or within the same 1-year period?

b. About how old were you the FIRST time SOME of these experiences with (*Name of drug category*) BEGAN to happen around the same time?

c. In your ENTIRE LIFE how many separate periods like this did you have when some of these experiences with (*Name of drug category*) were happening around the same time?

By separate periods, I mean times separated by at least a year when you EITHER STOPPED using (*Name of drug category*) entirely (PAUSE) OR you didn't have any of the experiences you just mentioned with (*Name of drug category*)?

1 <input type="checkbox"/> Sedatives	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	_____ Age	_____ Number
2 <input type="checkbox"/> Tranquillizers	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - SKIP to next drug category	_____ Age	_____ Number
3 <input type="checkbox"/> Painkillers	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - SKIP to next drug category	_____ Age	_____ Number
4 <input type="checkbox"/> Stimulants	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - SKIP to next drug category	_____ Age	_____ Number
5 <input type="checkbox"/> Marijuana	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - SKIP to next drug category	_____ Age	_____ Number
6 <input type="checkbox"/> Cocaine or Crack	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - SKIP to next drug category	_____ Age	_____ Number
7 <input type="checkbox"/> Hallucinogens	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - SKIP to next drug category	_____ Age	_____ Number
8 <input type="checkbox"/> Inhalants/Solvents	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - SKIP to next drug category	_____ Age	_____ Number
9 <input type="checkbox"/> Heroin	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - SKIP to next drug category	_____ Age	_____ Number
10 <input type="checkbox"/> OTHER - Specify ↓ _____	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - SKIP to Section 3D, page 57	_____ Age	_____ Number

Section 3C - MEDICINE EXPERIENCES (Continued)

<p>CHECK ITEM 3.21</p> <p>Is number in 15c, 2 or more or unknown?</p>	<p>d. In your ENTIRE LIFE what was the LONGEST period you had when SOME of these experiences with (Name of drug category) were happening around the same time?</p>	<p>e. About how old were you the MOST RECENT time when some of these experiences BEGAN to happen around the same time?</p>	<p>f. How long did this period last when some of these experiences with (Name of drug category) were happening around the same time?</p>	<p>CHECK ITEM 3.22</p> <p>Is at least 1 item marked in 14, column C OR 12, column C for this drug?</p>	<p>g. About how old were you when you FINALLY STOPPED having ANY of these problems with (Name of drug category)? By finally stopped, I mean they never started happening again.</p>
<p>1 <input type="checkbox"/> Yes →</p> <p>2 <input type="checkbox"/> No - SKIP to 15f</p>	<p>_____ Month(s) OR _____ Year(s)</p>	<p>_____ Age - Go to Check Item 3.22</p>	<p>_____ Month(s) OR _____ Year(s) } Go to Check Item 3.22</p>	<p>1 <input type="checkbox"/> Yes - Go to next marked drug category</p> <p>2 <input type="checkbox"/> No →</p>	<p>_____ Age - SKIP to next drug category</p>
<p>1 <input type="checkbox"/> Yes →</p> <p>2 <input type="checkbox"/> No - SKIP to 15f</p>	<p>_____ Month(s) OR _____ Year(s)</p>	<p>_____ Age - Go to Check Item 3.22</p>	<p>_____ Month(s) OR _____ Year(s) } Go to Check Item 3.22</p>	<p>1 <input type="checkbox"/> Yes - Go to next marked drug category</p> <p>2 <input type="checkbox"/> No →</p>	<p>_____ Age - SKIP to next drug category</p>
<p>1 <input type="checkbox"/> Yes →</p> <p>2 <input type="checkbox"/> No - SKIP to 15f</p>	<p>_____ Month(s) OR _____ Year(s)</p>	<p>_____ Age - Go to Check Item 3.22</p>	<p>_____ Month(s) OR _____ Year(s) } Go to Check Item 3.22</p>	<p>1 <input type="checkbox"/> Yes - Go to next marked drug category</p> <p>2 <input type="checkbox"/> No →</p>	<p>_____ Age - SKIP to next drug category</p>
<p>1 <input type="checkbox"/> Yes →</p> <p>2 <input type="checkbox"/> No - SKIP to 15f</p>	<p>_____ Month(s) OR _____ Year(s)</p>	<p>_____ Age - Go to Check Item 3.22</p>	<p>_____ Month(s) OR _____ Year(s) } Go to Check Item 3.22</p>	<p>1 <input type="checkbox"/> Yes - Go to next marked drug category</p> <p>2 <input type="checkbox"/> No →</p>	<p>_____ Age - SKIP to next drug category</p>
<p>1 <input type="checkbox"/> Yes →</p> <p>2 <input type="checkbox"/> No - SKIP to 15f</p>	<p>_____ Month(s) OR _____ Year(s)</p>	<p>_____ Age - Go to Check Item 3.22</p>	<p>_____ Month(s) OR _____ Year(s) } Go to Check Item 3.22</p>	<p>1 <input type="checkbox"/> Yes - Go to next marked drug category</p> <p>2 <input type="checkbox"/> No →</p>	<p>_____ Age - SKIP to next drug category</p>
<p>1 <input type="checkbox"/> Yes →</p> <p>2 <input type="checkbox"/> No - SKIP to 15f</p>	<p>_____ Month(s) OR _____ Year(s)</p>	<p>_____ Age - Go to Check Item 3.22</p>	<p>_____ Month(s) OR _____ Year(s) } Go to Check Item 3.22</p>	<p>1 <input type="checkbox"/> Yes - Go to next marked drug category</p> <p>2 <input type="checkbox"/> No →</p>	<p>_____ Age - SKIP to next drug category</p>
<p>1 <input type="checkbox"/> Yes →</p> <p>2 <input type="checkbox"/> No - SKIP to 15f</p>	<p>_____ Month(s) OR _____ Year(s)</p>	<p>_____ Age - Go to Check Item 3.22</p>	<p>_____ Month(s) OR _____ Year(s) } Go to Check Item 3.22</p>	<p>1 <input type="checkbox"/> Yes - Go to next marked drug category</p> <p>2 <input type="checkbox"/> No →</p>	<p>_____ Age - SKIP to next drug category</p>
<p>1 <input type="checkbox"/> Yes →</p> <p>2 <input type="checkbox"/> No - SKIP to 15f</p>	<p>_____ Month(s) OR _____ Year(s)</p>	<p>_____ Age - Go to Check Item 3.22</p>	<p>_____ Month(s) OR _____ Year(s) } Go to Check Item 3.22</p>	<p>1 <input type="checkbox"/> Yes - Go to next marked drug category</p> <p>2 <input type="checkbox"/> No →</p>	<p>_____ Age - SKIP to next drug category</p>
<p>1 <input type="checkbox"/> Yes →</p> <p>2 <input type="checkbox"/> No - SKIP to 15f</p>	<p>_____ Month(s) OR _____ Year(s)</p>	<p>_____ Age - Go to Check Item 3.22</p>	<p>_____ Month(s) OR _____ Year(s) } Go to Check Item 3.22</p>	<p>1 <input type="checkbox"/> Yes - Go to next marked drug category</p> <p>2 <input type="checkbox"/> No →</p>	<p>_____ Age - SKIP to next drug category</p>
<p>1 <input type="checkbox"/> Yes →</p> <p>2 <input type="checkbox"/> No - SKIP to 15f</p>	<p>_____ Month(s) OR _____ Year(s)</p>	<p>_____ Age - Go to Check Item 3.22</p>	<p>_____ Month(s) OR _____ Year(s) } Go to Check Item 3.22</p>	<p>1 <input type="checkbox"/> Yes - Go to Section 3D, page 57</p> <p>2 <input type="checkbox"/> No →</p>	<p>_____ Age - Go to Section 3D, page 57</p>

Section 3D - TREATMENT UTILIZATION

<p>1. Have you ever gone anywhere or seen anyone for a reason that was related in any way to your use of medicines or drugs - a physician, counselor, Narcotics Anonymous, or any other community agency or professional?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 4a, page 58</i></p>	
<p>2a. I am going to read you a list of community agencies and professionals. For each one, please tell me if you have ever gone there for any reason related to your medicine or drug use.</p> <p>In your entire life, did you EVER go to a/an ...(Repeat phrase frequently)</p>		<p>b. Did you go there during the last 12 months ONLY, before the last 12 months ONLY or during both time periods?</p>
<p>(1) Narcotics or Cocaine Anonymous, Alcoholics Anonymous or any 12-Step meeting?</p>	<p>1 <input type="checkbox"/> Yes \longrightarrow 2 <input type="checkbox"/> No - <i>Go to Next Agency</i></p>	<p>1 <input type="checkbox"/> Last 12 months only 2 <input type="checkbox"/> Before the last 12 months only 3 <input type="checkbox"/> Both time periods</p>
<p>(2) Family services or another social service agency?</p>	<p>1 <input type="checkbox"/> Yes \longrightarrow 2 <input type="checkbox"/> No - <i>Go to Next Agency</i></p>	<p>1 <input type="checkbox"/> Last 12 months only 2 <input type="checkbox"/> Before the last 12 months only 3 <input type="checkbox"/> Both time periods</p>
<p>(3) Drug or alcohol detoxification ward or clinic?</p>	<p>1 <input type="checkbox"/> Yes \longrightarrow 2 <input type="checkbox"/> No - <i>Go to Next Agency</i></p>	<p>1 <input type="checkbox"/> Last 12 months only 2 <input type="checkbox"/> Before the last 12 months only 3 <input type="checkbox"/> Both time periods</p>
<p>(4) Inpatient ward of a psychiatric or general hospital or community mental health program?</p>	<p>1 <input type="checkbox"/> Yes \longrightarrow 2 <input type="checkbox"/> No - <i>Go to Next Agency</i></p>	<p>1 <input type="checkbox"/> Last 12 months only 2 <input type="checkbox"/> Before the last 12 months only 3 <input type="checkbox"/> Both time periods</p>
<p>(5) Outpatient clinic, including outreach programs and day or partial patient programs?</p>	<p>1 <input type="checkbox"/> Yes \longrightarrow 2 <input type="checkbox"/> No - <i>Go to Next Agency</i></p>	<p>1 <input type="checkbox"/> Last 12 months only 2 <input type="checkbox"/> Before the last 12 months only 3 <input type="checkbox"/> Both time periods</p>
<p>(6) Drug or alcohol rehabilitation program?</p>	<p>1 <input type="checkbox"/> Yes \longrightarrow 2 <input type="checkbox"/> No - <i>Go to Next Agency</i></p>	<p>1 <input type="checkbox"/> Last 12 months only 2 <input type="checkbox"/> Before the last 12 months only 3 <input type="checkbox"/> Both time periods</p>
<p>(7) Methadone Maintenance Program?</p>	<p>1 <input type="checkbox"/> Yes \longrightarrow 2 <input type="checkbox"/> No - <i>Go to Next Agency</i></p>	<p>1 <input type="checkbox"/> Last 12 months only 2 <input type="checkbox"/> Before the last 12 months only 3 <input type="checkbox"/> Both time periods</p>
<p>(8) Emergency room for any reason related to your drug use?</p>	<p>1 <input type="checkbox"/> Yes \longrightarrow 2 <input type="checkbox"/> No - <i>Go to Next Agency</i></p>	<p>1 <input type="checkbox"/> Last 12 months only 2 <input type="checkbox"/> Before the last 12 months only 3 <input type="checkbox"/> Both time periods</p>
<p>(9) Halfway house, including therapeutic communities?</p>	<p>1 <input type="checkbox"/> Yes \longrightarrow 2 <input type="checkbox"/> No - <i>Go to Next Agency</i></p>	<p>1 <input type="checkbox"/> Last 12 months only 2 <input type="checkbox"/> Before the last 12 months only 3 <input type="checkbox"/> Both time periods</p>
<p>(10) Crisis Center for any reason related to your drug use?</p>	<p>1 <input type="checkbox"/> Yes \longrightarrow 2 <input type="checkbox"/> No - <i>Go to Next Agency</i></p>	<p>1 <input type="checkbox"/> Last 12 months only 2 <input type="checkbox"/> Before the last 12 months only 3 <input type="checkbox"/> Both time periods</p>
<p>(11) Employee Assistance Program (EAP)?</p>	<p>1 <input type="checkbox"/> Yes \longrightarrow 2 <input type="checkbox"/> No - <i>Go to Next Agency</i></p>	<p>1 <input type="checkbox"/> Last 12 months only 2 <input type="checkbox"/> Before the last 12 months only 3 <input type="checkbox"/> Both time periods</p>
<p>(12) Clergyman, priest, or rabbi for any reason related to your drug use?</p>	<p>1 <input type="checkbox"/> Yes \longrightarrow 2 <input type="checkbox"/> No - <i>Go to Next Agency</i></p>	<p>1 <input type="checkbox"/> Last 12 months only 2 <input type="checkbox"/> Before the last 12 months only 3 <input type="checkbox"/> Both time periods</p>

Section 3D - TREATMENT UTILIZATION (Continued)

2a. In your entire life, did you EVER go to a/an... <i>(Repeat phrase frequently)</i>		b. Did you go there during the last 12 months ONLY, before the last 12 months ONLY or during both time periods?	
(13) Private physician, psychiatrist, psychologist, social worker or any other professional?	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to Next Agency</i>	1 <input type="checkbox"/> Last 12 months only 2 <input type="checkbox"/> Before the last 12 months only 3 <input type="checkbox"/> Both time periods	
(14) Any other agency or professional?	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to 3a</i>	1 <input type="checkbox"/> Last 12 months only 2 <input type="checkbox"/> Before the last 12 months only 3 <input type="checkbox"/> Both time periods	
3a. How old were you the FIRST time you went anywhere for help or saw anyone for a reason that was related to your medicine or drug use?		_____ Age	
b. How old were you the MOST RECENT time you went anywhere for help or saw anyone for a reason that was related to your medicine or drug use?		_____ Age OR 0 <input type="checkbox"/> Happened only once	
4a. Was there ever a time when you thought you should see a doctor, counselor, or other health professional or seek any other help for your drug use, but you didn't go?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Section 3E, page 59</i>	
b. Did this happen during the last 12 months?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 4d</i>	
c. Did this happen before 12 months ago, that is, before last (Month one year ago)?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
(SHOW FLASHCARD 24) d. What were your reasons for not getting help? <i>Check (X) all that apply.</i>		1 <input type="checkbox"/> Wanted to go, but health insurance didn't cover 2 <input type="checkbox"/> Didn't think anyone could help 3 <input type="checkbox"/> Didn't know any place to go for help 4 <input type="checkbox"/> Couldn't afford to pay the bill 5 <input type="checkbox"/> Didn't have any way to get there 6 <input type="checkbox"/> Didn't have time 7 <input type="checkbox"/> Thought the problem would get better by itself 8 <input type="checkbox"/> Was too embarrassed to discuss it with anyone 9 <input type="checkbox"/> Was afraid of what my boss, friends, family, or others would think 10 <input type="checkbox"/> Thought it was something I should be strong enough to handle alone 11 <input type="checkbox"/> Was afraid they would put me into the hospital 12 <input type="checkbox"/> Was afraid of the treatment they would give me 13 <input type="checkbox"/> Hated answering personal questions 14 <input type="checkbox"/> The hours were inconvenient 15 <input type="checkbox"/> A member of my family objected 16 <input type="checkbox"/> My family thought I should go but I didn't think it was necessary 17 <input type="checkbox"/> Can't speak English very well 18 <input type="checkbox"/> Was afraid I would lose my job 19 <input type="checkbox"/> Couldn't arrange for child care 20 <input type="checkbox"/> Had to wait too long to get into a program 21 <input type="checkbox"/> Wanted to keep using a medicine or drug 22 <input type="checkbox"/> Didn't think medicine or drug problem was serious enough 23 <input type="checkbox"/> Didn't want to go 24 <input type="checkbox"/> Stopped using a medicine or drug on my own 25 <input type="checkbox"/> Friends or family helped me stop using a medicine or drug 26 <input type="checkbox"/> Tried getting help before and it didn't work 27 <input type="checkbox"/> Other reason	

Section 3E - FAMILY HISTORY - II

Statement K

Now I would like to ask you some further questions about whether your relatives, regardless of whether or not they are now living, have EVER had problems with drugs. By having problems with drugs I mean a person who has physical or emotional problems because of drug use (PAUSE); problems with a spouse, family or friends because of drug use (PAUSE); problems at work or school because of drug use (PAUSE); problems with the police because of drug use - like driving under the influence (PAUSE) or a person who seems to spend a lot of time using drugs or getting over their bad aftereffects. (Repeat definition frequently.)

<p>1. In your judgement, has your blood or natural father had problems with drugs at ANY time in his life?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 99 <input type="checkbox"/> DK</p>
<p>2. Has your blood or natural mother had problems with drugs at ANY time in her life?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 99 <input type="checkbox"/> DK</p>
<p>3. (Did your full brother have/How many of your full brothers had) problems with drugs at ANY time in (his life/their lives)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No OR _____ Number 0 <input type="checkbox"/> None</p>
<p>4. (Did your full sister have/How many of your full sisters had) problems with drugs at ANY time in (her life/their lives)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No OR _____ Number 0 <input type="checkbox"/> None</p>
<p>5. (Did your natural son have/How many of your natural sons had) problems with drugs at ANY time in (his life/their lives)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No OR _____ Number 0 <input type="checkbox"/> None</p>
<p>6. (Did your natural daughter have/How many of your natural daughters had) problems with drugs at ANY time in (her life/their lives)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No OR _____ Number 0 <input type="checkbox"/> None</p>
<p>7. (Did your natural father's full brother have/How many of your natural father's full brothers had) problems with drugs at ANY time in (his life/their lives)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No OR _____ Number 0 <input type="checkbox"/> None</p>
<p>8. (Did your natural father's full sister have/How many of your natural father's full sisters had) problems with drugs at ANY time in (her life/their lives)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No OR _____ Number 0 <input type="checkbox"/> None</p>
<p>9. (Did your natural mother's full brother have/How many of your natural mother's full brothers had) problems with drugs at ANY time in (his life/their lives)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No OR _____ Number 0 <input type="checkbox"/> None</p>
<p>10. (Did your natural mother's full sister have/How many of your natural mother's full sisters had) problems with drugs at ANY time in (her life/their lives)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No OR _____ Number 0 <input type="checkbox"/> None</p>

Section 3E - FAMILY HISTORY - II (Continued)

<p>11. Did your natural grandfather on your father's side have problems with drugs at ANY time in his life?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 99 <input type="checkbox"/> DK</p>
<p>12. Did your natural grandmother on your father's side have problems with drugs at ANY time in her life?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 99 <input type="checkbox"/> DK</p>
<p>13. Did your natural grandfather on your mother's side have problems with drugs at ANY time in his life?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 99 <input type="checkbox"/> DK</p>
<p>14. Did your natural grandmother on your mother's side have problems with drugs at ANY time in her life?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 99 <input type="checkbox"/> DK } <i>Go to Section 4A, page 61</i></p>

Section 4A - LOW MOOD I



Now I'd like to ask you some questions about moods and related experiences that many people have had.

1. In your ENTIRE LIFE, have you ever had a time when you felt sad, blue, depressed, or down most of the time for at least 2 weeks?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
2. In your ENTIRE LIFE, have you ever had a time, lasting at least 2 weeks, when you didn't care about the things that you usually cared about, or when you didn't enjoy the things you usually enjoyed?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
CHECK ITEM 4.1 Is "Yes" marked in 1 OR 2?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Section 4B, page 68</i>

4a. The next few questions are about experiences many people have had when they (felt sad, blue, depressed, or down/didn't care about things or enjoy things). During that time when (your mood was at it's lowest/you enjoyed or cared the least about things), did you . . .

(Repeat entire phrase frequently)

b.

