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│                  FAMILY INFORMANT INTERVIEW (4/21/2003)                    │
│                      Part I: Subject Screening Form                        │
│   Date Edited: ___ ___ /___ ___ /___ ___ ___ ___      Editor Number: ___ ___ │
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Form Completed: ___ ___ /___ ___ /___ ___ ___ ___   Interviewer Number: ___ ___
              m m   d d y y y y

Family Number: ___ ___ - ___ ___ ___

Subject Name: _____   Subject Number: ___ ___ ___ ___

Inf. #1 Name: _____   Inf. #1 Number: ___ ___ ___ ___

Inf. #2 Name: _____   Inf. #2 Number: ___ ___ ___ ___

FINAL RATINGS ONLY:

1.a. Subject's Sex:

	Inf. #1:	1	2	9	**Inf. #2:**	1	2	9	**Final**:	1	2	9
		Male	Female	Unknown		Male	Female	Unknown		Male	Female	Unknown

 b. How old is (Subject)? (IF DECEASED, ASK): How old was s/he when s/he died? (999 = Unknown)

    Inf. #1:   ___ ___ ___   **Inf. #2**:   ___ ___ ___   **Final**:   ___ ___ ___

 c. Please indicate whether the Subject is alive or dead:

	Inf. #1:	1	2	9	**Inf. #2:**	1	2	9	**Final**:	1	2	9
		Alive	Dead	Unknown		Alive	Dead	Unknown		Alive	Dead	Unknown

 d. What is the month and year of (Subject's) birth? (99 = Unknown Month, 9999 = Unknown Year)

    Inf. #1:   ___ ___ / ___ ___ ___ ___ (mm/yyyy)   **Final:** ___ ___ / ___ ___ ___ ___

    Inf. #2:   ___ ___ / ___ ___ ___ ___ (mm/yyyy)

IF SUBJECT IS ALIVE, SKIP TO QUESTION # 3, OTHERWISE, CONTINUE WITH QUESTION #2.

2. What was the cause of (his/her) death?

    Inf. #1:   _____   Death Code: _____

    Inf. #2:   _____

3. Where is (Subject) currently living?

Final:

	Inf. #1:	City: _____	State: ___ ___	City: _____
	Inf. #2::	City: _____	State: ___ ___	State: ___ ___

FAMILY INFORMANT INTERVIEW CONTINUED ON THE REVERSE PAGE.

Family Number: ___ ___ - ___ ___ ___   Subject Number: ___ ___ ___ ___

4. Has (he/she) ever had any serious medical problems, such as:

a. Encephalitis

Final Ratings:

Inf. #1:	1	2	3	9	Age at onset: ___ ___	1	2	3	9
	No	Yes	Yes, treated	Unknown		No	Yes	Yes, treated	Unknown
Inf. #2:	1	2	3	9	Age at onset: ___ ___	Age at onset: ___ ___			

b. Meningitis

Inf. #1:	1	2	3	9	Age at onset: ___ ___	1	2	3	9
	No	Yes	Yes, treated	Unknown		No	Yes	Yes, treated	Unknown
Inf. #2:	1	2	3	9	Age at onset: ___ ___	Age at onset: ___ ___			

c. Head Injury

Inf. #1:	1	2	3	9	Age at onset: ___ ___	1	2	3	9
	No	Yes	Yes, treated	Unknown		No	Yes	Yes, treated	Unknown
Inf. #2:	1	2	3	9	Age at onset: ___ ___	Age at onset: ___ ___			

d. Convulsions, Seizures, Epilepsy

Inf. #1:	1	2	3	9	Age at onset: ___ ___	1	2	3	9
	No	Yes	Yes, treated	Unknown		No	Yes	Yes, treated	Unknown
Inf. #2:	1	2	3	9	Age at onset: ___ ___	Age at onset: ___ ___			

e. High Blood Pressure

Inf. #1:	1	2	3	9	Age at onset: ___ ___	1	2	3	9
	No	Yes	Yes, treated	Unknown		No	Yes	Yes, treated	Unknown
Inf. #2:	1	2	3	9	Age at onset: ___ ___	Age at onset: ___ ___			

f. Heart Disease

Inf. #1:	1	2	3	9	Age at onset: ___ ___	1	2	3	9
	No	Yes	Yes, treated	Unknown		No	Yes	Yes, treated	Unknown
Inf. #2:	1	2	3	9	Age at onset: ___ ___	Age at onset: ___ ___			