(1) Lose at least 2 pounds a week for several weeks or at least 10 pounds altogether within a month, other than when you were physically ill or dieting?	1 <input type="checkbox"/> Yes - <i>Mark Box C1</i> 2 <input type="checkbox"/> No - <i>Go to next experience</i>	<p align="center">Box 1 <input type="checkbox"/> C1</p>
(2) Lose your appetite nearly every day for at least 2 weeks?	1 <input type="checkbox"/> Yes - <i>Mark Box C1</i> 2 <input type="checkbox"/> No - <i>Go to next experience</i>	
(3) Gain at least 2 pounds a week for several weeks or at least 10 pounds altogether within a month (other than when you were growing or pregnant)?	1 <input type="checkbox"/> Yes - <i>Mark Box C1</i> 2 <input type="checkbox"/> No - <i>Go to next experience</i>	
(4) Find that you wanted to eat a lot more than usual for no special reason, most days for at least 2 weeks?	1 <input type="checkbox"/> Yes - <i>Mark Box C1</i> 2 <input type="checkbox"/> No - <i>Go to next experience</i>	
(5) Have trouble falling asleep nearly every day for at least 2 weeks?	1 <input type="checkbox"/> Yes - <i>Mark Box C2</i> 2 <input type="checkbox"/> No - <i>Go to next experience</i>	<p align="center">Box 1 <input type="checkbox"/> C2</p>
(6) Wake up too early nearly every day for at least 2 weeks?	1 <input type="checkbox"/> Yes - <i>Mark Box C2</i> 2 <input type="checkbox"/> No - <i>Go to next experience</i>	
(7) Sleep more than usual nearly every day for at least 2 weeks?	1 <input type="checkbox"/> Yes - <i>Mark Box C2</i> 2 <input type="checkbox"/> No - <i>Go to next experience</i>	
(8) Feel tired nearly all the time or get tired easily most days for at least 2 weeks, even though you weren't doing more than usual?	1 <input type="checkbox"/> Yes - <i>Mark Box C3</i> 2 <input type="checkbox"/> No - <i>Go to next experience, page 62</i>	<p align="center">Box 1 <input type="checkbox"/> C3</p>

Section 4A - LOW MOOD I (Continued)

<p>4a. During that time when (your mood was at it's lowest/you enjoyed or cared the least about things), did you . . .</p> <p><i>(Repeat entire phrase frequently)</i></p>	<p>b.</p>	
<p>(9) Move or talk MUCH more slowly than usual, most days for at least 2 weeks?</p>	<p>1 <input type="checkbox"/> Yes - <i>Mark Box C4</i> 2 <input type="checkbox"/> No - <i>Go to next experience</i></p>	<p align="center">Box 1 <input type="checkbox"/> C4</p>
<p>(10) Become so restless that you fidgeted or paced most of the time for at least 2 weeks?</p>	<p>1 <input type="checkbox"/> Yes - <i>Mark Box C4</i> 2 <input type="checkbox"/> No - <i>Go to next experience</i></p>	
<p>(11) Become so restless that you felt uncomfortable for at least 2 weeks?</p>	<p>1 <input type="checkbox"/> Yes - <i>Mark Box C4</i> 2 <input type="checkbox"/> No - <i>Go to next experience</i></p>	
<p>(12) Feel worthless nearly all the time for at least 2 weeks?</p>	<p>1 <input type="checkbox"/> Yes - <i>Mark Box C5</i> 2 <input type="checkbox"/> No - <i>Go to next experience</i></p>	<p align="center">Box 1 <input type="checkbox"/> C5</p>
<p>(13) Feel guilty about things you normally wouldn't feel guilty about, most of the time for at least 2 weeks?</p>	<p>1 <input type="checkbox"/> Yes - <i>Mark Box C5</i> 2 <input type="checkbox"/> No - <i>Go to next experience</i></p>	
<p>(14) Have trouble concentrating or keeping your mind on things, most days for at least 2 weeks?</p>	<p>1 <input type="checkbox"/> Yes - <i>Mark Box C6</i> 2 <input type="checkbox"/> No - <i>Go to next experience</i></p>	<p align="center">Box 1 <input type="checkbox"/> C6</p>
<p>(15) Find it harder than usual to make decisions, most of the time for at least 2 weeks?</p>	<p>1 <input type="checkbox"/> Yes - <i>Mark Box C6</i> 2 <input type="checkbox"/> No - <i>Go to next experience</i></p>	
<p>(16) Attempt suicide?</p>	<p>1 <input type="checkbox"/> Yes - <i>Mark Box C7</i> 2 <input type="checkbox"/> No - <i>Go to next experience</i></p>	<p align="center">Box 1 <input type="checkbox"/> C7</p>
<p>(17) Think about committing suicide?</p>	<p>1 <input type="checkbox"/> Yes - <i>Mark Box C7</i> 2 <input type="checkbox"/> No - <i>Go to next experience</i></p>	
<p>(18) Feel like you wanted to die?</p>	<p>1 <input type="checkbox"/> Yes - <i>Mark Box C7</i> 2 <input type="checkbox"/> No - <i>Go to next experience</i></p>	
<p>(19) Think a lot about your own death?</p>	<p>1 <input type="checkbox"/> Yes - <i>Mark Box C7</i> 2 <input type="checkbox"/> No - <i>Go to Check Item 4.3</i></p>	
<p>CHECK ITEM 4.3</p>	<p>Are at least 4 Boxes marked for C1-C7 in column b, pages 61 - 62?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Section 4B, page 68</i></p>
<p>5. Now I'd like to ask you about some other things that might have happened to you during that time when (your mood was at its lowest/you enjoyed or cared the least about things) for at least 2 weeks and you had some of the other experiences you mentioned at the same time.</p> <p>During that time...</p>		
<p>(1) Were you uncomfortable or upset by your low mood or any of these other experiences?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>	
<p>(2) Did you have arguments or friction with friends, family, people at work or anyone else?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>	
<p>(3) Were you very troubled because of the way you felt at that time or did you often wish you could get better?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>	

Section 4A - LOW MOOD I (Continued)

<p>5. During that time when (your mood was at its lowest/you enjoyed or cared the least about things)...</p> <p>(4) Did you have any trouble doing things you were supposed to do - like working, doing your schoolwork, or taking care of your home or family?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(5) During that time, did you spend more time than usual by yourself, because you didn't want to be around people as much as usual?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(6) Did you find you couldn't do the things you usually did or wanted to do?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(7) Did you find you did a lot less than usual or were less active?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(8) Did you depend a lot more on people to take care of every day things for you or to give you a lot of reassurance or attention?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>6a. About how old were you the FIRST time you BEGAN (to feel sad, blue, depressed or down/not to care about things or enjoy things) for at least 2 weeks and when you also had some of the other experiences you just mentioned?</p> <p><i>Refer to other experiences marked "Yes" in 4a(1)-(19) and 5(1)-(8), pages 61 - 63, if necessary.</i></p>	<p>_____ Age</p>
<p>CHECK ITEM 4.4 Is respondent's age in 6a within 1 year of his/her present age or is present age or 6a unknown?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 7</i></p>
<p>6b. Did this FIRST time BEGIN to happen during the last 12 months?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>7. In you ENTIRE LIFE, how many SEPARATE times lasting at least 2 weeks were there when you (felt sad, blue, depressed, or down/didn't care about things or enjoy things) and when you also had some of the other experiences you mentioned? By separate times, I mean times separated by at least 2 months when your mood was much improved or back to normal and you DIDN'T have ANY of the other experiences you mentioned.</p>	<p>_____ Number</p>
<p>CHECK ITEM 4.5 Is number entered in 7, 2 or more or unknown?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 9e, page 64</i></p>
<p>8a. How old were you the MOST RECENT time you BEGAN (to feel sad, blue, depressed or down/not to care about things or enjoy things) for at least 2 weeks and when you also had some of these other experiences?</p>	<p>_____ Age</p>
<p>CHECK ITEM 4.6A Is respondent's age in 8a within 1 year of his/her present age or is present age or 8a unknown?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 9a</i></p>
<p>8b. Did this MOST RECENT time BEGIN to happen during the last 12 months?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>9a. How long did this MOST RECENT time last when you (felt sad, blue, depressed or down/didn't care about things or enjoy things)?</p> <p><i>(Must be at least 2 weeks.)</i></p>	<p>_____ Week(s) OR _____ Month(s) OR _____ Year(s)</p>
<p>b. Since this MOST RECENT time BEGAN, have there been at least 2 months when your mood was much improved or back to normal AND when you DIDN'T have ANY of the OTHER experiences you mentioned?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP 9d</i></p>
<p>CHECK ITEM 4.6B Is "Yes" marked in 8b?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to 9d</i> 2 <input type="checkbox"/> No</p>
<p>9c. Did this MOST RECENT time when your mood was much improved BEGIN to happen in the last 12 months?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>d. In your ENTIRE LIFE, what was the LONGEST time that you've had when you (felt sad, blue, depressed, or down/didn't care about things or enjoy things)?</p> <p><i>(Must be at least 2 weeks.)</i></p>	<p>_____ Week(s) OR _____ Month(s) OR _____ Year(s) } <i>SKIP to Check Item 4.7, page 64</i></p>

Section 4A - LOW MOOD I (Continued)

<p>9e. How long did that time last when you (felt sad, blue, depressed or down/didn't care about things or enjoy things)?</p> <p><i>(Must be at least 2 weeks.)</i></p>	<p>_____ Week(s) OR _____ Month(s) OR _____ Year(s)</p>
<p>f. Since that time BEGAN, have there been at least 2 months when your mood was much improved or back to normal AND you DIDN'T have ANY of the OTHER experiences you mentioned?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 4.7</i></p>
<p>CHECK ITEM 4.6C Is "Yes" marked in 6b?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to Check Item 4.7</i> 2 <input type="checkbox"/> No</p>
<p>9g. Did this time when your mood was much improved BEGIN to happen in the last 12 months?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 4.7 Is Check Item 4.5 marked "No"?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 4.8A</i></p>
<p>CHECK ITEM 4.8 Is number marked in 9e, 2 months or more or is Follow-up probe 9ep coded "Yes"?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to Check Item 4.10</i> 2 <input type="checkbox"/> No</p>
<p>10a. Did that time when you (felt sad, blue, depressed or down/didn't care about things or enjoy things) BEGIN to happen just after someone close to you died?</p>	<p>1 <input type="checkbox"/> Yes } <i>SKIP to Check Item 4.10</i> 2 <input type="checkbox"/> No }</p>
<p>CHECK ITEM 4.8A Is number in 9d, less than 2 months or is Follow-up probe 9dp coded "No"?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to Check Item 4.9A</i> 2 <input type="checkbox"/> No</p>
<p>10b. Did ALL of those times when you (felt sad, blue, depressed or down/didn't care about things or enjoy things) last for at least 2 months?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to Check Item 4.10</i> 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 4.9A Is 6b marked "Yes" or 8b marked "Yes" or 9c marked "Yes" or 9b marked "No"?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 4.9B</i></p>
<p>10c. Think about the times in the last 12 months when you (felt sad, blue, depressed or down/didn't care about things or enjoy things) for LESS than 2 months. Did ANY of those times BEGIN to happen just after someone close to you died?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 4.9B</i> 0 <input type="checkbox"/> No times lasting less than 2 months in the past 12 months - <i>SKIP to Check Item 4.9B</i></p>
<p>d. Did ALL of those times ONLY BEGIN to happen just after someone close to you died?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 4.9B Is 6b marked "Yes"?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to Check Item 4.10</i> 2 <input type="checkbox"/> No</p>
<p>10e. Think about the times BEFORE 12 months ago when you (felt sad, blue, depressed or down/didn't care about things or enjoy things) for LESS than 2 months. Did ANY of those times BEGIN to happen just after someone close to you died?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 4.10</i> 0 <input type="checkbox"/> No times lasting less than 2 months before 12 months ago - <i>SKIP to Check Item 4.10</i></p>
<p>f. Did ALL of those times ONLY BEGIN to happen just after someone close to you died?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 4.10 <i>Refer to Check Item 2.0, Section 2A, page 9.</i> Is the respondent a lifetime abstainer of alcohol?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to 13</i> 2 <input type="checkbox"/> No</p>
<p>11. Did (that time/ANY of those times) when you (felt sad, blue, depressed or down/didn't care about things or enjoy things) BEGIN to happen AFTER you were drinking heavily or a lot more than usual?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 13</i></p>
<p>12. Did (that time/ANY of those times) when you (felt sad, blue, depressed or down/didn't care about things or enjoy things) BEGIN to happen DURING a period when you were experiencing the bad aftereffects of drinking?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>13. Did (that time/ANY of those times) when you (felt sad, blue, depressed or down/didn't care about things or enjoy things) BEGIN to happen AFTER using a medicine or drug?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 4.11, page 65</i></p>

Section 4A - LOW MOOD I (Continued)

<p>14. Did (that time/ANY of those times) when you (felt sad, blue, depressed or down/didn't care about things or enjoy things) BEGIN to happen DURING a period when you were experiencing the bad aftereffects of a medicine or drug?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 4.11 Is at least 1 item marked "Yes" in 11, 12, 13 OR 14?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 16, page 66</i></p>
<p>CHECK ITEM 4.12 Is Check Item 4.5 marked "No"?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 4.13A</i></p>
<p>15a. During that time, did you STOP (drinking heavily/using any medicines or drugs/experiencing the bad aftereffects of drinking/medicines or drugs) for at least 1 month?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 16, page 66</i></p>
<p>b. Did you CONTINUE (to feel sad, blue, depressed or down/not to care about things or enjoy things) for at least 1 month AFTER you STOPPED (drinking heavily/using any medicines or drugs/experiencing the bad aftereffects of drinking/medicines or drugs)?</p>	<p>1 <input type="checkbox"/> Yes } <i>SKIP to 16, page 66</i> 2 <input type="checkbox"/> No }</p>
<p>CHECK ITEM 4.13A Is 6b marked "Yes" or 8b marked "Yes" or 9c marked "Yes" or 9b marked "No"?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 4.13B</i></p>
<p>15c. Did ANY of the times when you (felt sad, blue, depressed or down/didn't care about things or enjoy things) in the last 12 months BEGIN to happen (after drinking heavily/using a medicine or drug/when you were experiencing the bad aftereffects of drinking/medicines or drugs)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 4.13B</i></p>
<p>d. Did they ALL BEGIN to happen (after drinking heavily/using a medicine or drug/when your were experiencing the bad aftereffects of drinking/medicines or drugs)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>e. During ANY of those times in the last 12 months when you (felt sad, blue, depressed or down/didn't care about things or enjoy things) (after drinking heavily/using a medicine or drug), did you STOP (drinking heavily/using any medicines or drugs/ experiencing the bad aftereffects of drinking/medicines or drugs) for at least 1 month?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 4.13B</i></p>
<p>f. During ALL of those times, did you STOP (drinking heavily/using any medicines or drugs/experiencing the bad aftereffects of drinking/medicines or drugs) for at least 1 month?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>g. Did you CONTINUE (to feel sad, blue, depressed or down/not to care about things or enjoy things) for at least 1 month AFTER ANY of those times in the last 12 months when you STOPPED (drinking heavily/using any medicines or drugs/experiencing the bad aftereffects of drinking/medicines or drugs)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 4.13B</i></p>
<p>h. Did you CONTINUE (to feel sad, blue, depressed or down/not to care about things or enjoy things) for at least 1 month AFTER ALL of those times?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 4.13B Is 6b marked "Yes"?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to 16, page 66</i> 2 <input type="checkbox"/> No</p>
<p>15i. Did ANY of the times when you (felt sad, blue, depressed or down/didn't care about things or enjoy things) BEFORE 12 months ago BEGIN to happen (after drinking heavily/using a medicine or drug/when you were experiencing the bad aftereffects of drinking/medicines or drugs)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 16, page 66</i></p>
<p>j. Did they ALL BEGIN to happen (after drinking heavily/using a medicine or drug/when you were experiencing the bad aftereffects of drinking/medicines or drugs)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>k. During ANY of those times BEFORE 12 months ago when you (felt sad, blue, depressed or down/didn't care about things or enjoy things) (after drinking heavily/using a medicine or drug) did you STOP (drinking heavily/ using any medicines or drugs/ experiencing the bad aftereffects of drinking/medicines or drugs) for at least 1 month?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 16, page 66</i></p>

Section 4A - LOW MOOD I (Continued)

<p>15l. During ALL of those times, did you STOP (drinking heavily/using any medicines or drugs/experiencing the bad aftereffects of drinking/medicines or drugs) for at least 1 month?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>m. Did you CONTINUE (to feel sad, blue, depressed or down/not to care about things or enjoy things) for at least 1 month AFTER ANY of those times BEFORE 12 months ago when you STOPPED (drinking heavily/using any medicines or drugs/experiencing the bad aftereffects of drinking/medicines or drugs)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 16</i></p>
<p>n. Did you CONTINUE (to feel sad, blue, depressed or down/not to care about things or enjoy things) for at least 1 month AFTER ALL of those times?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>16. Did you EVER go to any kind of counselor, therapist, doctor, psychologist or any person like that to help improve your mood or make you feel better?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>17a. Were you a patient in a hospital for at least one night because you (felt sad, blue, depressed or down/didn't care about things or enjoy things)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>b. Did you EVER go to an emergency room for help during any time when you (felt sad, blue, depressed or down/didn't care about things or enjoy things)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>18. Did a doctor EVER prescribe any medicines or drugs to improve your mood or to make you feel better?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 4.14 Is at least 1 item marked "Yes" in 16-18? Did respondent ever seek help for their low mood?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 4.14A</i></p>
<p>19a. About how old were you the FIRST TIME you went anywhere or saw anyone to get help for (feeling sad, blue, depressed or down/not caring about things or enjoying things)?</p>	<p>_____ Age</p>
<p>b. How old were you the MOST RECENT time you went anywhere or saw anyone to get help for (feeling sad, blue, depressed or down/not caring about things or enjoying things)?</p>	<p>_____ Age OR 0 <input type="checkbox"/> Happened only once</p>
<p>CHECK ITEM 4.14A Refer to Check Item 2.0, Section 2A, page 9. Is respondent a lifetime abstainer of alcohol?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to Check Item 4.14B</i> 2 <input type="checkbox"/> No</p>
<p>20a. Did you EVER drink alcohol to improve your mood or to make yourself feel better when you (felt sad, blue, depressed, or down/didn't care about things or enjoy things) for at least two weeks?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 4.14B</i></p>
<p>b. Did this happen during the last 12 months?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 4.14B</i></p>
<p>c. Did this happen before 12 months ago, that is, before last (Month one year ago)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 4.14B Refer to Check Item 3.10, Section 3B, page 39. Is respondent a lifetime non-drug user?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to Check Item 4.15, page 67</i> 2 <input type="checkbox"/> No</p>
<p>21a. Did you EVER take any medicines or drugs ON YOUR OWN, that is, without a prescription, in greater amounts or more often or longer than prescribed to help improve your mood or to make yourself feel better when you (felt sad, blue, depressed, or down/didn't care about things or enjoy things)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 4.15, page 67</i></p>
<p>b. Did this happen during the last 12 months?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 4.15, page 67</i></p>

Section 4A - LOW MOOD I (Continued)

<p>21c. Did this happen before 12 months ago, that is, before last (<i>Month one year ago</i>)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 4.15 Is Check Item 4.5 marked “No”?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 4.16A</i></p>
<p>22a. Did that time when you (felt sad, blue, depressed or down/didn’t care about things or enjoy things) BEGIN to happen DURING a time when you were physically ill or getting over being physically ill?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Section 4B, page 68</i></p>
<p>b. Did a doctor or other health professional tell you that this time was related to your physical illness or medical condition?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } <i>SKIP to Section 4B, page 68</i></p>
<p>CHECK ITEM 4.16A Is 6b marked “Yes” or 8b marked “Yes” or 9c marked “Yes” or 9b marked “No”?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 4.16B</i></p>
<p>22c. Did ANY of the times when you (felt sad, blue, depressed or down/didn’t care about things or enjoy things) in the last 12 months BEGIN to happen DURING a time when you were physically ill or getting over being physically ill?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 4.16B</i></p>
<p>d. Did ALL of those times when you (felt sad, blue, depressed or down/didn’t care about things or enjoy things) in the last 12 months ONLY BEGIN to happen DURING times when you were physically ill or getting over being physically ill?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 22f</i></p>
<p>e. Did a doctor or other health professional tell you that ALL the times like this were related to your physical illness or medical condition?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to Check Item 4.16B</i> 2 <input type="checkbox"/> No</p>
<p>f. Did a doctor or other health professional tell you that ANY of the times like this were related to your physical illness or medical condition?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 4.16B Is 6b marked “Yes”?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to Section 4B, page 68</i> 2 <input type="checkbox"/> No</p>
<p>22g. Did ANY of the times BEFORE 12 months ago when you (felt sad, blue, depressed or down/didn’t care about things or enjoy things) BEGIN to happen DURING a time when you were physically ill or getting over being physically ill?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Section 4B, page 68</i></p>
<p>h. Did ALL of those times BEFORE 12 months ago when you (felt sad, blue, depressed or down/didn’t care about things or enjoy things) ONLY BEGIN to happen DURING times when you were physically ill or getting over being physically ill?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 22j</i></p>
<p>i. Did a doctor or other health professional tell you that ALL of the times like this were related to your physical illness or medical condition?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to Section 4B, page 68</i> 2 <input type="checkbox"/> No</p>
<p>j. Did a doctor or other health professional tell you that ANY of the times like this were related to your physical illness or medical condition?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } <i>Go to Section 4B, page 68</i></p>

Section 4B - FAMILY HISTORY - III

Now I would like to ask about whether any of your relatives, regardless of whether or not they are now living, have ever been depressed for a period of **AT LEAST 2 WEEKS**.

(SHOW FLASHCARD 25)

Statement M

By depressed I mean they felt down, sad, blue or didn't care about things and also ate or slept too little or too much, moved more slowly than usual, were tired or agitated, had trouble concentrating, making decisions or doing things, or felt worthless or thought about suicide.

(REFER TO FLASHCARD FREQUENTLY.)

1. Was your blood or natural father depressed at ANY time in his life?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 99 <input type="checkbox"/> DK
2. Was your blood or natural mother depressed at ANY time in her life?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 99 <input type="checkbox"/> DK
3. (Was your full brother/How many of your full brothers were) depressed at ANY time in (his life/their lives)?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No OR _____ Number 0 <input type="checkbox"/> None
4. (Was your full sister/How many of your full sisters were) depressed at ANY time in (her life/their lives)?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No OR _____ Number 0 <input type="checkbox"/> None
5. (Was your natural son/How many of your natural sons were) depressed at ANY time in (his life/their lives)?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No OR _____ Number 0 <input type="checkbox"/> None
6. (Was your natural daughter/How many of your natural daughters were) depressed at ANY time in (her life/ their lives)?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No OR _____ Number 0 <input type="checkbox"/> None
7. (Was your natural father's full brother/How many of your natural father's full brothers were) depressed at ANY time in (his life/their lives)?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No OR _____ Number 0 <input type="checkbox"/> None
8. (Was your natural father's full sister/How many of your natural father's full sisters were) depressed at ANY time in (her life/their lives)?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No OR _____ Number 0 <input type="checkbox"/> None
9. (Was your natural mother's full brother/How many of your natural mother's full brothers were) depressed at ANY time in (her life/their lives)?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No OR _____ Number 0 <input type="checkbox"/> None
10. (Was your natural mother's full sister/How many of your natural mother's full sisters were) depressed at ANY time in (her life/their lives)?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No OR _____ Number 0 <input type="checkbox"/> None

Section 4B - FAMILY HISTORY - III (Continued)

<p>11. Was your natural grandfather on your father's side depressed at ANY time in his life?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 99 <input type="checkbox"/> DK</p>
<p>12. Was your natural grandmother on your father's side depressed at ANY time in her life?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 99 <input type="checkbox"/> DK</p>
<p>13. Was your natural grandfather on your mother's side depressed at ANY time in his life?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 99 <input type="checkbox"/> DK</p>
<p>14. Was your natural grandmother on your mother's side been depressed at ANY time in her life?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 99 <input type="checkbox"/> DK } <i>Go to Section 4C, page 70</i></p>

Section 4C - LOW MOOD II

<p>1. Some people have reported that they have low moods that last for 2 years or longer.</p> <p>Have you ever had a time that lasted for at least 2 years when your mood was low, sad or depressed most of the day, more than half of the time?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Section 5, page 76</i></p>	
<p>3a. During that time when your mood was at its lowest, did you OFTEN... <i>(Repeat entire phrase frequently)</i></p>	<p>b.</p>	
<p>(1) Lose your appetite?</p>	<p>1 <input type="checkbox"/> Yes - <i>Mark Box D1</i> 2 <input type="checkbox"/> No - <i>Go to next experience</i></p>	<p>Box 1 <input type="checkbox"/> D1</p>
<p>(2) Find you wanted to eat a lot more than usual for no special reason?</p>	<p>1 <input type="checkbox"/> Yes - <i>Mark Box D1</i> 2 <input type="checkbox"/> No - <i>Go to next experience</i></p>	
<p>(3) Have trouble falling asleep, staying asleep or waking up too early?</p>	<p>1 <input type="checkbox"/> Yes - <i>Mark Box D2</i> 2 <input type="checkbox"/> No - <i>Go to next experience</i></p>	<p>Box 1 <input type="checkbox"/> D2</p>
<p>(4) Sleep more than usual?</p>	<p>1 <input type="checkbox"/> Yes - <i>Mark Box D2</i> 2 <input type="checkbox"/> No - <i>Go to next experience</i></p>	
<p>(5) Feel tired or feel you didn't have much energy?</p>	<p>1 <input type="checkbox"/> Yes - <i>Mark Box D3</i> 2 <input type="checkbox"/> No - <i>Go to next experience</i></p>	<p>Box 1 <input type="checkbox"/> D3</p>
<p>(6) Have trouble concentrating or keeping your mind on things?</p>	<p>1 <input type="checkbox"/> Yes - <i>Mark Box D4</i> 2 <input type="checkbox"/> No - <i>Go to next experience</i></p>	<p>Box 1 <input type="checkbox"/> D4</p>
<p>(7) Find it harder to make decisions?</p>	<p>1 <input type="checkbox"/> Yes - <i>Mark Box D4</i> 2 <input type="checkbox"/> No - <i>Go to next experience</i></p>	
<p>(8) Feel that you weren't as good as other people?</p>	<p>1 <input type="checkbox"/> Yes - <i>Mark Box D5</i> 2 <input type="checkbox"/> No - <i>Go to next experience</i></p>	<p>Box 1 <input type="checkbox"/> D5</p>
<p>(9) Feel down on yourself?</p>	<p>1 <input type="checkbox"/> Yes - <i>Mark Box D5</i> 2 <input type="checkbox"/> No - <i>Go to next experience</i></p>	
<p>(10) Feel that things were bad and would never get better?</p>	<p>1 <input type="checkbox"/> Yes - <i>Mark Box D6</i> 2 <input type="checkbox"/> No - <i>Go to next experience</i></p>	<p>Box 1 <input type="checkbox"/> D6</p>
<p>(11) Feel hopeless?</p>	<p>1 <input type="checkbox"/> Yes - <i>Mark Box D6</i> 2 <input type="checkbox"/> No - <i>Go to Check Item 4.23</i></p>	
<p>CHECK ITEM 4.23 Are at least 2 boxes marked for D1 - D6, column b?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>Go to Section 5, page 76</i></p>	

Section 4C - LOW MOOD II (Continued)

<p>4. Now I'd like to ask you about some other things that might have happened to you during that time when your mood was at its lowest for at least 2 years and you had some of the other experiences you mentioned around the same time.</p> <p>During those years, did you. . . (Repeat phrase frequently)</p> <p>(1) Feel uncomfortable or upset by your low mood or any of those other experiences?</p> <hr/> <p>(2) Wish you could get better?</p> <hr/> <p>(3) Have arguments or friction with family, friends, people at work or anyone else?</p> <hr/> <p>(4) Have difficulty doing the things you were supposed to do - like working, doing your schoolwork or taking care of your home or family?</p> <hr/> <p>(5) Dwell on the past or brood about the past?</p> <hr/> <p>(6) Find that you did a lot less than usual or were less active?</p> <hr/> <p>(7) Spend more time by yourself because you didn't want to be around people?</p> <hr/> <p>(8) Ask people for help so much that it caused problems getting along with them?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <hr/> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <hr/> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <hr/> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <hr/> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <hr/> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <hr/> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>5. About how old were you the FIRST time you BEGAN to have a low mood that lasted for at least 2 years and you often had some of the other experiences you just mentioned?</p> <p><i>Refer to other experiences marked "Yes" in 3a(1)-(11) and 4(1)-(8), pages 70 - 71, if necessary.</i></p>	<p>_____ Age</p>
<p>6. In your ENTIRE LIFE, how many SEPARATE times lasting at least 2 years were there when your mood was low and you often had some of the other experiences you mentioned?</p> <p>By separate times, I mean times separated by at least 2 months when your mood was much improved or back to normal AND you didn't have ANY of the OTHER experiences you mentioned.</p>	<p>_____ Number</p>
<p>CHECK ITEM 4.24A Is number entered in 6, 2 or more or unknown?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 8b, page 72</i></p>
<p>7a. How old were you the MOST RECENT time you BEGAN to have a low mood that lasted for at least 2 years and you often had some of the other experiences you mentioned?</p>	<p>_____ Age</p>
<p>b. For how many years did this MOST RECENT time last? (Must be at least 2 years.)</p>	<p>_____ Years</p>
<p>c. Since this MOST RECENT time BEGAN, has there been a time lasting at least 2 months when your mood was much improved or back to normal AND you DIDN'T have ANY of those OTHER experiences?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 8a, page 72</i></p>
<p>d. Did this MOST RECENT time when your mood was much improved BEGIN to happen in the last 12 months?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>

Section 4C - LOW MOOD II (Continued)

<p>8a. In your ENTIRE LIFE, what was the LONGEST period you had when your mood was low and you had some of those other experiences?</p> <p><i>(Must be at least 2 years.)</i></p>	<p align="center">_____ Years - <i>SKIP to Check Item 4.25</i></p>
<p>b. For how many years did that time last when your mood was low and you had some of the other experiences you mentioned?</p> <p><i>(Must be at least 2 years.)</i></p>	<p align="center">_____ Years</p>
<p>c. Since that time BEGAN, has there been a time lasting at least 2 months when your mood was much improved or back to normal AND you DIDN'T have ANY of those OTHER experiences?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 4.25</i></p>
<p>d. Did this time when your mood was much improved BEGIN to happen in the last 12 months?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 4.25 Refer to Check Item 2.0, Section 2A, page 9.</p> <p>Is respondent a lifetime abstainer of alcohol?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to 11</i> 2 <input type="checkbox"/> No</p>
<p>9. Did (that time/ANY of those times) when your mood was low for at least 2 years BEGIN to happen AFTER you were drinking heavily or a lot more than usual?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 11</i></p>
<p>10. Did (that time/ANY of those times) when your mood was low for at least 2 years BEGIN to happen DURING a period when you were experiencing the bad aftereffects of drinking?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>11. Did (that time/ANY of those times) when your mood was low for at least 2 years BEGIN to happen AFTER using a medicine or drug?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 4.26</i></p>
<p>12. Did (that time/ANY of those times) when your mood was low for at least 2 years BEGIN to happen DURING a period when you were experiencing the bad aftereffects of a medicine or drug?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 4.26 Is at least 1 item marked "Yes" in 9, 10, 11 OR 12?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 14, page 73</i></p>
<p>CHECK ITEM 4.27 Is number in 6a, 2 or more or unknown?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to 13c</i> 2 <input type="checkbox"/> No</p>
<p>13a. During that time, did you STOP (drinking heavily/using any medicines or drugs/experiencing the bad aftereffects of drinking/medicines or drugs) for at least 1 month?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 14, page 73</i></p>
<p>b. Did you CONTINUE to have a low mood for at least 1 month AFTER you STOPPED (drinking heavily/using any medicines or drugs/experiencing the bad aftereffects of drinking/medicines or drugs)?</p>	<p>1 <input type="checkbox"/> Yes } <i>SKIP to 14, page 73</i> 2 <input type="checkbox"/> No }</p>
<p>c. Did the MOST RECENT time when your mood was low for at least 2 years BEGIN to happen (after drinking heavily/using a medicine or drug/when you were experiencing the bad aftereffects of drinking/medicines or drugs)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 4.28, page 73</i></p>
<p>d. During that MOST RECENT time, did you STOP (drinking heavily/using any medicines or drugs/experiencing the bad aftereffects of drinking/medicines or drugs) for at least 1 month?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 4.28, page 73</i></p>
<p>e. Did you CONTINUE to have a low mood for at least 1 month AFTER you STOPPED (drinking heavily/using any medicines or drugs/experiencing the bad aftereffects of drinking/medicines or drugs)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>

Section 4C - LOW MOOD II (Continued)

CHECK ITEM 4.28	Is number entered in 6a, 3 or more or D or R?	1 <input type="checkbox"/> Yes - <i>SKIP to 13i</i> 2 <input type="checkbox"/> No
13f.	Did the earlier time when your mood was low for at least 2 years BEGIN to happen (after drinking heavily/using a medicine or drug/when you were experiencing the bad aftereffects of drinking/medicines or drugs)?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 14</i>
g.	During that earlier time, did you STOP (drinking heavily/using any medicine or drugs/experiencing the bad aftereffects of drinking/medicines or drugs) for at least 1 month?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 14</i>
h.	Did you CONTINUE to have a low mood for at least 1 month AFTER the earlier time when you STOPPED (drinking heavily/using any medicines or drugs/ experiencing the bad aftereffects of drinking/medicines or drugs)?	1 <input type="checkbox"/> Yes } <i>SKIP to 14</i> 2 <input type="checkbox"/> No }
i.	Did ANY of the earlier times when your mood was low for at least 2 years BEGIN to happen (after drinking heavily/using a medicine or drug/when you were experiencing the bad aftereffects of drinking/medicines or drugs)?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 14</i>
j.	Did they ALL BEGIN to happen (after drinking heavily/ using a medicine or drug/when you were experiencing the bad aftereffects of drinking/medicines or drugs)?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
k.	During ANY of those earlier times when your mood was low for at least 2 years (after drinking heavily/using a medicine or drug), did you STOP (drinking heavily/using any medicines or drugs/ experiencing the bad aftereffects of drinking/medicines or drugs) for at least 1 month?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 14</i>
l.	During ALL of those times, did you STOP (drinking heavily/using any medicines or drugs/experiencing the bad aftereffects of drinking/medicines or drugs) for at least 1 month?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
m.	Did you CONTINUE to have a low mood for at least 1 month AFTER ANY of those earlier times when you STOPPED (drinking heavily/using any medicines or drugs/experiencing the bad aftereffects of drinking/ medicines or drugs)?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 14</i>
n.	Did you CONTINUE to have a low mood for at least 1 month after ALL of those times?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
14.	DURING (that time/ANY of those times) when your mood was low for at least 2 years, did you EVER go to any kind of counselor, therapist, doctor, psychologist or any person like that to help improve your mood or make you feel better?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
15a.	DURING (that time/ANY of those times) when your mood was low for at least 2 years, were you a patient in a hospital for at least 1 night because of your low mood?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
b.	Did you EVER go to an emergency room for help during (that time/ANY of those times) when you felt low?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
16.	DURING (that time/ANY of those times) when your mood was low for at least 2 years, did a doctor prescribe any medicines or drugs to improve your mood or to make you feel better?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
CHECK ITEM 4.29	Is at least 1 item marked "Yes" in 14 - 16? Did respondent ever seek help for their persistent low mood?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 4.30, page 74</i>

Section 4C - LOW MOOD II (Continued)

<p>17a. About how old were you the FIRST time you went anywhere or saw anyone to get help for your low mood that lasted for at least 2 years?</p>	<p align="center">_____ Age</p>
<p>b. How old were you the MOST RECENT time you went anywhere or saw anyone to get help for your low mood that lasted for at least 2 years?</p>	<p align="center">_____ Age OR 0 <input type="checkbox"/> Happened only once</p>
<p>CHECK ITEM 4.30 Refer to Check Item 2.0, Section 2A, page 9. Is the respondent a lifetime abstainer of alcohol?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to Check Item 4.30A</i> 2 <input type="checkbox"/> No</p>
<p>18a. DURING (that time/ANY of those times) when your mood was low for at least 2 years did you OFTEN drink alcohol to improve your mood or to make yourself feel better?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 4.30A</i></p>
<p>b. Did this happen during the last 12 months?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 4.30A</i></p>
<p>c. Did this happen before 12 months ago, that is, before last (Month one year ago)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 4.30A Refer to Check Item 3.10, Section 3B, page 39. Is the respondent a lifetime non-drug user?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to Check Item 4.31</i> 2 <input type="checkbox"/> No</p>
<p>19a. DURING (that time/ANY of those times) when your mood was low for at least 2 years, did you take any medicines or drugs ON YOUR OWN, that is without a prescription, in greater amounts, or more often or longer than prescribed to help improve your mood or to make yourself feel better?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 4.31</i></p>
<p>b. Did this happen during the last 12 months?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No- <i>SKIP to Check Item 4.31</i></p>
<p>c. Did this happen before 12 months ago, that is, before last (Month one year ago)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 4.31 Is number in 6a, 2 or more or unknown?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to 20c</i> 2 <input type="checkbox"/> No</p>
<p>20a. Did that time when your mood was low for at least 2 years, BEGIN to happen DURING a time when you were physically ill or getting over being physically ill?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Section 5, page 76</i></p>
<p>b. Did a doctor or other health professional tell you that this time was related to your physical illness or medical condition?</p>	<p>1 <input type="checkbox"/> Yes } <i>SKIP to Section 5, page 76</i> 2 <input type="checkbox"/> No }</p>
<p>c. Did the MOST RECENT time when your mood was low for at least 2 years BEGIN to happen DURING a time when you were physically ill or getting over being physically ill?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 4.32</i></p>
<p>d. Did a doctor or other health professional tell you that this MOST RECENT time was related to your physical illness or medical condition?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 4.32 Is number entered in 6a, 3 or more or D or R?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to 20g</i> 2 <input type="checkbox"/> No</p>
<p>20e. Did the EARLIER time when your mood was low for at least 2 years BEGIN to happen DURING a time you were physically ill or getting over being physically ill?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Section 5, page 76</i></p>
<p>f. Did a doctor or other health professional tell you this EARLIER time was related to your physical illness or medical condition?</p>	<p>1 <input type="checkbox"/> Yes } <i>SKIP to Section 5, page 76</i> 2 <input type="checkbox"/> No }</p>
<p>g. Did ANY of the EARLIER times when your mood was low for at least 2 years BEGIN to happen DURING a time when you were physically ill or getting over being physically ill?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Section 5, page 76</i></p>

Section 4C - LOW MOOD II (Continued)

20h. Did ALL of those EARLIER times when your mood was low for at least 2 years ONLY BEGIN to happen DURING times when you were physically ill or getting over being physically ill?

- 1 Yes
- 2 No - SKIP to 20j

i. Did a doctor or other health professional tell you that ALL of the EARLIER times like this were related to your physical illness or medical condition?

- 1 Yes - SKIP to Section 5, page 76
- 2 No

j. Did a doctor or other health professional tell you that ANY of the EARLIER times like this were related to your physical illness or medical condition?

- 1 Yes
 - 2 No
- } Go to Section 5, page 76

Section 5 - HIGH MOOD

Statement

Now I'd like to ask you about OTHER moods and related experiences you may have had.

1. In your ENTIRE LIFE, have you ever had a time lasting at least 1 week when you felt so extremely excited, elated or hyper that other people thought you weren't your normal self?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
2. In your ENTIRE LIFE, have you ever had a time lasting at least 1 week when you felt so extremely excited, elated or hyper that other people were concerned about you?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
3. In your ENTIRE LIFE, have you ever had a time lasting a least 1 week when you were so irritable or easily annoyed that you would shout at people, throw or break things, or start fights or arguments?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
CHECK ITEM 5.1 Is at least 1 item marked "Yes" in 1 - 3?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Section 6, page 82</i>	
6a. The next few questions are about experiences many people have had when they felt extremely (excited, elated or hyper/irritable or easily annoyed). During that time when (you were the most excited, elated or hyper/you felt the most irritable or easily annoyed), did you . . . <i>(Repeat entire phrase frequently)</i>	b.	
(1) Need much less sleep than usual?	1 <input type="checkbox"/> Yes - <i>Mark Box E1</i> 2 <input type="checkbox"/> No - <i>Go to next experience</i>	Box 1 <input type="checkbox"/> E1
(2) Find you were more talkative than usual?	1 <input type="checkbox"/> Yes - <i>Mark Box E2</i> 2 <input type="checkbox"/> No - <i>Go to next experience</i>	Box 1 <input type="checkbox"/> E2
(3) Talk so fast that people had trouble understanding you or couldn't get a word in edgewise?	1 <input type="checkbox"/> Yes - <i>Mark Box E2</i> 2 <input type="checkbox"/> No - <i>Go to next experience</i>	Box 1 <input type="checkbox"/> E2
(4) Have trouble concentrating because little things going on around you easily got you off track?	1 <input type="checkbox"/> Yes - <i>Mark Box E3</i> 2 <input type="checkbox"/> No - <i>Go to next experience</i>	Box 1 <input type="checkbox"/> E3
(5) Find that your thoughts raced so fast that you couldn't keep track of them?	1 <input type="checkbox"/> Yes - <i>Mark Box E4</i> 2 <input type="checkbox"/> No - <i>Go to next experience</i>	Box 1 <input type="checkbox"/> E4
(6) Find that your thoughts raced so fast that it was hard to follow your own thoughts?	1 <input type="checkbox"/> Yes - <i>Mark Box E4</i> 2 <input type="checkbox"/> No - <i>Go to next experience</i>	Box 1 <input type="checkbox"/> E4
(7) Feel so restless that you fidgeted, paced, or couldn't sit still?	1 <input type="checkbox"/> Yes - <i>Mark Box E5</i> 2 <input type="checkbox"/> No - <i>Go to next experience</i>	Box 1 <input type="checkbox"/> E5
(8) Become more active than usual, at work, at home, or in pursuing other interests?	1 <input type="checkbox"/> Yes - <i>Mark Box E5</i> 2 <input type="checkbox"/> No - <i>Go to next experience</i>	Box 1 <input type="checkbox"/> E5
(9) Become more sexually active than usual or have sex with people you normally wouldn't be interested in?	1 <input type="checkbox"/> Yes - <i>Mark Box E5</i> 2 <input type="checkbox"/> No - <i>Go to next experience</i>	Box 1 <input type="checkbox"/> E5
(10) Become so physically restless that it made you uncomfortable?	1 <input type="checkbox"/> Yes - <i>Mark Box E5</i> 2 <input type="checkbox"/> No - <i>Go to next experience, page 77</i>	Box 1 <input type="checkbox"/> E5

Section 5 – HIGH MOOD (Continued)

6a. During that time when (you were the most excited, elated or hyper/you felt the most irritable or easily annoyed), did you . . . <i>(Repeat entire phrase frequently)</i>		b.
(11) Do anything unusual that could have gotten you into trouble - like buying things you couldn't afford or didn't need, making foolish decisions about money, or driving recklessly?	1 <input type="checkbox"/> Yes - Mark Box E6 2 <input type="checkbox"/> No - Go to next experience	Box 1 <input type="checkbox"/> E6
(12) Do anything that you later regretted - like spending time with people you normally wouldn't be interested in?	1 <input type="checkbox"/> Yes - Mark Box E6 2 <input type="checkbox"/> No - Go to next experience	
(13) Feel that you were an unusually important person or that you had special gifts, powers, or abilities to do things that most other people couldn't do?	1 <input type="checkbox"/> Yes - Mark Box E7 2 <input type="checkbox"/> No - Go to Check Item 5.3	Box 1 <input type="checkbox"/> E7
CHECK ITEM 5.3 Are at least 3 boxes marked for E1 - E7 in 6, column b?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - SKIP to Section 6, page 82	
7a. Now I'd like to ask you about some things that might have happened to you during that time when (you were the most excited, elated or hyper/you felt the most irritable or easily annoyed) for at least 1 week and when you had some of the other experiences you just mentioned. During that time . . .		
(1) Were you uncomfortable or upset by feeling extremely (excited, elated or hyper/irritable or easily annoyed) or by any of those other experiences?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
(2) Did you have any serious problems getting along with other people - like arguing with your friends, family, people at work or anyone else?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
(3) Did you have any serious problems doing things you were supposed to do - like working, doing your schoolwork, or taking care of your home or family?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
(4) Did you have trouble getting things done?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
(5) Did you have any legal trouble - like being arrested, held at the police station or put in jail?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
8b. About how old were you the FIRST time you BEGAN to feel extremely (excited, elated or hyper/irritable or easily annoyed) for at least 1 week and when you also had some of the other experiences you just mentioned? <i>Refer to other experiences marked "Yes" in 6a(1)-(13) and 7(1)-(5), pages 76 - 77, if necessary.</i>	_____ Age	
CHECK ITEM 5.4 Is respondent's age in 8b within 1 year of his/her present age or is present age or 8b unknown?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - SKIP to 9	
8c. Did this FIRST time BEGIN to happen during the last 12 months?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
9. In your ENTIRE LIFE, how many SEPARATE times lasting at least 1 week were there when you felt extremely (excited, elated or hyper/irritable or easily annoyed) and when you also had some of the other experiences you mentioned? By separate times, I mean times separated by at least 2 months when your mood was back to normal, AND you DIDN'T have ANY of the OTHER experiences you mentioned.	_____ Number	
CHECK ITEM 5.5 Is number in 9, 2 or more or unknown?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - SKIP to 11e, page 78	

Section 5 - HIGH MOOD (Continued)

<p>10a. How old were you the MOST RECENT time when you felt extremely (excited, elated or hyper/irritable or easily annoyed) and you also had some of those other experiences?</p>	<p align="center">_____ Age</p>
<p>CHECK ITEM 5.6A Is respondent's age in 10a within 1 year of his/her present age or is present age or 10a unknown?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 11a</i></p>
<p>10b. Did this MOST RECENT time BEGIN to happen during the last 12 months?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>11a. How long did this MOST RECENT time last when you felt extremely (excited, elated or hyper/irritable or easily annoyed)? <i>(Must be at least 1 week)</i></p>	<p>_____ Week(s) OR _____ Month(s) OR _____ Year(s)</p>
<p>b. Since this MOST RECENT time BEGAN, have there been at least 2 months when your mood was back to normal AND you DIDN'T have ANY of the OTHER experiences you mentioned?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 11d</i></p>
<p>CHECK ITEM 5.6B Is 10b marked "Yes"?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to 11d</i> 2 <input type="checkbox"/> No</p>
<p>11c. Did this MOST RECENT time when your mood was back to normal BEGIN to happen in the last 12 months?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>d. In your ENTIRE LIFE, what was the LONGEST time that you've had when you felt extremely (excited, elated or hyper/irritable or easily annoyed)? <i>(Must be at least 1 week)</i></p>	<p>_____ Week(s) OR _____ Month(s) OR _____ Year(s) } <i>SKIP to Check Item 5.7</i></p>
<p>e. How long did that time last when you felt extremely (excited, elated or hyper/irritable or easily annoyed)? <i>(Must be at least 1 week)</i></p>	<p>_____ Week(s) OR _____ Month(s) OR _____ Year(s)</p>
<p>f. Since that time BEGAN, have there been at least 2 months when your mood was back to normal AND you DIDN'T have ANY of the OTHER experiences that you mentioned?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 5.7</i></p>
<p>CHECK ITEM 5.6C Is 8c marked "Yes"?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to Check Item 5.7</i> 2 <input type="checkbox"/> No</p>
<p>11g. Did this time when your mood was back to normal BEGIN to happen in the last 12 months?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 5.7 Refer to Check Item 2.0, Section 2A, page 9. Is respondent a lifetime abstainer of alcohol?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to 14</i> 2 <input type="checkbox"/> No</p>
<p>12. Did (that time/ANY of those times) when you felt extremely (excited, elated or hyper/irritable or easily annoyed) BEGIN to happen AFTER you were drinking heavily or a lot more than usual?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 14</i></p>
<p>13. Did (that time/ANY of those times) when you felt extremely (excited, elated or hyper/irritable or easily annoyed) BEGIN to happen DURING a period when you were experiencing the bad aftereffects of drinking?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>14. Did (that time/ANY of those times) when you felt extremely (excited, elated or hyper/irritable or easily annoyed) BEGIN to happen AFTER using a medicine or drug?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 5.8</i></p>
<p>15. Did (that time/ANY of those times) when you felt extremely (excited, elated or hyper/irritable or easily annoyed) BEGIN to happen DURING a period when you were experiencing the bad aftereffects of a medicine or drug?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 5.8 Is at least 1 item marked "Yes" in 12, 13, 14 OR 15?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 17, page 80</i></p>
<p>CHECK ITEM 5.9 Is Check Item 5.5 marked "No"?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 5.10A, page 79</i></p>