g. Allergies/Asthma

Inf. #1:	1	2	3	9	Age at onset: ___ ___	1	2	3	9
	No	Yes	Yes, treated	Unknown		No	Yes	Yes, treated	Unknown
Inf. #2:	1	2	3	9	Age at onset: ___ ___	Age at onset: ___ ___			

h. Respiratory Illness

Inf. #1:	1	2	3	9	Age at onset: ___ ___	1	2	3	9
	No	Yes	Yes, treated	Unknown		No	Yes	Yes, treated	Unknown
Inf. #2:	1	2	3	9	Age at onset: ___ ___	Age at onset: ___ ___			

i. Liver Disease

Inf. #1:	1	2	3	9	Age at onset: ___ ___	1	2	3	9
	No	Yes	Yes, treated	Unknown		No	Yes	Yes, treated	Unknown
Inf. #2:	1	2	3	9	Age at onset: ___ ___	Age at onset: ___ ___			

j. Kidney Disease

Inf. #1:	1	2	3	9	Age at onset: ___ ___	1	2	3	9
	No	Yes	Yes, treated	Unknown		No	Yes	Yes, treated	Unknown
Inf. #2:	1	2	3	9	Age at onset: ___ ___	Age at onset: ___ ___			

k. **Hypothyroidism**

						Final Ratings:			
Inf. #1:	1	2	3	9	Age at onset: ___ ___	1	2	3	9
	No	Yes	Yes, treated	Unknown		No	Yes	Yes, treated	Unknown
Inf. #2:	1	2	3	9	Age at onset: ___ ___	Age at onset: ___ ___			

l. **Hyperthyroidism**

Inf. #1:	1	2	3	9	Age at onset: ___ ___	1	2	3	9
	No	Yes	Yes, treated	Unknown		No	Yes	Yes, treated	Unknown
Inf. #2:	1	2	3	9	Age at onset: ___ ___	Age at onset: ___ ___			

m. **Other Thyroid Problems**

Inf. #1:	1	2	3	9	Age at onset: ___ ___	1	2	3	9
	No	Yes	Yes, treated	Unknown		No	Yes	Yes, treated	Unknown
Inf. #2:	1	2	3	9	Age at onset: ___ ___	Age at onset: ___ ___			

n. **Diabetes**

Inf. #1:	1	2	3	9	Age at onset: ___ ___	1	2	3	9
	No	Yes	Yes, treated	Unknown		No	Yes	Yes, treated	Unknown
Inf. #2:	1	2	3	9	Age at onset: ___ ___	Age at onset: ___ ___			

o. **Rheumatoid Arthritis**

Inf. #1:	1	2	3	9	Age at onset: ___ ___	1	2	3	9
	No	Yes	Yes, treated	Unknown		No	Yes	Yes, treated	Unknown
Inf. #2:	1	2	3	9	Age at onset: ___ ___	Age at onset: ___ ___			

p. **Lupus**

Inf. #1:	1	2	3	9	Age at onset: ___ ___	1	2	3	9
	No	Yes	Yes, treated	Unknown		No	Yes	Yes, treated	Unknown
Inf. #2:	1	2	3	9	Age at onset: ___ ___	Age at onset: ___ ___			

q. **Cancer**

Inf. #1:	1	2	3	9	Age at onset: ___ ___	1	2	3	9
	No	Yes	Yes, treated	Unknown		No	Yes	Yes, treated	Unknown
Inf. #2:	1	2	3	9	Age at onset: ___ ___	Age at onset: ___ ___			

r. **Celiac Disease**

Inf. #1:	1	2	3	9	Age at onset: ___ ___	1	2	3	9
	No	Yes	Yes, treated	Unknown		No	Yes	Yes, treated	Unknown
Inf. #2:	1	2	3	9	Age at onset: ___ ___	Age at onset: ___ ___			

s. **Other Serious Illness:** _____

Inf. #1:	1	2	3	9	Age at onset: ___ ___	1	2	3	9
	No	Yes	Yes, treated	Unknown		No	Yes	Yes, treated	Unknown
Inf. #2:	1	2	3	9	Age at onset: ___ ___	Age at onset: ___ ___			

t. **Other Serious Illness:** _____

Inf. #1:	1	2	3	9	Age at onset: ___ ___	1	2	3	9
	No	Yes	Yes, treated	Unknown		No	Yes	Yes, treated	Unknown
Inf. #2:	1	2	3	9	Age at onset: ___ ___	Age at onset: ___ ___			

FAMILY INFORMANT INTERVIEW CONTINUES ON REVERSE PAGE

5. Did (Subject) ever have emotional problems or take medicine or see a doctor for problems with (his/her) nerves or emotions?

FINAL RATINGS ONLY:

Inf. #1:   1   2   9   Age at onset: ___ ___
           No   Yes Unknown

1   2   9
No   Yes Unknown

Inf. #2:   1   2   9   Age at onset: ___ ___

Age at onset: ___ ___

IF YES FROM EITHER INFORMANT, DESCRIBE:

_____

_____

6. Did (Subject) ever go into the hospital for psychiatric problems or for alcohol or drug problems?

FINAL:

Inf. #1:   1   2   9   Age 1st Hospitalized: ___ ___
          No   Yes Unknown

1   2   9
No   Yes Unknown

                                 # of Hospitalizations: ___ ___

Age 1st Hospitalized: ___ ___

Inf. #2:   1   2   9   Age 1st Hospitalized: ___ ___
          No   Yes Unknown

# of Hospitalizations: ___ ___

                                 # of Hospitalizations: ___ ___

IF YES FROM EITHER INFORMANT, DESCRIBE:

_____

_____

7. Did (Subject) ever use alcohol or drugs to the extent that it caused problems with health, family, job or the police?

FINAL:

Inf. #1:   1   2   9
          No   Yes Unknown

1   2   9
No   Yes Unknown

Inf. #2:   1   2   9

IF YES FROM EITHER INFORMANT, DESCRIBE:

_____

IF YES, GO TO ALCOHOL AND/OR DRUG ABUSE CHECKLIST.

8. Did (Subject) ever get depressed? Feel very low for a couple of weeks or more?

FINAL:

Inf. #1:   1   2   9
          No   Yes Unknown

1   2   9
No   Yes Unknown

Inf. #2:   1   2   9

IF YES FROM EITHER INFORMANT, DESCRIBE:

_____

IF YES, GO TO DEPRESSION CHECKLIST.

PSYCHIATRIC CONDITIONS CONTINUED ON THE NEXT PAGE.

9. **NOTE:** SKIP THIS ITEM IF DEPRESSION CHECKLIST WAS
FILLED OUT.
Did (Subject) ever attempt suicide?

FINAL:

Inf. #1:	1	2	3	9		1	2	3	9
	No	Yes	Yes, No checklist	Unknown		No	Yes	Yes, no checklist	Unknown
Inf. #2:	1	2	3	9					

IF YES FROM EITHER INFORMANT, DESCRIBE:

_____

_____

**IF ADDITIONAL INFORMATION RELEVANT TO DEPRESSION
OBTAINED, GO TO DEPRESSION CHECKLIST.**

10. Did (Subject) ever have manic episodes? Seem overexcited day and
night?

FINAL:

Inf. #1:	1	2	9		1	2	9
	No	Yes	Unknown		No	Yes	Unknown
Inf. #2:	1	2	9				

IF YES FROM EITHER INFORMANT, DESCRIBE:

_____

_____

IF YES, GO TO MANIA CHECKLIST.

11. Did (Subject) ever have visions? Hear voices? Have ideas that were not
true? Show unusual or bizarre behavior?

FINAL:

Inf. #1:	1	2	9		1	2	9
	No	Yes	Unknown		No	Yes	Unknown
Inf. #2:	1	2	9				

IF YES FROM EITHER INFORMANT, DESCRIBE:

_____

_____

IF YES, GO TO PSYCHOSIS CHECKLIST.

12. a. Did (Subject) complain about certain thoughts or images that kept
coming into (his/her) mind that (he/she) could not get rid of?

FINAL:

Inf. #1:	1	2	9		1	2	9
	No	Yes	Unknown		No	Yes	Unknown
Inf. #2:	1	2	9				

IF YES FROM EITHER INFORMANT, DESCRIBE:

_____

_____

PSYCHIATRIC CONDITIONS CONTINUED ON THE REVERSE PAGE.

12.b. Did (Subject) have to do certain things over and over again, like wash
their hands, check, count or arrange things in certain ways?