Section 5 - HIGH MOOD (Continued)

<p>16a. During that time, did you STOP (drinking heavily/using any medicines or drugs/experiencing the bad aftereffects of drinking/medicines or drugs) for at least 1 month?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 17, page 80</i></p>
<p>b. Did you CONTINUE to feel extremely (excited, elated or hyper/irritable or easily annoyed) for at least 1 month AFTER you STOPPED (drinking heavily/using any medicines or drugs/experiencing the bad aftereffects of drinking/medicines or drugs)?</p>	<p>1 <input type="checkbox"/> Yes } <i>SKIP to 17, page 80</i> 2 <input type="checkbox"/> No }</p>
<p>CHECK ITEM 5.10A Is 8c marked "Yes" or 10b marked "Yes" or 11c marked "Yes" or 11b marked "No"?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 5.10B</i></p>
<p>16c. Did ANY of the times when you felt extremely (excited, elated or hyper/irritable or easily annoyed) in the last 12 months BEGIN to happen (after drinking heavily/using a medicine or drug/when you were experiencing the bad aftereffects of drinking/medicines or drugs)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 5.10B</i></p>
<p>d. Did they ALL BEGIN to happen (after drinking heavily/using a medicine or drug/when you were experiencing the bad aftereffects of drinking/medicines or drugs)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>e. During ANY of those times in the last 12 months when you felt extremely (excited, elated or hyper/irritable or easily annoyed) after (drinking heavily/using a medicine or drug), did you STOP (drinking heavily/using any medicines or drugs/ experiencing the bad aftereffects of drinking/medicines or drugs) for at least 1 month?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 5.10B</i></p>
<p>f. During ALL of those times, did you STOP (drinking heavily/using any medicines or drugs/experiencing the bad aftereffects of drinking/medicines or drugs) for at least 1 month?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>g. Did you CONTINUE to feel extremely (excited, elated or hyper/irritable or easily annoyed) for at least 1 month AFTER ANY of those times in the last 12 months when you STOPPED (drinking heavily/using any medicines or drugs/experiencing the bad aftereffects of drinking/medicines or drugs)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 5.10B</i></p>
<p>h. Did you CONTINUE to feel extremely (excited, elated or hyper/irritable or easily annoyed) for at least 1 month after ALL of those times?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 5.10B Is 8c marked "Yes"?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to 17, page 80</i> 2 <input type="checkbox"/> No</p>
<p>16i. Did ANY of the times when you felt extremely (excited, elated or hyper/irritable or easily annoyed) BEFORE 12 months ago BEGIN to happen (after drinking heavily/using a medicine or drug/when you were experiencing the bad aftereffects of drinking/medicines or drugs)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 17, page 80</i></p>
<p>j. Did they ALL BEGIN to happen (after drinking heavily/using a medicine or drug/when you were experiencing the bad aftereffects of drinking/medicines or drugs)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>k. During ANY of those times BEFORE 12 months ago when you felt extremely (excited, elated or hyper/irritable or easily annoyed) after (drinking heavily/using a medicine or drug), did you STOP (drinking heavily/using any medicines or drugs/ experiencing the bad aftereffects of drinking/medicines or drugs) for at least 1 month?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 17, page 80</i></p>
<p>l. During ALL of those times, did you STOP (drinking heavily/using any medicines or drugs/experiencing the bad aftereffects of drinking/medicines or drugs) for at least 1 month?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>m. Did you CONTINUE to feel extremely (excited, elated or hyper/irritable or easily annoyed) for at least 1 month AFTER ANY of those times BEFORE 12 months ago when you STOPPED (drinking heavily/using any medicines or drugs/experiencing the bad aftereffects of drinking/medicines or drugs)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 17, page 80</i></p>

Section 5 - HIGH MOOD (Continued)

<p>16n. Did you CONTINUE to feel extremely (excited, elated or hyper/irritable or easily annoyed) for at least 1 month after ALL of those times?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>17. Did you EVER go to any kind of counselor, therapist, doctor, psychologist or any person like that to calm down or feel better when you felt extremely (excited, elated or hyper/irritable or easily annoyed)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>18a. Were you a patient in the hospital for at least 1 night because you felt extremely (excited, elated or hyper/irritable or easily annoyed)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>b. Did you EVER go to an emergency room for help at any time when you felt extremely (excited, elated or hyper/irritable or easily annoyed)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>19. Did a doctor EVER prescribe any medicines or drugs to help you calm down or feel better?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 5.11 Is at least 1 item marked "Yes" in 17 - 19?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 5.11A</i></p>
<p>20a. About how old were you the FIRST time you went anywhere or saw anyone to get help for feeling extremely (excited, elated or hyper/irritable or easily annoyed)?</p>	<p>_____ Age</p>
<p>b. How old were you the MOST RECENT time you went anywhere or saw anyone to get help for feeling extremely (excited, elated or hyper/irritable or easily annoyed)?</p>	<p>_____ Age OR 0 <input type="checkbox"/> Happened only once</p>
<p>CHECK ITEM 5.11A Refer to Check Item 2.0, Section 2A, page 9. Is the respondent a lifetime abstainer of alcohol?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to Check Item 5.11B</i> 2 <input type="checkbox"/> No</p>
<p>21a. Did you EVER drink alcohol to calm down or to feel better when you felt extremely (excited, elated or hyper/irritable or easily annoyed)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 5.11B</i></p>
<p>b. Did this happen during the last 12 months?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 5.11B</i></p>
<p>c. Did this happen before 12 months ago, that is, before last (Month one year ago)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 5.11B Refer to Check Item 3.10, Section 3B, page 39. Is the respondent a lifetime non-drug user?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to Check Item 5.12</i> 2 <input type="checkbox"/> No</p>
<p>22a. Did you EVER take any medicines or drugs ON YOUR OWN, that is, without a prescription, in greater amounts, or more often or longer than prescribed, to help calm down or feel better when you felt extremely (excited, elated or hyper/irritable or easily annoyed)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 5.12</i></p>
<p>b. Did this happen during the last 12 months?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 5.12</i></p>
<p>c. Did this happen before 12 months ago, that is, before last (Month one year ago)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 5.12 Is Check Item 5.5 marked "No"?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 5.13A</i></p>
<p>23a. Did that time when you felt extremely (excited, elated or hyper/irritable or easily annoyed) BEGIN to happen DURING a time when you were physically ill or getting over being ill?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 24a, page 81</i></p>
<p>b. Did a doctor or other health professional tell you that this time was related to your physical illness or medical condition?</p>	<p>1 <input type="checkbox"/> Yes } <i>SKIP to 24a, page 81</i> 2 <input type="checkbox"/> No }</p>
<p>CHECK ITEM 5.13A Is 8c marked "Yes" or 10b marked "Yes" or 11c marked "Yes" or 11b marked "No"?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 5.13B, page 81</i></p>

Section 5 - HIGH MOOD (Continued)

<p>23c. Did ANY of the times when you felt extremely (excited, elated or hyper/irritable or easily annoyed) in the last 12 months BEGIN to happen DURING a time when you were physically ill or getting over being physically ill?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 5.13B</i></p>
<p>d. Did ALL of those times when you felt extremely (excited, elated or hyper/irritable or easily annoyed) in the last 12 months ONLY BEGIN to happen DURING times when you were physically ill or getting over being physically ill?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 23f</i></p>
<p>e. Did a doctor or other health professional tell you that ALL of the times like this were related to your physical illness or medical condition?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to Check Item 5.13B</i> 2 <input type="checkbox"/> No</p>
<p>f. Did a doctor or other health professional tell you that ANY of the times like this were related to your physical illness or medical condition?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 5.13B Is 8c marked "Yes"?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to 24a</i> 2 <input type="checkbox"/> No</p>
<p>23g. Did ANY of the times BEFORE 12 months ago when you felt extremely (excited, elated or hyper/irritable easily annoyed) BEGIN to happen DURING a time when you were physically ill or getting over being physically ill?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 24a</i></p>
<p>h. Did ALL of those times BEFORE 12 months ago when you felt extremely (excited, elated or hyper/irritable or easily annoyed) ONLY BEGIN to happen DURING times when you were physically ill or getting over being physically ill?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 23j</i></p>
<p>i. Did a doctor or other health professional tell you that ALL of the times like this were related to your physical illness or medical condition?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to 24a</i> 2 <input type="checkbox"/> No</p>
<p>j. Did a doctor or other health professional tell you that ANY of the times like this were related to your physical illness or medical condition?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>24a. During (that time/ANY of those times) when you felt extremely (excited, elated, or hyper/irritable or easily annoyed), did you ever have a period lasting at least 1 week when you went back and forth between feeling extremely (excited, elated or hyper/irritable or easily annoyed) and feeling sad, blue, depressed or down or not caring about things or enjoying things?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Section 6, page 82</i></p>
<p>b. During ALL of those times, did you have periods lasting at least 1 week when you went back and forth between feeling (excited, elated or hyper/irritable or easily annoyed) and feeling sad, blue, depressed or down or not caring about things or enjoying things?</p>	<p>1 <input type="checkbox"/> Yes } <i>Go to Section 6, page 82</i> 2 <input type="checkbox"/> No }</p>

Section 6 - ANXIETY

Statement T

Now I'd like to ask you about feelings of nervousness that you might have experienced at some time in your life.

<p>1. Have you EVER had a panic attack, when ALL OF A SUDDEN you felt frightened, overwhelmed or nervous, almost as if you were in great danger, but really weren't?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>2. Were you EVER very surprised by a panic attack that happened totally out-of-the-blue, for no real reason, or in a situation where you didn't expect to be frightened or nervous?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>3. Did you EVER think you were having a heart attack, but the doctor said it was just nerves or you were having a panic attack?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 6.1 Is at least 1 item marked "Yes" in 1 - 3?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Section 7, page 88</i></p>
<p>6. Now I'd like you to think about the time when you were having your worst panic attacks that happened OUT-OF-THE-BLUE. By worst panic attacks, I mean the ones that made you the most frightened, nervous, or overwhelmed.</p> <p>During your worst panic attacks did you . . . <i>(Repeat phrase frequently)</i></p>	
<p>(1) Have trouble catching your breath, feel short of breath, or feel like you were smothering?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(2) Feel your heart racing, pounding or skipping?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(3) Tremble or shake?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(4) Perspire or sweat?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(5) Feel as if you were choking?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(6) Feel dizzy, lightheaded or as if you might faint?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(7) Feel that things around you seemed unreal or feel that you were detached from the things around you?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(8) Have tingling or numbness in any part of your body?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(9) Have flushes, hot flashes or chills?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(10) Feel nauseous, have an upset stomach, or feel you might vomit or have diarrhea?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(11) Have pain or pressure in your chest?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>

Section 6 - ANXIETY (Continued)

<p>6. During your worst panic attacks did you . . .</p> <p>(12) Feel you might go crazy or lose control?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(13) Feel you might die?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 6.3 Are at least 4 items marked "Yes" in 6 (1) - (13)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Section 7, page 88</i></p>
<p>7. During the time you were having your worst panic attacks, did at least 4 of the other experiences you just mentioned begin suddenly and become very intense within 10 minutes or less?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>8. After your worst panic attacks did you worry for at least 1 month that you might have another one?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>9. After having your worst panic attacks did you worry a lot for at least 1 month about what might happen if you DID have another panic attack?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>10. Did you make any changes in your everyday life, usual activities, or future plans after you had your worst panic attacks?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>11. Now I'd like to ask you about some other things that may have happened to you after you had your worst panic attacks.</p> <p>After those worst panic attacks. . .</p> <p>(1) Were you uncomfortable or upset by your panic attacks or by any of these other experiences?</p> <p>(2) Did you have any serious problems getting along with other people - like arguing with them or avoiding them more than usual?</p> <p>(3) Did you have any serious problems doing things you were supposed to do - like working, doing your school work, or taking care of your home or family?</p> <p>(4) Did you restrict your usual activities in any way because of your panic attacks?</p> <p>(5) Was there anything you were unable to do because of your panic attacks?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>12a. About how old were you the FIRST time you BEGAN to have panic attacks along with some of the other experiences you told me about?</p> <p><i>Refer to experiences marked "Yes" in 6(1) - (13) and 11(1) - (5), pages 82 - 83, if necessary.</i></p>	<p>_____ Age</p>
<p>CHECK ITEM 6.4 Is respondent's age in 12a within 1 year of his/her present age or is present age or 12a unknown?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 12c</i></p>
<p>12b. Did this FIRST time when you were having panic attacks BEGIN to happen during last 12 months?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>c. After your first attacks, did you worry a lot about having another one for at least 1 month (PAUSE) or make a change in your everyday life or future plans as the result of having a panic attack?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>13. In your ENTIRE LIFE, about how many SEPARATE times were there when you were having panic attacks along with some of those other experiences you mentioned?</p> <p>By separate times, I mean times separated by at least 2 months when you DIDN'T have any panic attacks.</p>	<p>_____ Number</p>
<p>CHECK ITEM 6.5 Is number in 13, 2 or more or unknown?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 15e, page 84</i></p>

Section 6 - ANXIETY (Continued)

<p>14a. How old were you the MOST RECENT time you BEGAN to have panic attacks along with some of the other experiences you mentioned?</p>	<p align="center">_____ Age</p>
<p>CHECK ITEM 6.6A Is respondent's age in 14a within 1 year of his/her present age or is present age or 14a unknown?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 14c</i></p>
<p>14b. Did this MOST RECENT time BEGIN to happen during the last 12 months?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>c. After these MOST RECENT attacks, did you worry about having another one for at least 1 month (<i>PAUSE</i>) or make a change in your everyday life or plans as the result of having the attacks?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>15a. How long did this MOST RECENT time last when you were experiencing panic attacks, that is from the time the first attack happened to the time the attacks completely stopped for 2 months?</p>	<p align="center">_____ Day(s) OR _____ Week(s) OR _____ Month(s) OR _____ Year(s)</p>
<p>b. Since this MOST RECENT time when your panic attacks BEGAN, have there been at least 2 months when you DIDN'T have ANY panic attacks?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 15d</i></p>
<p>CHECK ITEM 6.6B Is 14b marked "Yes"?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to 15d</i> 2 <input type="checkbox"/> No</p>
<p>15c. Did this MOST RECENT time you DIDN'T have ANY panic attacks for at least 2 months BEGIN to happen in the last 12 months?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>d. In your ENTIRE LIFE, what was the LONGEST period you had when you were having panic attacks, that is, from the time the first attack happened to the time the attacks stopped completely for at least 2 months?</p>	<p align="center">_____ Day(s) OR _____ Week(s) OR _____ Month(s) OR _____ Year(s) } <i>SKIP to Check Item 6.7</i></p>
<p>e. How long did that time last when you were having panic attacks, that is, from the time the first panic attack happened to the time the attacks stopped completely for at least 2 months?</p>	<p align="center">_____ Day(s) OR _____ Week(s) OR _____ Month(s) OR _____ Year(s)</p>
<p>f. Since that time when your panic attacks BEGAN, have there been at least 2 months when you DIDN'T have ANY panic attacks?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 6.7</i></p>
<p>CHECK ITEM 6.6C Is 12b marked "Yes"?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to Check Item 6.7</i> 2 <input type="checkbox"/> No</p>
<p>15g. Did that time when you DIDN'T have ANY panic attacks for at least 2 months BEGIN to happen in the last 12 months?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 6.7 Refer to Check Item 2.0, Section 2A, page 9. Is respondent a lifetime abstainer of alcohol?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to 18</i> 2 <input type="checkbox"/> No</p>
<p>16. Did (that time/ANY of those times) when you were having panic attacks BEGIN to happen AFTER you were drinking heavily or a lot more than usual?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 18</i></p>
<p>17. Did (that time/ANY of those times) when you were having panic attacks BEGIN to happen DURING a period when you were experiencing the bad aftereffects of drinking?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>18. Did (that time/ANY of those times) when you were having panic attacks BEGIN to happen AFTER using a medicine or drug?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 6.8, page 85</i></p>

Section 6 - ANXIETY (Continued)

<p>19. Did (that time/ANY of those times) when you were having panic attacks BEGIN to happen DURING a period when you were experiencing the bad aftereffects of a medicine or drug?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 6.8 Is at least 1 item marked “Yes” in 16, 17, 18 OR 19?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 21, page 86</i></p>
<p>CHECK ITEM 6.9 Is Check Item 6.5 marked “No”?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 6.10</i></p>
<p>20a. During that time did you STOP (drinking heavily/using any medicines or drugs/experiencing the bad aftereffects of drinking/medicines or drugs) for at least 1 month?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 21, page 86</i></p>
<p>b. Did you CONTINUE to have panic attacks for at least 1 month AFTER you STOPPED (drinking heavily/using any medicines or drugs/experiencing the bad aftereffects of drinking/medicines or drugs)?</p>	<p>1 <input type="checkbox"/> Yes } <i>SKIP to 21, page 86</i> 2 <input type="checkbox"/> No }</p>
<p>CHECK ITEM 6.10 Is 12b marked “Yes” or 14b marked “Yes” or 15c marked “Yes” or 15b marked “No”?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 6.10A</i></p>
<p>20c. Did ANY of the times when you were having panic attacks in the last 12 months BEGIN to happen (after drinking heavily/using a medicine or drug/when you were experiencing the bad aftereffects of drinking/medicines or drugs)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 6.10A</i></p>
<p>d. Did they ALL BEGIN to happen (after drinking heavily/using a medicine or drug/when you were experiencing the bad aftereffects of drinking/medicines or drugs)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>e. During ANY of those times in the last 12 months when you were having panic attacks after (drinking heavily/ using a medicine or drug), did you STOP (drinking heavily/using any medicines or drugs/experiencing the bad aftereffects of drinking/medicines or drugs) for at least 1 month?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 6.10A</i></p>
<p>f. During ALL of those times, did you STOP (drinking heavily/using any medicines or drugs/experiencing the bad aftereffects of drinking/medicines or drugs) for at least 1 month?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>g. Did you CONTINUE to have panic attacks for at least 1 month AFTER ANY of those times in the last 12 months when you STOPPED (drinking heavily/using any medicines or drugs/experiencing the bad aftereffects of drinking/medicines or drugs)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 6.10A</i></p>
<p>h. Did you CONTINUE to have panic attacks for at least 1 month AFTER ALL of those times?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 6.10A Is 12b marked “Yes”?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to 21, page 86</i> 2 <input type="checkbox"/> No</p>
<p>20i. Did ANY of the times when you were having panic attacks BEFORE 12 months ago BEGIN to happen (after drinking heavily/using a medicine or drug/when you were experiencing the bad aftereffects of drinking/ medicines or drugs)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 21, page 86</i></p>
<p>j. Did they ALL BEGIN to happen (after drinking heavily/using a medicine or drug/when you were experiencing the bad aftereffects of drinking/medicines or drugs)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>k. During ANY of those times BEFORE 12 months ago when you were having panic attacks after (drinking heavily/using a medicine or drug), did you STOP (drinking heavily/using any medicines or drugs/ experiencing the bad aftereffects of drinking/medicines or drugs) for at least 1 month?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 21, page 86</i></p>
<p>l. During ALL of those times, did you STOP (drinking heavily/using any medicines or drugs/experiencing the bad aftereffects of drinking/medicines or drugs) for at least 1 month?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>

Section 6 - ANXIETY (Continued)

<p>20m. Did you CONTINUE to have panic attacks for at least 1 month AFTER ANY of those times BEFORE 12 months ago when you STOPPED (drinking heavily/using any medicines or drugs/experiencing the bad aftereffects of drinking/medicines or drugs)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 21</i></p>
<p>n. Did you CONTINUE to have panic attacks for at least 1 month AFTER ALL of those times?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>21. Did you EVER go to any kind of counselor, therapist, doctor, psychologist or any other person like that to get help for panic attacks?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>22. Did you EVER go to an emergency room to get help for your panic attacks?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>23. Were you EVER a patient in any kind of hospital overnight or longer because of your panic attacks?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>24. Did a doctor EVER prescribe any medicines or drugs for your panic attacks?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 6.11 Is at least 1 item marked "Yes" in 21 - 24? Did respondent ever seek help for their panic attacks?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 6.11A</i></p>
<p>25a. How old were you the FIRST time you went anywhere or saw anyone to get help for panic attacks?</p>	<p>_____ Age</p>
<p>b. How old were you the MOST RECENT time you went anywhere or saw anyone to get help for your panic attacks?</p>	<p>_____ Age OR 0 <input type="checkbox"/> Happened only once</p>
<p>CHECK ITEM 6.11A Refer to Check Item 2.0, Section 2a, page 9. Is the respondent a lifetime abstainer of alcohol?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to Check Item 6.11B</i> 2 <input type="checkbox"/> No</p>
<p>26a. Did you EVER drink alcohol to keep from having panic attacks?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 6.11B</i></p>
<p>b. Did this happen in the last 12 months?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 6.11B</i></p>
<p>c. Did this happen before 12 months ago, that is, before last (Month one year ago)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 6.11B Refer to Check Item 3.10, Section 3B, page 39. Is the respondent a lifetime non-drug abuser?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to Check Item 6.12</i> 2 <input type="checkbox"/> No</p>
<p>27a. Did you ever take any medicines or drugs ON YOUR OWN, that is, without a prescription, in greater amounts, or more often or longer than prescribed to keep from having panic attacks?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 6.12</i></p>
<p>b. Did this happen during the last 12 months?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 6.12</i></p>
<p>c. Did this happen before 12 months ago, that is, before last (Month one year ago)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 6.12 Is Check Item 6.5 marked "No"?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 6.13, page 87</i></p>
<p>28a. Did your panic attacks BEGIN to happen DURING a time when you where physically ill or getting over being physically ill?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 29a, page 87</i></p>
<p>b. Did a doctor or other health professional tell you that these panic attacks were related to your physical illness or medical condition?</p>	<p>1 <input type="checkbox"/> Yes } 2 <input type="checkbox"/> No } <i>SKIP to 29a, page 87</i></p>