FINAL:

Inf. #1:   1   2   9   1   2   9
           No   Yes Unknown   No   Yes Unknown

Inf. #2:   1   2   9

IF YES FROM EITHER INFORMANT, DESCRIBE:

_____

_____
IF YES FOR 12a OR 12b, GO TO OBSESSIVE-COMPULSIVE DISORDER CHECKLIST.

13. Did (Subject) ever complain about having sudden attacks of terror or
panic that seemed to come out of the blue?

FINAL:

Inf. #1:   1   2   9   1   2   9
           No   Yes Unknown   No   Yes Unknown

Inf. #2:   1   2   9

IF YES FROM EITHER INFORMANT, DESCRIBE:

_____

_____
IF YES, GO TO PANIC DISORDER CHECKLIST.

14. Did (Subject) ever suffer from periods of anxiety or worry? If so, what
was going on at that time in (his/her) life? (ASK FOR ADDITIONAL
DETAIL ONLY IF NO PRECIPITANT, OR IF THE REACTION
SEEMS DIS-PROPORTIONATE TO THE STRESSOR).

FINAL:

Inf. #1:   1   2   9   1   2   9
           No   Yes Unknown   No   Yes Unknown

Inf. #2:   1   2   9

IF YES FROM EITHER INFORMANT, DESCRIBE:

_____

_____
IF YES, GO TO GENERALIZED ANXIETY DISORDER CHECKLIST.

15. Did (Subject) ever avoid leaving the house? Or avoid any travel
situations? Or have to force him/herself to enter these
situations, but at the cost of great anxiety while he/she was there?

FINAL:

Inf. #1:   1   2   9   1   2   9
           No   Yes Unknown   No   Yes Unknown

Inf. #2:   1   2   9

IF YES FROM EITHER INFORMANT, DESCRIBE:

_____

_____
IF YES, GO TO AGORAPHOBIA CHECKLIST.

PSYCHIATRIC CONDITIONS CONTINUED ON THE NEXT PAGE.

16. Did (Subject) ever fear or avoid any social situations like speaking in public, parties, etc.?

Inf. #1:   1   2   9
                  No   Yes Unknown
Inf. #2:   1   2   9

FINAL:
1   2   9
No   Yes Unknown

IF YES FROM EITHER INFORMANT, DESCRIBE:

_____

_____

IF YES, GO TO SOCIAL PHOBIA CHECKLIST.

17. Did (Subject) ever fear or avoid any specific situations or things like heights, the dark, dogs, etc.?

Inf. #1:   1   2   9
                  No   Yes Unknown
Inf. #2:   1   2   9

FINAL:
1   2   9
No   Yes Unknown

IF YES FROM EITHER INFORMANT, DESCRIBE:

_____

_____

IF YES, GO TO SIMPLE PHOBIA CHECKLIST.

18. (Other than during Manic or Depressive episodes) did (Subject) have trouble concentrating or attending to situations? (Other than during manic episodes) did (Subject) seem hyperactive and act impulsively? More than his/her peers?

Inf. #1:   1   2   9
                  No   Yes Unknown
Inf. #2:   1   2   9

FINAL:
1   2   9
No   Yes Unknown

IF YES FROM EITHER INFORMANT, DESCRIBE:

_____

_____

IF YES, GO TO ADHD CHECKLIST.

19. Are there any other problems or behaviors that (Subject) showed that were unusual?

Inf. #1:   1   2   3   9
                  No   Yes Yes, not spectrum Unknown
Inf. #2:   1   2   3   9

FINAL:
1   2   3   9
No   Yes Yes, not spectrum Unknown

IF YES FROM EITHER INFORMANT, DESCRIBE:

_____

IF INFORMATION OBTAINED IS RELEVANT TO PARANOID, SCHIZOID OR SCHIZOTYPAL PERSONALITY DISORDER DIAGNOSIS, GO TO PERSONALITY DISORDER CHECKLIST.

UPON COMPLETION OF THIS FORM (BOTH INFORMANTS AND FINAL RATINGS), PLEASE FILL OUT A FAMILY INFORMANT INTERVIEW PART II FORM (FINAL DIAGNOSIS AND VIGNETTE) IF <u>ANY</u> PSYCHIATRIC SYMPTOMS WERE REPORTED FOR THIS SUBJECT.