Section 6 - ANXIETY (Continued)

CHECK ITEM 6.13	Is 12b marked "Yes" or 14b marked "Yes" or 15c marked "Yes" or 15b marked "No"?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 6.13A</i>
28c.	Did ANY of the panic attacks you had in the last 12 months BEGIN to happen DURING a time when you were physically ill or getting over being physically ill?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 6.13A</i>
d.	Did ALL of those panic attacks that you had in the last 12 months ONLY BEGIN to happen DURING times when you were physically ill or getting over being physically ill?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 28f</i>
e.	Did a doctor or other health professional tell you that ALL of the panic attacks you had like this were related to your physical illness or medical condition?	1 <input type="checkbox"/> Yes - <i>SKIP to Check Item 6.13A</i> 2 <input type="checkbox"/> No
f.	Did a doctor or other health professional tell you that ANY of the panic attacks you had like this were related to your physical illness or medical condition?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
CHECK ITEM 6.13A	Is 12b marked "Yes"?	1 <input type="checkbox"/> Yes - <i>SKIP to 29a</i> 2 <input type="checkbox"/> No
28g.	Did ANY of the panic attacks you had BEFORE 12 months ago BEGIN to happen DURING a time when you were physically ill or getting over being physically ill?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 29a</i>
h.	Did ALL of those panic attacks you had BEFORE 12 months ago ONLY BEGIN to happen DURING times when you were physically ill or getting over being ill?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 28j</i>
i.	Did a doctor or other health professional tell you that ALL of the panic attacks you had like this were related to your physical illness or medical condition?	1 <input type="checkbox"/> Yes - <i>SKIP to 29a</i> 2 <input type="checkbox"/> No
j.	Did a doctor or other health professional tell you that ANY of the panic attacks you had like this were related to your physical illness or medical condition?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
29a.	Did you EVER have a panic attack during a time when you were thinking about an extremely stressful experience you had in the past - like being in a war, being attacked, or being in a bad accident or a fire?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 30a</i>
b.	Did your panic attacks ONLY happen when you were thinking about an extremely stressful experience you had in the past?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
30a.	Did you EVER have a panic attack during a time when you were frightened and nervous about being away from home or away from the people who were important to you?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 31a</i>
b.	Did your panic attacks ONLY happen when you were nervous and worried about being away from home or away from the people who were important to you?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
31a.	Did you EVER have a panic attack during a time when you were afraid of being contaminated by dirt or germs?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 32a</i>
b.	Did your panic attacks ONLY happen when you were afraid of being contaminated by dirt or germs?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
32a.	Did you EVER have a panic attack during a time when you were afraid you might be embarrassed by having to do something over and over to make yourself feel comfortable - like counting, checking, ordering or repeating things over and over?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 33a</i>
b.	Did your panic attacks ONLY happen when you were afraid you might be embarrassed by having to do something over and over to make yourself feel comfortable?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
33a.	Did you EVER have a panic attack during a time when you were afraid that you WOULDN'T be able to do things over and over again to make yourself feel comfortable?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Section 7, page 88</i>
b.	Did your panic attacks ONLY happen when you were afraid you WOULDN'T be able to do things over and over again to make yourself feel comfortable?	1 <input type="checkbox"/> Yes } <i>Go to Section 7, page 88</i> 2 <input type="checkbox"/> No }

Section 7 - SOCIAL SITUATIONS

Statement U

The next few questions are about **SOCIAL SITUATIONS** which may have made you nervous at some time in your life.

<p>1. Some people have such a strong fear of social situations, like doing things in front of other people or being the center of attention, that they become very frightened and nervous or they try to avoid them.</p> <p>Did you EVER have such a STRONG FEAR or avoidance of any social situation?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>2. Did you EVER have a STRONG FEAR or avoidance of any social situation because you were afraid of being embarrassed by what you might say or do around other people?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>3. Did you EVER have a STRONG FEAR or avoidance of any social situation because you were afraid you would become speechless, have nothing to say or you might say something foolish?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 7.0 Is "Yes" marked in 1 or 2 or 3? Did respondent ever have a strong fear of any social situation?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Section 8, page 95</i></p>
<p>4a. Now I'd like to know about the kinds of social situations that made you very frightened and nervous. Have you EVER had a strong fear or avoidance of . . . <i>(Repeat phrase frequently).</i></p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(1) Speaking or talking in front of other people?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(2) Having conversations with people you don't know well?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(3) Going to parties or other social gatherings?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(4) Eating or drinking in public?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(5) Writing while someone else was watching?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(6) Dating?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(7) Being in a small group situation?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(8) Taking part or speaking in a class?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(9) Being interviewed?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(10) Taking part or speaking at a meeting?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(11) Performing in front of other people?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(12) Taking an important exam?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(13) Speaking to an authority figure - like a teacher or a boss?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>b. Have you EVER had a strong fear or avoidance of any other social situation that made you nervous, frightened or anxious?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>5. Did THINKING ABOUT any of these social situations ALMOST ALWAYS make you nervous, frightened or anxious?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>

Section 7 - SOCIAL SITUATIONS (Continued)

<p>6. When you had to be in any of these social situations, did you USUALLY become upset, nervous or anxious?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>7. Did you EVER remain in any of these social situations because you had to be there, even though it made you very frightened, nervous or anxious?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>8. Did you EVER avoid any of these social situations because of your STRONG FEAR OF THEM?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>9. Did you EVER think that you were more frightened, nervous or anxious about these social situations than most people?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>10. Did you EVER think that your fear or avoidance of any of these social situations was stronger than it should have been?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 7.1 Is "Yes" marked in Check Item 6.3, Section 6, page 83? Did respondent ever have a panic attack?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 16</i></p>
<p>11. When you were in any of these social situations that made you frightened and nervous, did you EVER have a panic attack?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 13</i></p>
<p>12. Did your panic attacks ONLY happen when you were in any of these social situations or when you thought you might have to be in them?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>13. Were you ever frightened of any of these social situations because you were afraid of having a panic attack or afraid you might be embarrassed or not able to find help if you had a panic attack?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>14. Did you ever remain in any of these social situations because you had to be there, even though you were very nervous and anxious about having a panic attack?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>15a. Did you avoid any of these social situations because you were afraid of having a panic attack?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>b. When you had to be in any of these social situations, did you often need to bring someone along with you in case you had a panic attack?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>16. Did being in any of these social situations, or THINKING ABOUT THEM, or avoiding them, EVER . . . (<i>Repeat phrase frequently</i>)</p>	
<p>(1) Upset you or make you feel uncomfortable?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(2) Interfere with your relationships with other people - like arguing with them or avoiding them?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(3) Interfere with doing things you were supposed to do - like working, doing your schoolwork, or taking care of your home or family?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(4) Restrict your usual activities in any way?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(5) Keep you from doing something you wanted to do?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>17a. About how old were you the FIRST TIME you BEGAN to experience a strong fear or avoidance of any social situation?</p>	<p>_____ Age</p>
<p>CHECK ITEM 7.2A Is respondent's age in 17a within 1 year of his/her present age or is 17a or present age unknown?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 17c, page 90</i></p>

Section 7 - SOCIAL SITUATIONS (Continued)

<p>17b. Did this FIRST time BEGIN to happen during the last 12 months?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>c. In your ENTIRE LIFE how many SEPARATE times were there when you had a strong fear or avoidance of any social situation?</p> <p>By separate times, I mean times separated by at least 2 months when you WEREN'T afraid of social situations and you DIDN'T try to avoid them.</p> <p><i>If respondent says "All my life" or "There was never a time when I didn't fear or avoid situation", code 1.</i></p>	<p>_____ Number</p>
<p>CHECK ITEM 7.2B Is number entered in 17c, 2 or more or unknown?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 20a</i></p>
<p>18a. How old were you the MOST RECENT time you BEGAN to experience a strong fear or avoidance of any social situation?</p>	<p>_____ Age</p>
<p>CHECK ITEM 7.3A Is respondent's age in 18a within 1 year of his/her present age or is present age or 18a unknown?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 19a</i></p>
<p>18b. Did this MOST RECENT time when you feared or avoided any social situation BEGIN to happen during the last 12 months?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>19a. How long did this MOST RECENT time last when you were afraid of or avoided any social situation?</p>	<p>_____ Week(s) OR _____ Month(s) OR _____ Year(s)</p>
<p>b. Since this MOST RECENT time BEGAN, have there been at least 2 months when you WEREN'T afraid of any social situation and you DIDN'T try to avoid them?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 19d</i></p>
<p>CHECK ITEM 7.3B Is 18b marked "Yes" or unknown?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to 19d</i> 2 <input type="checkbox"/> No</p>
<p>19c. Did this MOST RECENT time when you WEREN'T afraid of any social situation and DIDN'T try to avoid them BEGIN to happen in the last 12 months?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>d. In your ENTIRE LIFE, what was the LONGEST period you had when you were afraid of or avoided any social situation.</p>	<p>_____ Week(s) } OR } <i>SKIP to Check Item 7.4</i> _____ Month(s) } OR } _____ Year(s) }</p>
<p>20a. How long did that period last when you were afraid of or avoided any social situation?</p>	<p>_____ Week(s) OR _____ Month(s) OR _____ Year(s)</p>
<p>b. Since that time BEGAN, have there been at least 2 months when you WEREN'T afraid of any social situation and you DIDN'T try to avoid them?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 7.4</i></p>
<p>CHECK ITEM 7.3C Is 17b marked "Yes"?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to Check item 7.4</i> 2 <input type="checkbox"/> No</p>
<p>20c. Did that time when you WEREN'T afraid of social situations and DIDN'T try to avoid them BEGIN to happen in the last 12 months?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 7.4 Refer to Check Item 2.0, Section 2A, page 9. Is the respondent a lifetime abstainer of alcohol?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to 23, page 91</i> 2 <input type="checkbox"/> No</p>

Section 7 - SOCIAL SITUATIONS (Continued)

<p>21. Did (that time/ANY of those times) when you had a strong fear or avoidance of social situations BEGIN to happen AFTER you were drinking heavily or a lot more than usual?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 23</i></p>
<p>22. Did (that time/ANY of those times) when you had a strong fear or avoidance of social situations BEGIN to happen DURING a period when you were experiencing the bad aftereffects of drinking?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>23. Did (that time/ANY of those times) when you had a strong fear or avoidance of social situations BEGIN to happen AFTER using a medicine or drug?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 7.5</i></p>
<p>24. Did (that time/ANY of those times) when you had a strong fear or avoidance of social situations BEGIN to happen DURING a period when you were experiencing the bad aftereffects of a medicine or drug?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 7.5 Is at least 1 item marked "Yes" in 21, 22, 23 or 24?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 26</i></p>
<p>CHECK ITEM 7.6A Is Check Item 7.2B marked "No"?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 7.6B</i></p>
<p>25a. During that time, did you STOP (drinking heavily/using any medicines or drugs/experiencing the bad aftereffects of drinking/medicines or drugs) for at least 1 month?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 26</i></p>
<p>b. Did you CONTINUE to have a strong fear or avoidance of any social situation for at least 1 month AFTER you STOPPED (drinking heavily/using any medicines or drugs/experiencing the bad aftereffects of drinking/medicines or drugs)?</p>	<p>1 <input type="checkbox"/> Yes } <i>SKIP to 26, page 92</i> 2 <input type="checkbox"/> No }</p>
<p>CHECK ITEM 7.6B Is 17b marked "Yes" or 18b marked "Yes" or 19c marked "Yes" or 19b marked "No"?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 7.6C</i></p>
<p>25c. Did ANY of the times when you had a strong fear or avoidance of social situations in the last 12 months BEGIN to happen (after drinking heavily/using a medicine or drug/when you were experiencing the bad aftereffects of drinking/medicines or drugs)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 7.6C</i></p>
<p>d. Did they ALL BEGIN to happen when you were (drinking heavily/using a medicine or drug/experiencing the bad aftereffects of drinking/medicines or drugs)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>e. During ANY of those times in the last 12 months when you had a strong fear or avoidance of social situations after (drinking heavily/using a medicine or drug), did you STOP (drinking heavily/using any medicines or drugs/experiencing the bad aftereffects of drinking/medicines or drugs) for at least 1 month?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 7.6C</i></p>
<p>f. During ALL of those times, did you STOP (drinking heavily/using any medicines or drugs/experiencing the bad aftereffects of drinking/medicines or drugs) for at least 1 month?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>g. Did you CONTINUE to have a strong fear or avoidance of any social situation for at least 1 month AFTER ANY of those times in the last 12 months when you STOPPED (drinking heavily/using any medicines or drugs/ experiencing the bad aftereffects of drinking/medicines or drugs)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 7.6C</i></p>
<p>h. Did you CONTINUE to have a strong fear or avoidance of any social situation for at least 1 month AFTER ALL of those times?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 7.6C Is 17b marked "Yes"?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to 26, page 92</i> 2 <input type="checkbox"/> No</p>

Section 7 - SOCIAL SITUATIONS (Continued)

<p>25i. Did ANY of the times when you had a strong fear or avoidance of social situations BEFORE 12 months ago BEGIN to happen (after drinking heavily/using a medicine or drug/when you were experiencing the bad aftereffects of drinking/medicines or drugs)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 26</i></p>
<p>j. Did they ALL BEGIN to happen (after drinking heavily/using a medicine or drug/when you were experiencing the bad aftereffects of drinking/medicines or drugs)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>k. During ANY of those times BEFORE 12 months ago when you had a strong fear or avoidance of social situations after (drinking heavily/using a medicine or drug), did you STOP (drinking heavily/using any medicines or drugs/experiencing the bad aftereffects of drinking/medicines or drugs) for at least 1 month?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP 26</i></p>
<p>l. During ALL of those times, did you STOP (drinking heavily/using any medicines or drugs/experiencing the bad aftereffects of drinking/medicines or drugs) for at least 1 month?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>m. Did you CONTINUE to have a strong fear or avoidance of any social situation for at least 1 month AFTER ANY of those times BEFORE 12 months ago when you STOPPED (drinking heavily/using any medicines or drugs/experiencing the bad aftereffects of drinking/medicines or drugs)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 26</i></p>
<p>n. Did you CONTINUE to have a strong fear or avoidance of any social situation for at least 1 month AFTER ALL of those times?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>26. Did you EVER go to any kind of counselor, therapist, doctor, psychologist or any person like that to get help for your fear or avoidance of social situations?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>27. Did you EVER go to an emergency room to get help for your fear or avoidance of social situations?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>28. Were you EVER a patient in any kind of hospital overnight or longer because of your fear or avoidance of any social situation?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>29. Did a doctor EVER prescribe any medicines or drugs for your fear or avoidance of social situations?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 7.7 Is at least 1 item marked "Yes" in 26 - 29? Did respondent ever seek help for fear of social situations?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 7.7A</i></p>
<p>30a. About how old were you the FIRST time you went anywhere or saw anyone to get help for your fear or avoidance of social situations?</p>	<p>_____ Age</p>
<p>b. How old were you the MOST RECENT time you went anywhere or saw anyone to get help for your fear or avoidance of social situations?</p>	<p>_____ Age OR 0 <input type="checkbox"/> Happened only once</p>
<p>CHECK ITEM 7.7A Refer to Check Item 2.0, Section 2A, page 9. Is the respondent a lifetime abstainer of alcohol?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to Check Item 7.7B, page 93</i> 2 <input type="checkbox"/> No</p>
<p>31a. Did you EVER drink alcohol to reduce your fear or avoidance of any social situation?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 7.7B, page 93</i></p>
<p>b. Did this happen during the last 12 months?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 7.7B, page 93</i></p>
<p>c. Did this happen before 12 months ago, that is, before last (Month one year ago)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>

Section 7 - SOCIAL SITUATIONS (Continued)

CHECK ITEM 7.7B	<p><i>Refer to Check Item 3.10, Section 3B, page 39.</i></p> <p>Is the respondent a lifetime non-drug user?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to Check Item 7.8</i></p> <p>2 <input type="checkbox"/> No</p>
<p>32a. Did you EVER take any medicines or drugs ON YOUR OWN, that is without a prescription, in greater amounts or more often or longer than prescribed to reduce your fear or avoidance of social situations?</p>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No - <i>SKIP to Check Item 7.8</i></p>	
<p>b. Did this happen during the last 12 months?</p>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No - <i>SKIP to Check Item 7.8</i></p>	
<p>c. Did this happen before 12 months ago, that is, before last (Month one year ago)?</p>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p>	
CHECK ITEM 7.8	<p>Check Item 7.2B marked "No"?</p>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No - <i>SKIP to Check Item 7.9A</i></p>
<p>33a. Did your fear or avoidance of social situations BEGIN to happen during a time when you were physically ill or getting over being physically ill?</p>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No - <i>SKIP to 34a</i></p>	
<p>b. Did a doctor or other health professional tell you that your fear or avoidance of social situations was related to your physical illness or medical condition?</p>	<p>1 <input type="checkbox"/> Yes } <i>SKIP to 34a</i></p> <p>2 <input type="checkbox"/> No }</p>	
CHECK ITEM 7.9A	<p>Is 17b marked "Yes" or 18b marked "Yes" or 19c marked "Yes" or 19b marked "No"?</p>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No - <i>SKIP to Check Item 7.9B</i></p>
<p>33c. Did ANY of the times when you feared or avoided social situations in the last 12 months BEGIN to happen DURING a time you were physically ill or getting over being physically ill?</p>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No - <i>SKIP to Check Item 7.9B</i></p>	
<p>d. Did ALL of those times when you feared or avoided social situations in the last 12 months ONLY BEGIN to happen DURING times when you were physically ill or getting over being physically ill?</p>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No - <i>SKIP to 33f</i></p>	
<p>e. Did a doctor or other health professional tell you that ALL of the times like this were related to your physical illness or medical condition?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to Check Item 7.9B</i></p> <p>2 <input type="checkbox"/> No</p>	
<p>f. Did a doctor or other health professional tell you that ANY of the times like this were related to your physical illness or medical condition?</p>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p>	
CHECK ITEM 7.9B	<p>Is 17b marked "Yes"?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to 34a</i></p> <p>2 <input type="checkbox"/> No</p>
<p>33g. Did ANY of the times when you feared or avoided social situations BEFORE 12 months ago BEGIN to happen DURING a time when you were physically ill or getting over being ill?</p>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No - <i>SKIP to 34a</i></p>	
<p>h. Did ALL of those times when you feared or avoided social situations BEFORE 12 months ago ONLY BEGIN to happen DURING times when you were physically ill or getting over being physically ill?</p>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No - <i>SKIP to 33j</i></p>	
<p>i. Did a doctor or other health professional tell you that ALL of the times like this were related to your physical illness or medical condition?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to 34a</i></p> <p>2 <input type="checkbox"/> No</p>	
<p>j. Did a doctor or other health professional tell you that ANY of the times like this were related to your physical illness or medical condition?</p>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p>	
<p>34a. Did your fear or avoidance of social situations EVER happen during a period when you were afraid you might be embarrassed by a physical problem that you couldn't always control - like stuttering, twitching, blinking your eyes, or being unable to control your bladder?</p>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No - <i>SKIP to 35a, page 94</i></p>	
<p>b. Did your fear of social situations ONLY happen when you were afraid you might be embarrassed by a physical problem you couldn't always control?</p>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p>	

Section 7 - SOCIAL SITUATIONS (Continued)

<p>35a. Did your fear or avoidance of social situations EVER happen during a period when you were afraid you might be embarrassed by your eating habits - like eating large amounts of food in a very short period of time (<i>PAUSE</i>) or eating too little because you were afraid of getting too fat?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 36a</i></p>
<p>b. Did your fear of social situations ONLY happen when you were afraid you might be embarrassed by your eating habits?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>36a. Did your fear or avoidance of social situations EVER happen during a period when you were afraid you might be embarrassed by a physical illness or problem or something you felt was terribly wrong with the way you looked?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 37a</i></p>
<p>b. Did your fear of social situations ONLY happen when you were afraid you might be embarrassed by a physical illness or problem or something you felt was terribly wrong with the way you looked?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>37a. Did your fear or avoidance of social situations EVER happen during a period when you were thinking about an extremely stressful experience you had in the past - like being in a war, being attacked, or being in a bad accident or a fire?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 38a</i></p>
<p>b. Did your fear of social situations ONLY happen when you were thinking about an extremely stressful experience you had in the past?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>38a. Did your fear or avoidance of social situations EVER happen during a period when you were frightened, nervous or worried about being away from home or away from the people who were important to you?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 39a</i></p>
<p>b. Did your fear of social situations ONLY happen when you were frightened, nervous or worried about being away from home or away from the people who were important to you?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>39a. Did your fear or avoidance of social situations EVER happen during a period when you were afraid of being contaminated by dirt or germs?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 40a</i></p>
<p>b. Did your fear of social situations ONLY happen when you were afraid of being contaminated by dirt or germs?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>40a. Did your fear or avoidance of social situations EVER happen during a period when you were afraid you might be embarrassed by having to do something over and over to make yourself comfortable - like counting, checking, ordering or repeating things over and over?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 41a</i></p>
<p>b. Did your fear of social situations ONLY happen when you were afraid you might be embarrassed by having to do something over and over to make yourself comfortable?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>41a. Did your fear or avoidance of social situations EVER happen during a period when you were afraid that you WOULDN'T be able to do things over and over to make yourself comfortable?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Section 8, page 95</i></p>
<p>b. Did your fear of social situations ONLY happen when you were afraid that you WOULDN'T be able to do things over and over to make yourself comfortable?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } <i>Go to Section 8, page 95</i></p>

Section 8 - SPECIFIC SITUATIONS

Statement V

The next few questions are about objects or OTHER situations which may have made you nervous at some time in your life.

<p>1a. Some people have such a strong fear of SPECIFIC SITUATIONS or OBJECTS that they become very frightened and nervous in such situations or THINKING ABOUT such objects or situations, or they try to avoid them.</p> <p>Have you EVER had a strong fear or avoidance of . . . (Repeat phrase frequently)</p>	
<p>(1) Insects, snakes, birds or other animals?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(2) Heights - like tall buildings, bridges or mountains?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(3) Storms, thunder or lightning?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(4) Being in or on the water - like swimming or boating?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(5) Flying?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(6) Being in a crowd or standing in a line?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(7) Being in closed spaces - like a cave, tunnel or elevator?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(8) Seeing blood or getting an injection?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(9) Traveling in buses, cars or trains?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(10) Going to the dentist?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(11) Visiting or being in a hospital?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(12) Being outside your home alone?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>b. Have you EVER had a strong fear or avoidance of any other SPECIFIC object or situation? Do not include social situations.</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 8.0 Is at least 1 item marked "Yes" in 1a (1) - (12) or in 1b?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Section 9, page 101</i></p>
<p>2. When you had to be near any of these objects or in any of these situations, did you USUALLY become upset, nervous or anxious?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>3. Did THINKING about any of these objects or situations ALMOST ALWAYS make you nervous, frightened or anxious?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>4. Did you ever go near any of these objects or into any of these situations because you had to be there, even though they made you very nervous, frightened or anxious?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>5. Did you avoid any of these objects or situations because of your STRONG FEAR OF THEM?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>6. Did you ever think that you were more frightened and nervous of these objects or situations than most people?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>7. Did you ever think that your fear of any of these objects or situations was stronger than it should have been?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>

Section 8 - SPECIFIC SITUATIONS (Continued)

CHECK ITEM 8.1	Is Check Item 6.3, Section 6, page 83, marked "Yes"?	
	Did respondent ever have a panic attack?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 13</i>
8a.	When you were near any of these objects or in any of the situations that made you frightened, nervous or anxious, did you EVER have a panic attack?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 9</i>
b.	Did your panic attacks ONLY happen when you were near any of these objects or in any of these situations or when you thought you might have to be near them or in them?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
9.	Were you ever frightened of any of these objects or situations because you were afraid of having a panic attack or afraid you might be embarrassed or not able to find help if you had a panic attack?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
10.	Did you avoid any of these objects or situations because you were afraid of having a panic attack?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
11.	Did you ever go near any of these objects or go into any of these situations because you had to, even though you were worried about having a panic attack?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
12.	When you had to be near any of these objects or in any of these situations, did you need to bring someone along with you in case you had a panic attack?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
13.	<p>Did being near any of these objects or in any of these situations, or THINKING ABOUT THEM or avoiding them, EVER . . . (Repeat phrase frequently)</p> <p>(1) Upset you or make you feel uncomfortable?</p> <hr/> <p>(2) Interfere with your relationships with other people - like arguing with them or avoiding them?</p> <hr/> <p>(3) Interfere with doing things you were supposed to do - like working, doing your schoolwork, or taking care of your home or family?</p> <hr/> <p>(4) Restrict your usual activities in any way?</p> <hr/> <p>(5) Keep you from doing something you wanted to do?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <hr/> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <hr/> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <hr/> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <hr/> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
14a.	About how old were you the FIRST TIME you BEGAN to experience a strong fear or avoidance of any of these objects or situations?	_____ Age
CHECK ITEM 8.2	Is respondent's age in 14a within 1 year of his/her present age or is present age or 14a unknown?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 14c</i>
14b.	Did this FIRST time BEGIN to happen during the last 12 months?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
c.	<p>In your ENTIRE LIFE, how many SEPARATE times were there when you had a strong fear or avoidance of any of these objects or situations?</p> <p>By separate times, I mean times separated by at least 2 months when you WEREN'T afraid of any of these objects or situations and you DIDN'T try to avoid them.</p> <p><i>If respondent says "All my life" or "There was never a time when I didn't fear or avoid object or situation", code 1.</i></p>	_____ Number
CHECK ITEM 8.2A	Is number entered in 14c, 2 or more or unknown?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 17a, page 97</i>
15a.	How old were you the MOST RECENT time you BEGAN to experience a strong fear or avoidance of any of these objects or situations?	_____ Age

Section 8 - SPECIFIC SITUATIONS (Continued)

CHECK ITEM 8.3A	Is respondent's age in 15a within 1 year of his/her present age or is present age or 15a unknown?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 16a</i>
15b.	Did this MOST RECENT time when you feared or avoided any of these objects or situations BEGIN to happen during the last 12 months?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
16a.	How long did this MOST RECENT time last when you were afraid of or avoided any of these objects or situations?	____ Week(s) OR ____ Month(s) OR ____ Year(s)
b.	Since the MOST RECENT time BEGAN , have there been at least 2 months when you WEREN'T afraid of any of these objects or situations and you DIDN'T try to avoid them?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 16d</i>
CHECK ITEM 8.3B	Is 15b marked "Yes"?	1 <input type="checkbox"/> Yes - <i>SKIP to 16d</i> 2 <input type="checkbox"/> No
16c.	Did this MOST RECENT time when you WEREN'T afraid of any of these objects or situations and you DIDN'T try to avoid them BEGIN to happen during the last 12 months?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
d.	In your ENTIRE LIFE , what was the LONGEST period you had when you were afraid or avoided of any of these objects or situations?	____ Week(s) OR ____ Month(s) OR ____ Year(s) } <i>SKIP to Check Item 8.4</i>
17a.	How long did that period last when you were afraid of or avoided any of these objects or situations?	____ Week(s) OR ____ Month(s) OR ____ Year(s)
b.	Since that time BEGAN , have there been at least 2 months when you WEREN'T afraid of any of these objects or situations and you DIDN'T try to avoid them?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 8.4</i>
CHECK ITEM 8.3C	Is 14b marked "Yes"?	1 <input type="checkbox"/> Yes - <i>SKIP to Check Item 8.4</i> 2 <input type="checkbox"/> No
17c.	Did that time when you WEREN'T afraid of any of these objects or situations and you DIDN'T try to avoid them BEGIN to happen during the last 12 months?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
CHECK ITEM 8.4	<i>Refer to Check Item 2.0, Section 2A, page 9.</i> Is respondent a lifetime abstainer of alcohol?	1 <input type="checkbox"/> Yes - <i>SKIP to 20</i> 2 <input type="checkbox"/> No
18.	Did (that time/ ANY of those times) when you had a strong fear or avoidance of these objects or situations BEGIN to happen AFTER you were drinking heavily or a lot more than usual?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 20</i>
19.	Did (that time/ ANY of those times) when you had a strong fear or avoidance of these objects or situations BEGIN to happen DURING a period when you were experiencing the bad aftereffects of drinking?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
20.	Did (that time/ ANY of those times) when you had a strong fear or avoidance of these objects or situations BEGIN to happen AFTER using a medicine or drug?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 8.5</i>
21.	Did (that time/ ANY of those times) when you had a strong fear or avoidance of these objects or situations BEGIN to happen DURING a period when you were experiencing the bad aftereffects of a medicine or drug?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
CHECK ITEM 8.5	Is at least 1 item marked "Yes" in 18, 19, 20 OR 21?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 23, page 99</i>
CHECK ITEM 8.6A	Is Check Item 8.2A marked "No"?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 8.6B, page 98</i>

Section 8 - SPECIFIC SITUATIONS (Continued)

<p>22a. During that time, did you STOP (drinking heavily/using any medicines or drugs/experiencing the bad aftereffects of drinking/medicines or drugs) for at least 1 month?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 23</i></p>
<p>b. Did you CONTINUE to have a strong fear or avoidance of any of these objects or situations for at least 1 month AFTER you STOPPED (drinking heavily/using any medicines or drugs/ experiencing the bad aftereffects of drinking/medicines or drugs)?</p>	<p>1 <input type="checkbox"/> Yes } 2 <input type="checkbox"/> No } <i>SKIP to 23</i></p>
<p>CHECK ITEM 8.6B Is 14b marked “Yes” or 15b marked “Yes” or 16c marked “Yes” or 16b marked “No”?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 8.6C</i></p>
<p>22c. Did ANY of the times when you had a strong fear or avoidance of these objects or situations in the last 12 months BEGIN to happen (after drinking heavily/using a medicine or drug/when you were experiencing the bad aftereffects of drinking/medicines or drugs)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 8.6C</i></p>
<p>d. Did they ALL BEGIN to happen (after drinking heavily/ using a medicine or drug/when you were experiencing the bad aftereffects of drinking/medicines or drugs)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>e. During ANY of those times in the last 12 months when you had a strong fear or avoidance of these objects or situations after (drinking heavily/using a medicine or drug), did you STOP (drinking heavily/using any medicines or drugs/ experiencing the bad aftereffects of drinking/medicines or drugs) for at least 1 month?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 8.6C</i></p>
<p>f. During ALL of those times, did you STOP (drinking heavily/using any medicines or drugs/experiencing the bad aftereffects of drinking/medicines or drugs) for at least 1 month?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>g. Did you CONTINUE to have a strong fear or avoidance of any of these objects or situations for at least 1 month AFTER ANY of those times in the last 12 months when you STOPPED (drinking heavily/using any medicines or drugs/ experiencing the bad aftereffects of drinking/medicines or drugs)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 8.6C</i></p>
<p>h. Did you CONTINUE to have a strong fear or avoidance of any of these objects or situations for at least 1 month AFTER ALL of those times?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 8.6C Is 14b marked “Yes”?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to 23, page 99</i> 2 <input type="checkbox"/> No</p>
<p>22i. Did ANY of the times when you had a strong fear of avoidance of these objects or situations BEFORE 12 months ago BEGIN to happen (after drinking heavily/using a medicine or drug/when you were experiencing the bad aftereffects of drinking/medicines or drugs)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 23, page 99</i></p>
<p>j. Did they ALL BEGIN to happen (after drinking heavily/ using a medicine or drug/when you were experiencing the bad aftereffects of drinking/medicines or drugs)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>k. During ANY of those times BEFORE 12 months ago when you had a strong fear or avoidance of these objects or situations after (drinking heavily/using a medicine or drug) did you STOP (drinking heavily/using any medicines or drugs/experiencing the bad aftereffects of drinking/medicines or drugs) for at least 1 month?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 23, page 99</i></p>
<p>l. During ALL of those times, did you STOP (drinking heavily/using any medicines or drugs/experiencing the bad aftereffects of drinking or medicines or drugs) for at least 1 month?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>m. Did you CONTINUE to have a strong fear or avoidance of any of these objects or situations for at least 1 month AFTER ANY of those times BEFORE 12 months ago when you STOPPED (drinking heavily/using any medicines or drugs/experiencing the bad aftereffects of drinking/ medicines or drugs)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 23, page 99</i></p>
<p>n. Did you CONTINUE to have a strong fear or avoidance of any of these objects or situations for at least 1 month AFTER ALL of those times?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>

Section 8 - SPECIFIC SITUATIONS (Continued)

<p>23. Did you EVER go to any counselor, therapist, doctor, psychologist or any person like that to get help for your fear or avoidance of any of these objects or situations?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>24a. Did you EVER go to an emergency room to get help for your fear or avoidance of any of these objects or situations?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>b. Were you EVER a patient in any kind of hospital overnight or longer because of your fear or avoidance of any of these objects or situations?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>25. Did a doctor EVER prescribe any medicines or drugs for your fear or avoidance of any of these objects or situations?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 8.7 Is at least 1 item marked “Yes” in 23 - 25? Did respondent ever seek help for his/her fear or avoidance of an object or situation?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 8.7A</i></p>
<p>26a. About how old were you the FIRST time you went anywhere or saw anyone to get help for your fear or avoidance of any of these objects or situations?</p>	<p>_____ Age</p>
<p>b. How old were you the MOST RECENT time you went anywhere or saw anyone to get help for your fear or avoidance of any of these objects or situations?</p>	<p>_____ Age OR 0 <input type="checkbox"/> Happened only once</p>
<p>CHECK ITEM 8.7A Refer to Check Item 2.0, Section 2A, page 9. Is the respondent a lifetime abstainer of alcohol?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to Check Item 8.7B</i> 2 <input type="checkbox"/> No</p>
<p>27a. Did you EVER drink alcohol to reduce your fear or avoidance of any of these objects or situations?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 8.7B</i></p>
<p>b. Did this happen during the last 12 months?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No — <i>SKIP to Check Item 8.7B</i></p>
<p>c. Did this happen before 12 months ago, that is, before last (Month one year ago)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 8.7B Refer to Check Item 3.10, Section 3B, page 39. Is the respondent a lifetime non-drug user?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to Check Item 8.8</i> 2 <input type="checkbox"/> No</p>
<p>28a. Did you EVER take any medicines or drugs ON YOUR OWN, that is without a prescription, in greater amounts, or more often or longer than prescribed to reduce your fear or avoidance of any of these objects or situations?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 8.8</i></p>
<p>b. Did this happen during the last 12 months?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 8.8</i></p>
<p>c. Did this happen before 12 months ago, that is before last (Month one year ago)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 8.8 Is Check Item 8.2A marked “No”?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 8.9A</i></p>
<p>29a. Did your fear or avoidance of these objects or situations BEGIN to happen during a time when you were physically ill or getting over being physically ill?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 31a, page 100</i></p>
<p>b. Did a doctor or other health professional tell you that your fear of these objects or situations was related to your physical illness or medical condition?</p>	<p>1 <input type="checkbox"/> Yes } 2 <input type="checkbox"/> No } <i>SKIP to 31a, page 100</i></p>
<p>CHECK ITEM 8.9A Is 14b marked “Yes” or 15b marked “Yes” or 16c marked “Yes” or 16b marked “No”?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 8.9B, page 100</i></p>
<p>30a. Did ANY of the times when you feared or avoided these objects or situations in the last 12 months BEGIN to happen DURING a time when you were physically ill or getting over being physically ill?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 8.9B, page 100</i></p>

Section 8 - SPECIFIC SITUATIONS (Continued)

<p>30b. Did ALL of those times when you feared or avoided these objects or situations in the last 12 months ONLY BEGIN to happen DURING times when you were physically ill or getting being ill?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 30d</i></p>
<p>c. Did a doctor or other health professional tell you that ALL of the times like this were related to your physical illness or medical condition?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to Check Item 8.9B</i> 2 <input type="checkbox"/> No</p>
<p>d. Did a doctor or other health professional tell you that ANY of the times like this were related to your physical illness or medical condition?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 8.9B Is 14b marked "Yes"?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to 31a</i> 2 <input type="checkbox"/> No</p>
<p>30e. Did ANY of the times when you feared or avoided these objects or situations BEFORE 12 months ago BEGIN to happen DURING a time when you were physically ill or getting over being ill?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 31a</i></p>
<p>f. Did ALL of those times when you feared or avoided these objects or situations BEFORE 12 months ago ONLY BEGIN to happen DURING times when you were physically ill or getting over being ill?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 30h</i></p>
<p>g. Did a doctor or other health professional tell you that ALL of the times like this were related to your physical illness or medical condition?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to 31a</i> 2 <input type="checkbox"/> No</p>
<p>h. Did a doctor or other health professional tell you that ANY of the times like this were related to your physical illness or medical condition?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>31a. Did your fear or avoidance of these objects or situations EVER happen during a time when you were THINKING ABOUT an extremely stressful experience you had in the past - like being in a war, being attacked, or being in a bad accident or a fire?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 32a</i></p>
<p>b. Did your fear of these objects or situations ONLY happen when you were thinking about an extremely stressful experience you had in the past?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>32a. Did your fear or avoidance of these objects or situations EVER happen during a time when you were frightened, nervous or worried about being away from home or away from people who were important to you?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 33a</i></p>
<p>b. Did your fear of these objects or situations ONLY happen when you were nervous or worried about being away from home or away from the people who were important to you?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>33a. Did your fear or avoidance of these objects or situations EVER happen during a time when you were afraid of being contaminated by dirt or germs?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 34a</i></p>
<p>b. Did your fear of these objects or situations ONLY happen when you were afraid of being contaminated by dirt or germs?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>34a. Did your fear or avoidance of these objects or situations EVER happen during a time when you were afraid of having to do something over and over to make yourself comfortable - like counting, checking, ordering, and repeating things over and over?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 35a</i></p>
<p>b. Did your fear of these objects or situations ONLY happen when you were afraid you might be embarrassed by having to do something over and over to make yourself feel comfortable?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>35a. Did your fear or avoidance of these objects or situations EVER happen during a time when you were afraid that you WOULDN'T be able to do things over and over to make yourself feel comfortable?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Section 9, page 101</i></p>
<p>b. Did your fear of these objects or situations ONLY happen when you were afraid you WOULDN'T be able to do things over and over to make yourself feel comfortable?</p>	<p>1 <input type="checkbox"/> Yes } <i>Go to Section 9, page 101</i> 2 <input type="checkbox"/> No }</p>

Section 9 - GENERAL ANXIETY

Statement W

Now I'd like to ask you about times in your life when you may have been tense, nervous, or worried over a long period of time.

1a. Have you EVER had a time lasting at least 6 months when you felt tense, nervous, or worried most of the time?	1 <input type="checkbox"/> Yes - <i>SKIP to 3</i> 2 <input type="checkbox"/> No
b. Have you EVER had a time lasting at least 6 months when you felt very tense, nervous or worried most of the time about everyday problems?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Section 10, page 109</i>
3. Now I'd like you to think about your WORST period lasting at least 6 months when you were the most tense, nervous or worried. During your worst period of feeling tense, nervous or worried for 6 months or more, did you EVER . . . <i>(Repeat phrase frequently)</i>	
(1) Worry a lot about things you usually didn't worry about?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(2) Worry about more than one thing?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(3) Find it difficult to stop being tense, nervous or worried?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(4) Worry about things that were very unlikely to happen?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(5) Think that your worrying was excessive?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(6) Worry about things that weren't really serious?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(7) Worry about what other people might do or what would happen to them?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
4. During your worst period of 6 months or more when you were very tense, nervous or worried, did you OFTEN . . . <i>(Repeat entire phrase frequently)</i>	
(1) Get tired easily?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(2) Become startled easily?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(3) Have tense, sore or aching muscles?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(4) Become so restless that you fidgeted, paced, or couldn't sit still?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(5) Feel keyed up or on edge?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(6) Have trouble concentrating or keeping your mind on things?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(7) Feel irritable?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(8) Have trouble falling asleep or staying asleep?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(9) Have times when you forgot what you were talking about or your mind went blank?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(10) Feel your heart racing, skipping, or pounding in your chest?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No

Section 9 - GENERAL ANXIETY (Continued)

<p>4. During your worst period of 6 months or more when you were very tense, nervous or worried, did you OFTEN . . . <i>(Repeat entire phrase frequently)</i></p> <p>(11) Perspire or sweat?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(12) Have cold and clammy hands?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(13) Have a dry mouth?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(14) Feel dizzy, lightheaded, or like you might faint?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(15) Feel nauseous, have an upset stomach, or feel like you might vomit or have diarrhea?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(16) Urinate frequently?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(17) Have trouble swallowing or feel like you had a lump in your throat?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(18) Have pain or pressure in your chest?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(19) Find yourself trembling or shaking?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(20) Have trouble catching your breath or feel like you were smothering?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 9.3 Are at least 3 items marked "Yes" in 4(1) - 4(20), pages 101 - 102?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Section 10, page 109</i></p>
<p>5. Now I'd like to ask you about some things that might have happened to you during your worst period when you felt nervous or worried most of the time for at least 6 months and had some of the other experiences you just mentioned at the same time.</p> <p>During that period, did you . . . <i>(Repeat phrase frequently)</i></p> <p>(1) Feel uncomfortable or upset about feeling nervous or anxious or by any of these other things that were going on at the same time?</p> <p>(2) Have arguments or friction with family, friends, people at work or anyone else?</p> <p>(3) Have difficulty doing things you were supposed to do - like working, doing your schoolwork, or taking care of your home or family?</p> <p>(4) Restrict your usual activities in any way?</p> <p>(5) Find that you were unable to do something you wanted to do?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>6a. About how old were you the FIRST time you BEGAN to feel tense, nervous or worried for at least 6 months and also had some of the other experiences you mentioned?</p>	<p>_____ Age</p>
<p>CHECK ITEM 9.4 Is respondent's age in 6a within 1 year of his/her present age or is present age or 6a unknown?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 7</i></p>
<p>6b. Did this FIRST time BEGIN to happen during the last 12 months?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>7. In your ENTIRE LIFE, how many SEPARATE times lasting at least 6 months were there when you felt tense, nervous or worried for most of the time and had some of the other experiences you mentioned?</p> <p>By separate times, I mean times separated by at least 2 months when you DIDN'T feel tense, nervous or worried AND you DIDN'T have ANY of these OTHER experiences.</p>	<p>_____ Number</p>

Section 9 - GENERAL ANXIETY (Continued)

CHECK ITEM 9.5	Is number entered in 7, 2 or more or unknown?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 9e</i>
8a.	How old were you the MOST RECENT time you BEGAN to feel tense, nervous or worried most of the time for at least 6 months and also had some of those other experiences?	_____ Age
CHECK ITEM 9.6	Is respondent's age in 8a within 1 year of his/her present age or is present age or 8a unknown?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 9a</i>
8b.	Did this MOST RECENT time when you felt tense, nervous or worried BEGIN to happen in the last 12 months?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
9a.	How long did this MOST RECENT period last when you felt tense, nervous, or worried? <i>(Must be at least 6 months.)</i>	_____ Month(s) OR _____ Year(s)
b.	Since this MOST RECENT time BEGAN , have there been at least 2 months when you DIDN'T feel tense, nervous or worried AND DIDN'T have any of the OTHER experiences you mentioned?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 9d</i>
c.	Did this MOST RECENT time when you DIDN'T feel tense, nervous or worried BEGIN to happen during the last 12 months?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
d.	In your ENTIRE LIFE , what was the LONGEST period you had when you felt tense, nervous or worried most of the time? <i>(Must be at least 6 months.)</i>	_____ Months } OR } <i>SKIP to Check Item 9.7</i> _____ Year(s) }
e.	How long did that period last when you felt tense, nervous, or worried most of the time? <i>(Must be at least 6 months.)</i>	_____ Month(s) OR _____ Year(s)
f.	Since that time BEGAN , have there been at least 6 months when you DIDN'T feel tense, nervous or worried AND DIDN'T have any of the OTHER experiences you mentioned?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 9.7</i>
CHECK ITEM 9.6A	Is 6b marked "Yes"?	1 <input type="checkbox"/> Yes - <i>SKIP to Check Item 9.7</i> 2 <input type="checkbox"/> No
9g.	Did that time when you DIDN'T feel tense, nervous or worried BEGIN to happen during the last 12 months?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
CHECK ITEM 9.7	<i>Refer to Check Item 2.0, Section 2A, page 9.</i> Is respondent a lifetime abstainer of alcohol?	1 <input type="checkbox"/> Yes - <i>SKIP to 12</i> 2 <input type="checkbox"/> No
10.	Did (that time/ ANY of those times) when you were tense, nervous or worried for at least 6 months BEGIN to happen AFTER you were drinking heavily or a lot more than usual?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 12</i>
11.	Did (that time/ ANY of those times) when you were tense, nervous or worried for at least 6 months BEGIN to happen DURING a period when you were experiencing the bad aftereffects of drinking?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
12.	Did (that time/ ANY of those times) when you were tense, nervous or worried for at least 6 months BEGIN to happen AFTER using a medicine or drug?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 9.8</i>
13.	Did (that time/ ANY of those times) when you were tense, nervous or worried for at least 6 months BEGIN to happen DURING a period when you were experiencing the bad aftereffects of a medicine or drug?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
CHECK ITEM 9.8	Is at least 1 item marked "Yes" in 10, 11, 12 OR 13?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 15, page 105</i>
CHECK ITEM 9.9	Is Check Item 9.5 marked "No"?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 9.10, page 104</i>

Section 9 - GENERAL ANXIETY (Continued)

<p>14a. During that time, did you STOP (drinking heavily/using any medicines or drugs/experiencing the bad aftereffects of drinking/medicines or drugs) for at least 1 month?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - SKIP to 15, page 105</p>
<p>b. Did you CONTINUE to feel tense, nervous or worried for at least 1 month AFTER you STOPPED (drinking heavily/using any medicines or drugs/experiencing the bad aftereffects of drinking/medicines or drugs)?</p>	<p>1 <input type="checkbox"/> Yes } 2 <input type="checkbox"/> No } SKIP to 15, page 105</p>
<p>CHECK ITEM 9.10 Is 6b marked "Yes" or 8b marked "Yes" or 9c marked "Yes" or 9b marked "No"?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - SKIP to Check Item 9.10A</p>
<p>14c. Did ANY of those times in the last 12 months when you were tense, nervous or worried for at least 6 months BEGIN to happen (after drinking heavily/using a medicine or drug/when you were experiencing the bad aftereffects of drinking/medicines or drugs)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - SKIP to Check Item 9.10A</p>
<p>d. Did they ALL BEGIN to happen (after drinking heavily/using a medicine or drug/when you were experiencing the bad aftereffects of drinking/medicine or drugs)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>e. During ANY of those times in the last 12 months when you were tense, nervous or worried for at least 6 months after (drinking heavily/using a medicine or drug), did you STOP (drinking/using any medicines or drugs /experiencing the bad aftereffects of drinking/medicines or drugs) for at least 1 month?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - SKIP to Check Item 9.10A</p>
<p>f. During ALL of those times, did you STOP (drinking heavily/using any medicines or drugs/experiencing the bad aftereffects of drinking/medicines or drugs) for at least 1 month?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>g. Did you CONTINUE to feel tense, nervous or worried for at least 1 month AFTER ANY of those times in the last 12 months when you STOPPED (drinking heavily/ using any medicines or drugs/experiencing the bad aftereffects of drinking/medicines or drugs)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - SKIP to Check Item 9.10A</p>
<p>h. Did you CONTINUE to feel tense, nervous or worried for at least 1 month AFTER ALL of those times?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 9.10A Is 6b marked "Yes"?</p>	<p>1 <input type="checkbox"/> Yes - SKIP to 15, page 105 2 <input type="checkbox"/> No</p>
<p>14i. Did ANY of those times BEFORE 12 months ago when you were tense, nervous or worried for at least 6 months BEGIN to happen (after drinking heavily/using a medicine or drug/when you were experiencing the bad aftereffects of drinking/medicines or drugs)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - SKIP to 15, page 105</p>
<p>j. Did they ALL BEGIN to happen (after drinking heavily/using a medicine or drug/when you were experiencing the bad aftereffects of drinking/medicines or drugs)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>k. During ANY of those times BEFORE 12 months ago when you were tense, nervous or worried for at least 6 months after (drinking heavily/using a medicine or drug), did you STOP (drinking heavily/using any medicines or drugs/experiencing the bad aftereffects of drinking/medicines or drugs) for at least 1 month?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - SKIP to 15, page 105</p>
<p>l. During ALL of those times, did you STOP (drinking heavily/using any medicines or drugs/experiencing the bad aftereffects of drinking/medicines or drugs) for at least 1 month?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>m. Did you CONTINUE to feel tense, nervous or worried for at least 1 month AFTER ANY of those times BEFORE 12 months ago when you STOPPED (drinking heavily/using any medicines or drugs/experiencing the bad aftereffects of drinking/medicines or drugs)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - SKIP to 15, page 105</p>
<p>n. Did you CONTINUE to feel tense, nervous or worried for at least 1 month AFTER ALL of those times?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>

Section 9 - GENERAL ANXIETY (Continued)

<p>15. Did you EVER go to any kind of counselor, therapist, doctor, psychologist or any person like that because you were feeling tense, nervous or worried?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>16a. Did you EVER go to an emergency room to get help for feeling tense, nervous or worried?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>b. Were you EVER a patient in any kind of hospital overnight or longer because you were feeling tense, nervous or worried?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>17. Did a doctor EVER prescribe any medicines or drugs to help calm you down or quiet your nerves?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 9.11 Is at least 1 item marked “Yes” in 15 - 17? Did respondent ever seek help for feeling tense, nervous or worried for at least 6 months?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 9.11A</i></p>
<p>18a. About how old were you the FIRST time you went anywhere or saw anyone to get help for feeling tense, nervous or worried?</p>	<p>_____ Age</p>
<p>b. How old were you the MOST RECENT time you went anywhere or saw anyone to get help for feeling tense, nervous or worried?</p>	<p>_____ Age OR 0 <input type="checkbox"/> Happened only once</p>
<p>CHECK ITEM 9.11A Refer to Check Item 2.0, Section 2A, page 9. Is the respondent a lifetime abstainer of alcohol?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to Check Item 9.11B</i> 2 <input type="checkbox"/> No</p>
<p>19a. Did you EVER drink to calm down or help quiet your nerves when you felt tense, nervous or worried?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 9.11B</i></p>
<p>b. Did this happen during the last 12 months?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 9.11B</i></p>
<p>c. Did this happen before 12 months ago, that is, before last (Month one year ago)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 9.11B Refer to Check Item 3.10, Section 3B, page 39. Is the respondent a lifetime non-drug user?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to Check Item 9.12</i> 2 <input type="checkbox"/> No</p>
<p>20a. Did you EVER take any medicine or drugs ON YOUR OWN, that is, without a prescription, in greater amounts, or more often or longer than prescribed to help calm down or quiet your nerves when you felt tense, nervous, or worried?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 9.12</i></p>
<p>b. Did this happen during the last 12 months?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 9.12</i></p>
<p>c. Did this happen before 12 months ago, that is, before last (Month one year ago)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 9.12 Is Check Item 9.5 marked “No”?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 9.13</i></p>
<p>21a. Did that time when you were tense, nervous or worried for at least 6 months BEGIN to happen DURING a time when you were physically ill or getting over being physically ill?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 22a, page 106</i></p>
<p>b. Did a doctor or other health professional tell you that this time was related to your physical illness or medical condition?</p>	<p>1 <input type="checkbox"/> Yes } <i>SKIP to 22a, page 106</i> 2 <input type="checkbox"/> No }</p>
<p>CHECK ITEM 9.13 Is 6b marked “Yes” or 8b marked “Yes” or 9c marked “Yes” or 9b marked “No”?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 9.13A, page 106</i></p>
<p>21c. Did ANY of the times when you were tense, nervous or worried in the last 12 months BEGIN to happen DURING a time when you were physically ill or getting over being ill?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 9.13A, page 106</i></p>

Section 9 - GENERAL ANXIETY (Continued)

<p>21d. Did ALL of those times when you were tense, nervous or worried in the last 12 months ONLY BEGIN to happen DURING times when you were physically ill or getting over being physically ill?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 21f</i></p>
<p>e. Did a doctor or other health professional tell you that ALL of the times like this were related to your physical illness or medical condition?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to Check Item 9.13A</i> 2 <input type="checkbox"/> No</p>
<p>f. Did a doctor or other health professional tell you that ANY of the times like this were related to you physical illness or medical condition?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 9.13A Is 6b marked "Yes"?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to 22a</i> 2 <input type="checkbox"/> No</p>
<p>21g. Did ANY of the times BEFORE 12 months ago when you were tense, nervous or worried BEGIN to happen DURING a time when you were physically ill or getting over being physically ill?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 22a</i></p>
<p>h. Did ALL of those times BEFORE 12 months ago when you were tense, nervous or worried ONLY BEGIN to happen DURING times when you were physically ill or getting over being physically ill?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 21j</i></p>
<p>i. Did a doctor or other health professional tell you that ALL of the times like this were related to your physical illness or medical condition?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to 22a</i> 2 <input type="checkbox"/> No</p>
<p>j. Did a doctor or other health professional tell you that ANY of the times like this were related to your physical illness or medical condition?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>22a. Did (that time/ANY of those times) when you were tense, nervous or worried for at least 6 months happen during a time when you were worrying about an extremely stressful experience you had in the past - like being in a war, being attacked, or being in a bad accident or a fire?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 23a</i></p>
<p>b. Did ALL of those times ONLY happen when you were thinking about an extremely stressful experience you had in the past?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>23a. Did (that time/ANY of those times) when you were tense, nervous or worried for at least 6 months happen during a time when you were frightened, nervous or worried about being away from home or away from the people who were important to you?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 24a</i></p>
<p>b. Did ALL of those times ONLY happen when you were nervous or worried about being away from home or away from the people who were important to you?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>24a. Did (that time/ANY of those times) when you were tense, nervous or worried for at least 6 months happen during a time when you were afraid of being contaminated by dirt or germs?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 25a</i></p>
<p>b. Did ALL of those times ONLY happen when you were afraid of being contaminated by dirt germs?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>25a. Did (that time/ANY of those times) when you were tense, nervous or worried for at least 6 months happen during a time when you were afraid you might be embarrassed by having to do something over and over to make yourself comfortable - like counting, checking, ordering or repeating things over and over?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 26a</i></p>
<p>b. Did ALL of those times ONLY happen when you were afraid you might be embarrassed by having to do something over and over to make yourself comfortable?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>26a. Did (that time/ANY of those times) when you were tense, nervous or worried for at least 6 months happen during a time when you were afraid that you WOULDN'T be able to do things over and over to make yourself comfortable?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 27a, page 107</i></p>
<p>b. Did ALL of those times ONLY happen when you were afraid that you WOULDN'T be able to do things over and over again to make yourself comfortable?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>

Section 9 - GENERAL ANXIETY (Continued)

<p>27a. Did (that time/ANY of those times) when you were tense, nervous or worried for at least 6 months happen during a time when you were very worried about gaining weight or getting too fat?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 28a</i></p>
<p>b. Did ALL of those times ONLY happen when you were very worried about gaining weight or getting too fat?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>28a. Did (that time/ANY of those times) when you were tense, nervous or worried for at least 6 months happen during a time when you thought you had a serious physical illness even though a doctor assured you there was nothing physically wrong?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 29a</i></p>
<p>b. Did ALL of those times ONLY happen when you thought you had a serious illness even though a doctor assured you there was nothing physically wrong?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>29a. Did (that time/ANY of those times) when you were tense, nervous or worried for at least 6 months happen during a time when you had numerous physical problems that a doctor couldn't fully explain?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 9.14</i></p>
<p>b. Did ALL of those times ONLY happen when you had numerous physical problems that a doctor couldn't fully explain?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 9.14 Is "Yes" marked in Check Item 6.3, Section 6, page 83?</p> <p>Did respondent ever have a panic attack?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 9.15</i></p>
<p>30a. Did (that time/ANY of those times) when you were tense, nervous or worried for at least 6 months happen when you were afraid of having a panic attack?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 9.15</i></p>
<p>b. Did ALL of those times ONLY happen when you were afraid of having a panic attack?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 9.15 Is "Yes" marked in Check Item 4.3, Section 4A, page 62?</p> <p>Has respondent ever had a period of low mood?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 9.16</i></p>
<p>31a. Did (that time/ANY of those times) when you were tense, nervous or worried for at least 6 months happen during a period you mentioned earlier when you felt sad, blue, depressed, or down (<i>PAUSE</i>) or when you didn't care about things or enjoy things that you usually cared about or enjoyed?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 9.16</i></p>
<p>b. Did ALL of those times ONLY happen when you felt very sad, blue, depressed, or down (<i>PAUSE</i>) or when you didn't care about things or enjoy things?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 9.16 Is "Yes" marked in Check Item 5.3, Section 5, Page 77?</p> <p>Has respondent ever had a period of high mood or irritability?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 9.17</i></p>
<p>32a. Did (that time/ANY of those times) when you were tense, nervous or worried for at least 6 months happen during a period you mentioned earlier when you felt extremely good, excited or hyper (<i>PAUSE</i>) or when you felt extremely irritable or easily annoyed?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 9.17</i></p>
<p>b. Did ALL of those times when you were tense, nervous or worried ONLY happen when you felt extremely good, excited or hyper or when you extremely irritable or easily annoyed?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 9.17 Is "Yes" marked in Check Item 7.0, Section 7, page 88?</p> <p>Has respondent ever had a fear or avoidance of social situations?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Section 10, page 109</i></p>

Section 9 - GENERAL ANXIETY (Continued)

33a. Did (that time/ANY of those times) when you were tense, nervous or worried for at least 6 months happen during a time when you were experiencing a strong fear or avoidance of social situations?

- 1 Yes
- 2 No - *SKIP to Section 10, page 109*

b. Did ALL of those times ONLY happen when you were experiencing a strong fear or avoidance of social situations?

- 1 Yes
- 2 No } *Go to Section 10, page 109*

Section 10 - USUAL FEELINGS AND ACTIONS

Statement S

The questions I'm going to ask you now are about how you have felt or acted **MOST** of the time throughout your life regardless of the situation or whom you were with. **Do NOT** include times when you weren't yourself or when you acted differently than usual because you were depressed or hyper, anxious or nervous or drinking heavily, using medicines or drugs or experiencing their bad aftereffects, or times when you were physically ill.

1a. Most of the time throughout your life, regardless of the situation or whom you were with. . . <i>(Repeat phrase frequently)</i>		b. Did this ever trouble you or cause problems at work or school, or with your family or other people?
(1) Have you avoided jobs or tasks that dealt with a lot of people?	1 <input type="checkbox"/> Yes \longrightarrow 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(2) Do you avoid getting involved with people unless you are certain they will like you?	1 <input type="checkbox"/> Yes \longrightarrow 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(3) Do you find it hard to be "open" even with people you are close to?	1 <input type="checkbox"/> Yes \longrightarrow 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(4) Do you often worry about being criticized or rejected in social situations?	1 <input type="checkbox"/> Yes \longrightarrow 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(5) Do you believe that you're not as good, as smart, or as attractive as most other people?	1 <input type="checkbox"/> Yes \longrightarrow 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(6) Are you usually quiet or do you have very little to say when you meet new people because you believe they are better than you are?	1 <input type="checkbox"/> Yes \longrightarrow 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(7) Are you afraid of trying new things or doing things outside your usual routine because you're afraid of being embarrassed?	1 <input type="checkbox"/> Yes \longrightarrow 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(8) Do you need a lot of advice or reassurance from others before you can make everyday decisions-like what to wear or what to order in a restaurant?	1 <input type="checkbox"/> Yes \longrightarrow 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(9) Do you depend on other people to handle important areas in your life such as finances, child care, or living arrangements?	1 <input type="checkbox"/> Yes \longrightarrow 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(10) Do you find it hard to disagree with people even when you think they are wrong because you fear losing their support or approval?	1 <input type="checkbox"/> Yes \longrightarrow 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(11) Do you find it hard to start or work on tasks when there is no one to help you?	1 <input type="checkbox"/> Yes \longrightarrow 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(12) Have you often volunteered to do things even if they are unpleasant in order to get others to like you?	1 <input type="checkbox"/> Yes \longrightarrow 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(13) Do you usually feel uncomfortable when you are by yourself because you are afraid you can't take care of yourself?	1 <input type="checkbox"/> Yes \longrightarrow 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(14) When a close relationship ends, do you feel you immediately have to find someone else to take care of you?	1 <input type="checkbox"/> Yes \longrightarrow 2 <input type="checkbox"/> No - <i>Go to next experience, page 110</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No

Section 10 - USUAL FEELINGS AND ACTIONS (Continued)

1a. Most of the time throughout your life, regardless of the situation or whom you were with. . . (Repeat phrase frequently)	b. Did this ever trouble you or cause problems at work or school, or with your family or other people?	
(15) Have you worried a lot about being left alone to take care of yourself?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(16) Are you the kind of person who focuses on details, order and organization or likes to make lists and schedules?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(17) Do you sometimes get so caught up with details, schedules or organization that you lose sight of what you wanted to accomplish?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(18) Do you have trouble finishing jobs because you spend so much time trying to get things exactly right?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(19) Do you or other people feel that you are so devoted to work or school that you have no time left for anyone else or for just having fun?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(20) Do other people think you have unreasonably high standards and morals about what is right and what is wrong?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(21) Do you have trouble throwing out worn-out or worthless things even if they don't have sentimental value?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(22) Is it hard for you to let other people help you if they don't agree to do things exactly the way you want?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(23) Is it hard for you to spend money on yourself and other people even when you have enough?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(24) Are you often so sure you are right that it doesn't matter what other people say?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(25) Have other people told you that you are stubborn or rigid?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(26) Do you often have to keep an eye out to keep people from using you, hurting you or lying to you?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(27) Do you spend a lot of time wondering if you can trust your friends or the people you work with?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(28) Do you find that it is best not to let other people know much about you because they will use it against you?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(29) Do you often detect hidden threats or insults in things people say or do?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(30) Are you the kind of person who takes a long time to forgive people who have insulted or slighted you?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience, page 111</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No

Section 10 - USUAL FEELINGS AND ACTIONS (Continued)

1a. Most of the time throughout your life, regardless of the situation or whom you were with . . . (Repeat phrase frequently)		b. Did this ever trouble you or cause problems at work or school, or with your family or other people?
(31) Have there been many people you can't forgive because they did or said something to you a long time ago?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(32) Do you often get angry or lash out when someone criticizes or insults you in some way?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(33) Have you OFTEN suspected that your spouse or partner has been unfaithful?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(35) When you are around people, do you often feel that you are being watched or stared at?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(43) Are there very few people that you're really close to outside of your immediate family?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(45) Would you be just as happy without having any close relationships?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(46) Do you take little pleasure in being with other people?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(47) Have you almost always preferred to do things alone rather than with other people?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(48) Could you be content without ever being sexually involved with anyone?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(49) Do you rarely show much emotion?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(50) Are there really very few things that give you pleasure?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(51) Do you rarely react to praise or criticism?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(52) Are you the sort of person who doesn't care about what people think of you?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(53) Do you find that nothing makes you very happy or very sad?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(54) Do you like to be the center of attention?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(55) Do your feelings often change very suddenly or unexpectedly, sometimes for no reason?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience, page 112</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No

Section 10 - USUAL FEELINGS AND ACTIONS (Continued)

1a. Most of the time throughout your life, regardless of the situation or whom you were with . . . <i>(Repeat phrase frequently)</i>	b. Did this ever trouble you or cause problems at work or school, or with your family or other people?	
(56) Do you feel uncomfortable if you are not the center of attention?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(57) Have you ever discovered that people aren't as close to you as you thought they were?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(58) Do you flirt a lot?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(59) Do you display your emotions in obvious or dramatic ways so that people always know how you feel?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(60) Do you often find yourself "coming on" to people?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(61) Do you try to draw attention to yourself by the way you dress or look?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(62) Do you often make a point of being dramatic and colorful?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(63) Have you often changed your mind about things depending on the people you're with or what you have just read or seen on TV?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(64) Do you often express yourself using generalities and very little detail?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to Section 11A, page 116</i>	1 <input type="checkbox"/> Yes } <i>Go to Section 11A,</i> 2 <input type="checkbox"/> No } <i>Page 116</i>

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Section 11A - BEHAVIOR

Statement O

Now I'd like to ask you some questions about experiences you may have had. As I read each experience, please tell me if it has ever happened.

1a. In your ENTIRE life, did you EVER . . . <i>(Repeat entire phrase frequently)</i>		b. Did this happen BEFORE you were 15?	c. Has this happened SINCE you were 15?
(1) Often cut class, not go to class or go to school and then leave without permission?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	Ask Before 13 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	Ask Since 13 1 <input type="checkbox"/> Yes } <i>Go to next experience</i> 2 <input type="checkbox"/> No }
(2) Stay out late at night even though your parents told you to stay home?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	Ask Before 13 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	Ask Since 13 1 <input type="checkbox"/> Yes } <i>Go to next experience</i> 2 <input type="checkbox"/> No }
(3) Have a time when you bullied or pushed people around or tried to make them afraid of you?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes } <i>Go to next experience</i> 2 <input type="checkbox"/> No }
(4) Run away from home overnight at least twice when you were living at home or run away and stay away for a longer time?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes } <i>Go to next experience</i> 2 <input type="checkbox"/> No }
(5) Have a time when you were absent from work or school a lot, other than the times you were sick or taking care of someone else who was sick?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes } <i>Go to next experience</i> 2 <input type="checkbox"/> No }
(6) More than once quit a job without knowing where you would find another one?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes } <i>Go to next experience</i> 2 <input type="checkbox"/> No }
(7) More than once quit a school program without knowing what you would do next?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes } <i>Go to next experience</i> 2 <input type="checkbox"/> No }
(8) Travel around from place to place for a month or more without making any plans ahead of time or not knowing how long you would be gone or where you were going to work?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes } <i>Go to next experience</i> 2 <input type="checkbox"/> No }
(9) Have a time that lasted at least 1 month when you had no regular place to live – like living on the street or in a car?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes } <i>Go to next experience</i> 2 <input type="checkbox"/> No }
(10) Have a time that lasted at least 1 month when you lived with friends, acquaintances or relatives because you didn't really have your own place to live?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience, page 117</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes } <i>Go to next experience, page 117</i> 2 <input type="checkbox"/> No }

Section 11A - BEHAVIOR (Continued)

1a. Did you EVER . . . <i>(Repeat entire phrase frequently)</i>		b. Did this happen BEFORE you were 15?	c. Has this happened SINCE you were 15?
(11) Have a time in your life when you lied a lot, not counting any times you lied to keep from being hurt?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes } <i>Go to next</i> 2 <input type="checkbox"/> No } <i>experience</i>
(12) Use a false or made-up name or alias?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes } <i>Go to next</i> 2 <input type="checkbox"/> No } <i>experience</i>
(13) Scam or con someone for money, to avoid responsibility or just for fun?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes } <i>Go to next</i> 2 <input type="checkbox"/> No } <i>experience</i>
(14) Do things that could have easily hurt you or someone else - like speeding or driving after having too much to drink?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes } <i>Go to next</i> 2 <input type="checkbox"/> No } <i>experience</i>
(15) Get more than 3 traffic tickets for reckless or careless driving, speeding, or causing an accident?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes } <i>Go to next</i> 2 <input type="checkbox"/> No } <i>experience</i>
(16) Have your driver's license suspended or revoked for moving violations?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes } <i>Go to next</i> 2 <input type="checkbox"/> No } <i>experience</i>
(17) Destroy, break, or vandalize someone else's property - like their car, home, or other personal belongings?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes } <i>Go to next</i> 2 <input type="checkbox"/> No } <i>experience</i>
(18) Start a fire on purpose to destroy someone else's property or just to see it burn?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes } <i>Go to next</i> 2 <input type="checkbox"/> No } <i>experience</i>
(19) Fail to pay off your debts - like moving to avoid paying rent, not making payments on a loan or mortgage, failing to make alimony or child support payments or filing for bankruptcy?	1 <input type="checkbox"/> Yes } <i>Go to next</i> 2 <input type="checkbox"/> No } <i>experience</i>		
(20) Steal anything from someone or someplace when no one was around?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes } <i>Go to next</i> 2 <input type="checkbox"/> No } <i>experience</i>
(21) Forge someone else's signature - like on a legal document or on a check?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes } <i>Go to next</i> 2 <input type="checkbox"/> No } <i>experience</i>
(22) Shoplift?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience, page 118</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes } <i>Go to next</i> 2 <input type="checkbox"/> No } <i>experience, page 118</i>

Section 11A - BEHAVIOR (Continued)

1a. Did you EVER . . . <i>(Repeat entire phrase frequently)</i>	b. Did this happen BEFORE you were 15?	c. Has this happened SINCE you were 15?
(23) Rob or mug someone or snatch a purse?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes } <i>Go to next experience</i> 2 <input type="checkbox"/> No }
(24) Make money illegally - like selling stolen property or selling drugs?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes } <i>Go to next experience</i> 2 <input type="checkbox"/> No }
(25) Do anything that you could have been arrested for, regardless of whether or not you were caught?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes } <i>Go to next experience</i> 2 <input type="checkbox"/> No }
(26) Force someone to have sex with you against their will?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes } <i>Go to next experience</i> 2 <input type="checkbox"/> No }
(27) Get into a lot of fights that you started?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes } <i>Go to next experience</i> 2 <input type="checkbox"/> No }
(28) Get into a fight that came to swapping blows with someone like a husband, wife, girlfriend or boyfriend?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes } <i>Go to next experience</i> 2 <input type="checkbox"/> No }
(29) Use a weapon like a stick, knife, or gun in a fight?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes } <i>Go to next experience</i> 2 <input type="checkbox"/> No }
(30) Hit someone so hard that you injured them or they had to see a doctor?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes } <i>Go to next experience</i> 2 <input type="checkbox"/> No }
(31) Harass, threaten or blackmail someone?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes } <i>Go to next experience</i> 2 <input type="checkbox"/> No }
(32) Physically hurt another person in any other way on purpose?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes } <i>Go to next experience</i> 2 <input type="checkbox"/> No }
(33) Hurt or be cruel to an animal or pet on purpose?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to Check Item 11.0</i>	1 <input type="checkbox"/> Yes } <i>Go to Check Item 11.0</i> 2 <input type="checkbox"/> No }
CHECK ITEM 11.0	Are at least 3 items marked "Yes" in column a, pages 116 - 118?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Section 11B, page 121</i>
1d. About how old were you the FIRST time SOME of these experiences BEGAN to happen?	_____ Age	
CHECK ITEM 11.1	Are at least 3 items marked "Yes" in 1, column b, pages 116 - 118?	
Did respondent demonstrate at least 3 behaviors BEFORE age 15?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 11.2, page 119</i>	

Section 11A - BEHAVIOR (Continued)

<p>2. You just mentioned some experiences you had BEFORE you were 15 years old.</p> <p>Did any of these experiences you had BEFORE you were 15 years old cause any problems with your family or friends, at school or with the law?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>3. Did at least 1 of these experiences you mentioned happen BEFORE you were 10 years old?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>3a. Did at least 3 of these experiences you had BEFORE you were 15 years old happen around the same time or within a 1-year period?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 11.1A Refer to Check Item 2.0, Section 2A, page 9</p> <p>Is the respondent a lifetime abstainer of alcohol?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to 5a</i> 2 <input type="checkbox"/> No</p>
<p>4a. Now I'd like you to think about ALL of the experiences you just mentioned that happened BEFORE you were 15 years old.</p> <p>Did ANY of these experiences you had BEFORE you were 15 happen WHILE you were drinking heavily, or AFTER you had been drinking heavily?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 5a</i></p>
<p>b. Did ALL of these experiences ONLY happen WHILE you were drinking heavily, or AFTER you had been drinking heavily?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>5a. Did ANY of these experiences you had BEFORE you were 15 happen WHILE you were using or AFTER you had used any medicines or drugs?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 11.1B</i></p>
<p>b. Did ALL of these experiences ONLY happen WHILE you were using or AFTER you had used any medicines or drugs?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 11.1B Is "Yes" marked in Check Item 5.3, Section 5, page 77?</p> <p>Did respondent ever have a period of high mood?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 11.2</i></p>
<p>5c. Did ANY of these experiences you had BEFORE you were 15 happen during a period when you felt extremely excited, elated or hyper or extremely irritable or easily annoyed?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 11.2</i></p>
<p>d. Did ALL of those experiences ONLY happen during periods when you felt extremely excited, elated or hyper or extremely irritable or easily annoyed?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 11.2 Are at least 3 items marked "Yes" in 1, column c, or "No" in 1, column b, or "Yes" in 1(19), column a, pages 116 - 118?</p> <p>Did respondent demonstrate at least 3 behaviors SINCE age 15?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Section 11B, page 121</i></p>
<p>CHECK ITEM 11.2A Refer to Check Item 2.0, Section 2A, page 9.</p> <p>Is the respondent a lifetime abstainer of alcohol?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to 7a</i> 2 <input type="checkbox"/> No</p>
<p>6a. You mentioned some experiences you had SINCE you were 15 years old.</p> <p>Did ANY of these experiences you had SINCE you were 15 happen WHILE you were drinking heavily, or AFTER you had been drinking heavily?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 7a</i></p>
<p>b. Did ALL of these experiences ONLY happen WHILE you were drinking heavily, or AFTER you had been drinking heavily?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>7a. Did ANY of these experiences you had SINCE you were 15 happen WHILE you were using or AFTER you had used any medicines or drugs?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 11.2B, page 120</i></p>

Section 11A - BEHAVIOR (Continued)

<p>7b. Did ALL of these experiences ONLY happen WHILE you were using or AFTER you had used medicine or drugs?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 11.2B Is "Yes" marked in Check Item 5.3, Section 5, page 77?</p> <p>Did respondent ever have a period of high mood?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 11.3</i></p>
<p>7c. Did ANY of the experiences you had SINCE you were 15, happen during a time when you felt extremely excited, elated or hyper or extremely irritable or easily annoyed?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 11.3</i></p>
<p>d. Did ALL of those experiences ONLY happen during periods when you felt extremely excited, elated or hyper or extremely irritable or easily annoyed?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 11.3 Is at least 1 item marked "Yes" in 1(17) - 1(33), column c, or "No" in 1(17) - 1(33), column b, or "Yes" in 1(19), column a, pages 117 - 118?</p> <p>Has respondent ever destroyed or stolen property or mistreated or harmed another person?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Section 11B, page 121</i></p>
<p>8. You mentioned some experiences that you've had in your life when you (destroyed property/stole something/ mistreated or harmed another person).</p> <p>(a) Since (this/these things) happened, have you regretted doing (this/these things) or wished (it/they) had never happened?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(b) Did you feel you had a right to do (this/these things) or feel that the other people deserved what they got?</p>	<p>1 <input type="checkbox"/> Yes } <i>Go to Section 11B, page 121</i> 2 <input type="checkbox"/> No }</p>

Section 11B - FAMILY HISTORY - IV

Now I would like to ask you about whether any of your relatives, regardless of whether or not they are now living, have ever had behavior problems.

(SHOW FLASHCARD 26)



By behavior problems I mean being cruel to people or animals, fighting or destroying property, trouble keeping a job or paying bills, being impulsive, reckless or not planning ahead, lying or conning people or getting arrested. These people also do not seem to care if they hurt others and often have problems at an early age such as truancy, staying out all night or running away.

(REFER TO FLASHCARD FREQUENTLY)

<p>1. In your judgement, did your blood or natural father have some of these behavior problems like this ANY time in his life?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 99 <input type="checkbox"/> DK</p>
<p>2. Did your blood or natural mother have some of these behavior problems like this ANY time in her life?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 99 <input type="checkbox"/> DK</p>
<p>3. (Did your full brother have/How many of your full brothers had) some of these behavior problems at ANY time in (his life/their lives)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No OR _____ Number 0 <input type="checkbox"/> None</p>
<p>4. (Did your full sister have/How many of your full sisters had) some of these behavior problems at ANY time in (her life/ their lives)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No OR _____ Number 0 <input type="checkbox"/> None</p>
<p>5. (Did your natural son have/How many of your natural sons had) some of these behavior problems at ANY time in (his life/their lives)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No OR _____ Number 0 <input type="checkbox"/> None</p>
<p>6. (Did your natural daughter have/How many of your natural daughters had) some of these behavior problems at ANY time in (her life/their lives)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No OR _____ Number 0 <input type="checkbox"/> None</p>
<p>7. (Did your natural father's full brother have/How many of your natural father's full brothers had) some of these behavior problems at ANY time in (his life/their lives)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No OR _____ Number 0 <input type="checkbox"/> None</p>
<p>8. (Did your natural father's full sister have/How many of your natural father's full sisters had) some of these behavior problems at ANY time in (her life/their lives)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No OR _____ Number 0 <input type="checkbox"/> None</p>
<p>9. (Did your natural mother's full brother have/How many of your natural mother's full brothers had) some of these behavior problems at ANY time in (his life/ their lives)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No OR _____ Number 0 <input type="checkbox"/> None</p>
<p>10. (Did your natural mother's full sister have/How many of your natural mother's full sisters had) some of these behavior problems at ANY time in (her life/their lives)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No OR _____ Number 0 <input type="checkbox"/> None</p>

Section 11B - FAMILY HISTORY - IV (Continued)

11. Did your natural grandfather on your father's side have some of these behavior problems at ANY time in his life?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 99 <input type="checkbox"/> DK
12. Did your natural grandmother on your father's side have some of these behavior problems at ANY time in her life?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 99 <input type="checkbox"/> DK
13. Did your natural grandfather on your mother's side have some of these behavior problems at ANY time in his life?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 99 <input type="checkbox"/> DK
14. Did your natural grandmother on your mother's side have some of these behavior problems at ANY time in her life?	1 <input type="checkbox"/> Yes } 2 <input type="checkbox"/> No } <i>Go to Section 12, page 123</i> 99 <input type="checkbox"/> DK }

Section 12 – BETTING

(SHOW FLASHCARD 27)

Statement Q

Now I'd like to ask you a few questions about gambling. By gambling I mean playing cards for money, betting on the horses or dogs or sports games, playing the stock or commodities market, buying lottery tickets or playing bingo or KENO or gambling at a casino, including playing the slot machines.

1. Have you ever gambled at least 5 times in any one year of your life?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Section 13, page 126</i>		
2a. The next few questions are about experiences that people have had with gambling. As I read each experience, please tell me if it has EVER happened to you. In your ENTIRE LIFE did you EVER . . . (PAUSE) (Repeat phrase frequently)		b. Did this happen in the last 12 months?	c. Did this happen before 12 months ago, that is, before last (Month one year ago)?
(1) Gamble to get out of a bad mood -- like feeling nervous, sad or down?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark Yes in column c</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(2) Gamble to forget your problems?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark Yes in column c</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(3) More than once try to quit or cut down on your gambling, but found you couldn't do it?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark Yes in column c</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(4) Find that you had to increase the amount of money you would gamble to keep it exciting?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark Yes in column c</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(5) Spend a lot of time gambling, planning your bets or studying the odds?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark Yes in column c</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(6) Spend a lot of time thinking about ways to get money together so you could gamble?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark Yes in column c</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(7) Spend a lot of time thinking about the times when you won or lost?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark Yes in column c</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(8) Have job or school trouble because of your gambling -- like missing too much work, being demoted at work, losing your job or dropping out of school?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark Yes in column c</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(8a) Break up or come close to breaking up with anyone who was important to you because of your gambling?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark Yes in column c</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(9) Try to keep your family or friends from knowing how much you gambled?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark Yes in column c</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(10) Have such financial trouble as a result of your gambling that you had to get help with living expenses from family, friends or welfare?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark Yes in column c</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(11) Find that you became restless, irritable or anxious when trying to quit or cut down on your gambling?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience, page 124</i>	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark Yes in column c</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No

Section 12 -BETTING (Continued)

2a. In your ENTIRE LIFE did you EVER . . . (PAUSE) <i>(Repeat phrase frequently)</i>	b. Did this happen in the last 12 months?	c. Did this happen before 12 months ago, that is, before last (Month one year ago)?
(12) Raise gambling money by writing a bad check, signing someone else's name to a check, stealing, cashing someone else's check or in some other illegal way?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(13) Find you had to gamble again as soon as possible after LOSING in order to win back your losses?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(14) Find you had to gamble again as soon as possible after WINNING in order to win more?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to Check Item 12.1</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
CHECK ITEM 12.1 Are at least 5 Boxes marked in 2, column c, pages 123 - 124?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 12.4</i>	
3a. You just mentioned some experiences with gambling that happened in the past, that is, before 12 months ago. Before last (Month one year ago), was there EVER a period when SOME of these experiences were happening around the same time most days FOR AT LEAST A MONTH?	1 <input type="checkbox"/> Yes - <i>SKIP to 3d</i> 2 <input type="checkbox"/> No	
b. Before last (Month one year ago), was there EVER a period when SOME of these experiences were happening around the same time ON AND OFF FOR A FEW MONTHS OR LONGER?	1 <input type="checkbox"/> Yes - <i>SKIP to 3d</i> 2 <input type="checkbox"/> No	
c. Before last (Month one year ago), was there EVER a time when SOME of these experiences happened within the same 1-year period?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 12.4</i>	
d. About how old were you the FIRST time SOME of these experiences BEGAN to happen around the same time?	_____ Age	
e. In your ENTIRE LIFE, how many separate periods like this did you have when some of these experiences with gambling were happening around the same time? By separate periods I mean times that were separated by at least 1 year when you stopped gambling completely OR you didn't have any of the experiences you mentioned with gambling at all.	_____ Number	
CHECK ITEM 12.2 Is number marked in 3e, 2 or more or unknown?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 3h</i>	
3f. What was the LONGEST period you had when SOME of these experiences were happening around the same time?	_____ Month(s) OR _____ Years(s)	
g. How old were you the MOST RECENT time SOME of these experiences BEGAN to happen around the same time?	_____ Age - <i>SKIP to Check Item 12.3</i>	
h. How long did this period last when SOME of these experiences were happening around the same time?	_____ Month(s) OR _____ Years(s)	
CHECK ITEM 12.3 Is at least 1 item marked in 2, column b, pages 123 - 124?	1 <input type="checkbox"/> Yes - <i>SKIP to 4, page 125</i> 2 <input type="checkbox"/> No	
3i. About how old were you when you FINALLY STOPPED gambling OR stopped having any of these experiences? By finally STOPPED I mean they never started again.	_____ Age	

Section 12 - BETTING (Continued)

<p>(SHOW FLASHCARD 27)</p> <p>4. Before 12 months ago, what kind or kinds of gambling were you doing when you had some of these experiences you mentioned with gambling?</p> <p><i>Mark(X) all that apply.</i></p>	<p>CASINO</p> <p>1 <input type="checkbox"/> Card games 2 <input type="checkbox"/> Dice games 3 <input type="checkbox"/> Roulette 4 <input type="checkbox"/> Slot or video machines 5 <input type="checkbox"/> Other casino gambling</p> <p>NON-CASINO</p> <p>6 <input type="checkbox"/> Bingo or KENO 7 <input type="checkbox"/> Dice games 8 <input type="checkbox"/> Dog races or fights 9 <input type="checkbox"/> Card games 10 <input type="checkbox"/> Games of skill 11 <input type="checkbox"/> Horse races 12 <input type="checkbox"/> Lottery or numbers 13 <input type="checkbox"/> Sports games 14 <input type="checkbox"/> Stock/commodities market 15 <input type="checkbox"/> Other gambling outside casino</p>
<p>CHECK ITEM 12.4 Are at least 5 Boxes marked in 2, column b, pages 123 - 124?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 12.4A</i></p>
<p>(SHOW FLASHCARD 27)</p> <p>5. During the last 12 months, what kind or kinds of gambling were you doing when you had some of these experiences you mentioned with gambling?</p> <p><i>Mark(X) all that apply.</i></p>	<p>CASINO</p> <p>1 <input type="checkbox"/> Card games 2 <input type="checkbox"/> Dice games 3 <input type="checkbox"/> Roulette 4 <input type="checkbox"/> Slot or video machines 5 <input type="checkbox"/> Other casino gambling</p> <p>NON-CASINO</p> <p>6 <input type="checkbox"/> Bingo or KENO 7 <input type="checkbox"/> Dice games 8 <input type="checkbox"/> Dog races or fights 9 <input type="checkbox"/> Card games 10 <input type="checkbox"/> Games of skill 11 <input type="checkbox"/> Horse races 12 <input type="checkbox"/> Lottery or numbers 13 <input type="checkbox"/> Sports games 14 <input type="checkbox"/> Stock/commodities market 15 <input type="checkbox"/> Other gambling outside casino</p>
<p>CHECK ITEM 12.4A Are at least 5 Boxes marked in 2, column b OR are at least 5 Boxes marked in 2, column c?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Section 13, page 126</i></p>
<p>6a. Have you EVER gone to Gamblers Anonymous?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 7a</i></p>
<p>b. Did you go to Gamblers Anonymous in the last 12 months?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 7a</i></p>
<p>c. Did you go to Gamblers Anonymous before 12 months ago, that is, before last (Month one year ago)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>7a. Did you EVER go to any kind of counselor, therapist, doctor, psychologist or any other person like that for help with your gambling?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 12.5</i></p>
<p>b. Did you go to any doctor or other health professional in the last 12 months?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 12.5</i></p>
<p>c. Did you go to any doctor or other health professional before 12 months ago, that is, before last (Month one year ago)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 12.5 Is Check Item 5.3, Section 5, page 77 marked "Yes"?</p> <p>Did respondent have a period of high mood?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Section 13, page 126</i></p>
<p>8a. Did ANY of those times when you gambled happen during a period when you felt extremely excited, elated or hyper or extremely irritable or easily annoyed?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Section 13, page 126</i></p>
<p>b. Did ALL of the times when you gambled ONLY happen during periods when you felt extremely excited, elated or hyper or extremely irritable or easily annoyed?</p>	<p>1 <input type="checkbox"/> Yes } 2 <input type="checkbox"/> No } <i>Go to Section 13, page 126</i></p>

Section 13 - MEDICAL CONDITIONS

Statement R

Now I'd like to ask some questions about your health.

<p>1. (Not counting hospitalization for delivery of a healthy liveborn infant,) How many separate times did you stay in a hospital overnight or longer in the last 12 months?</p>	<p>_____ Number of times (If "0", SKIP to 3)</p>
<p>2. (Again not counting hospitalization for delivery of a healthy liveborn infant,) How many days altogether did you spend in the hospital in the last 12 months?</p>	<p>_____ Number of days</p>
<p>3. In the last 12 months, how many times did you receive medical care or treatment in a hospital emergency room?</p>	<p>_____ Number of times</p>
<p>4. In the last 12 months, how many injuries have you had that caused you to seek medical help or to cut down your usual activities for more than half a day?</p>	<p>_____ Number of injuries</p>
<p>5. In the past 12 months, how many times were you PERSONALLY the victim of a crime or attempted crime, such as if a stranger or someone you knew beat you up, mugged or attacked you, hit you with something, took something from you by force or threat of force or forced you to have sex with them? Do not count robberies that occurred when you were not present.</p>	<p>_____ Number of times</p>

<p>6a. In the past 12 months, have you had . . . <i>(Repeat phrase frequently)</i></p>	<p>b. Did a doctor or other health professional tell you that you had <i>(Name of condition)?</i></p>
<p>(1) Hardening of the arteries or arteriosclerosis?</p>	<p>1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Go to next condition</p>
<p>(2) High blood pressure or hypertension?</p>	<p>1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Go to next condition</p>
<p>(3) Cirrhosis of the liver?</p>	<p>1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Go to next condition</p>
<p>(4) Any other form of liver disease?</p>	<p>1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Go to next condition</p>
<p>(5) Chest pain or angina pectoris?</p>	<p>1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Go to next condition</p>
<p>(6) Rapid heart beat or tachycardia?</p>	<p>1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Go to next condition</p>
<p>(7) A heart attack or myocardial infarction?</p>	<p>1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Go to next condition</p>
<p>(8) Any other form of heart disease?</p>	<p>1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Go to next condition</p>
<p>(9) A stomach ulcer?</p>	<p>1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Go to next condition, page 127</p>

Section 13 - MEDICAL CONDITIONS (Continued)

6a. In the past 12 months, have you had:		b. Did a doctor or other health professional tell you that you had (Name of condition)?
(10) Gastritis?	1 <input type="checkbox"/> Yes _____ 2 <input type="checkbox"/> No - <i>Go to next condition</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(11) Arthritis?	1 <input type="checkbox"/> Yes _____ 2 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
6c. Did a doctor or other health professional EVER tell you that you had schizophrenia or a psychotic illness or episode?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 13.1</i>	
d. Did this happen in the last 12 months?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 13.1</i>	
e. Did this happen before 12 months ago?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
CHECK ITEM 13.1 Is the respondent a female aged 18 - 55?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Section 10</i>	
7a. Are you pregnant at this time?	1 <input type="checkbox"/> Yes - <i>SKIP to 7c</i> 2 <input type="checkbox"/> No	
b. Were you pregnant at any time during the last year?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Section 10</i>	
c. (Did you experience/Have you experienced) any complications with your pregnancy (or during delivery)?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
CHECK ITEM 13.2 Is respondent a current drinker?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Section 10</i>	
8a. Earlier, you told me about how much and how often you drank during the last 12 months. Was this the way you drank during the time you WERE pregnant, during the time you WERE NOT pregnant, or averaged over both?	1 <input type="checkbox"/> During pregnancy 2 <input type="checkbox"/> Not during pregnancy 3 <input type="checkbox"/> Averaged over both	
b. During the months you WERE pregnant, did you drink about the same, drink more or drink less than when you WERE NOT pregnant?	1 <input type="checkbox"/> Drank about the same 2 <input type="checkbox"/> Drank more 3 <input type="checkbox"/> Drank less 4 <input type="checkbox"/> Didn't drink at all } <i>SKIP to Section 10</i>	