Form 11	**Date Completed** *dtcomplete*							
	M	M	D	D	Y	Y	Y	Y

Assessment: 2 ☐ baseline

ANXIETY COMORBIDITY MODULE

Social Phobia

1. Have you been very anxious in social situations or felt overly concerned about embarrassing or humiliating yourself in front of others, such as when speaking, eating, or writing? *phobia* *If yes, ask the subject to describe.*_____ *phobia_desc*	1 ☐ YES	0 ☐ NO Go to #7
2. Do you always feel anxious when you are _____? *phobia_1*	1 ☐ YES	0 ☐ NO
3. Do you go out of your way to avoid _____ or if unavoidable, do you tolerate_____ with extreme anxiety or distress? *phobia_2*	1 ☐ YES	0 ☐ NO
4. Do you think you are more afraid of _____ than you should be? *phobia_3*	1 ☐ YES	0 ☐ NO
5. Has (*the avoidance of* ____) made it hard for you to do your work, take care of things at home, or get along with other people? *phobia_4*	1 ☐ YES	0 ☐ NO
6. Are #2 –5 coded **YES**? *is_phobia*	1 ☐ YES **Social Phobia**	0 ☐ NO

Form 11	**Date Completed** *dtcomplete*							
	M	M	D	D	Y	Y	Y	Y

Assessment: 2 ☐ baseline

Obsessive Compulsive Disorder

Obsessions

7. Have you been bothered by intrusive thoughts that you had over and over again and could not get out of your head? *obsession* *If yes, ask the subject to describe.* _____*obsession_desc*	1 ☐ YES	0 ☐ NO Go to #13
Don't include brooding about problems or worrying about realistic dangers.		
8. Do these thoughts seem excessive or unreasonable? *obsession_1*	1 ☐ YES	0 ☐ NO
9. Do these thoughts bother or distress you a lot? *obsession_2*	1 ☐ YES	0 ☐ NO
10. Have these thoughts made it hard for you to do your work, get things done at home or get along with other people? *obsession_3*	1 ☐ YES	0 ☐ NO
11. Do these thoughts take more than one hour per day? *obsession_4*	1 ☐ YES	0 ☐ NO
12. Are #7 – 11 coded **YES**? *is_obsession*	1 ☐ YES **Obsessive DO**	0 ☐ NO

Compulsions

13. Have you ever felt that you had to do certain things over and over again, and couldn't resist doing them (e.g., hand washing, checking things several times)? *compulsion_1*	1 ☐ YES	0 ☐ NO Go to #19
14. Do these behaviors seem excessive or unreasonable? *compulsion_2*	1 ☐ YES	0 ☐ NO
15. Do these activities bother or distress you a lot? *compulsion_3*	1 ☐ YES	0 ☐ NO
16. Have these activities made it hard for you to do your work, get things done at home or get along with other people? *compulsion_4*	1 ☐ YES	0 ☐ NO
17. Do these behaviors take more than one hour per day? *compulsion_5*	1 ☐ YES	0 ☐ NO
18. Are #13 – 17 coded **YES**? *is_compulsion*	1 ☐ YES **Compulsive DO**	0 ☐ NO

Form 11	**Date Completed** *dtcomplete*							
	M	M	D	D	Y	Y	Y	Y

Assessment: 2 ☐ baseline

Posttraumatic Stress Disorder

19. Have you ever experienced or witnessed a very dangerous or life-threatening event such as being attacked, raped, seeing someone badly injured or killed, combat, accidents, or natural or man-made disasters? *stress_1*	1 ☐ YES	0 ☐ NO **STOP**
20. Did you feel extremely frightened, helpless, or experience a sense of horror when this happened? *stress_2*	1 ☐ YES	0 ☐ NO
Now I want to ask you about the symptoms you may have experienced since this event. Since then have you… Interviewer: if more than one event is identified, ask them to think about the worst one- the one that was most upsetting to them.		
21. had repeated and upsetting recollections of the event (such as thoughts or images of the event)? *stress_3*	1 ☐ YES	0 ☐ NO
22. had repeated, upsetting dreams of the event? *stress_4*	1 ☐ YES	0 ☐ NO
23. often had the feeling or acted as if the event were recurring (e.g., having illusions, hallucinations, or flashbacks of the event, including those that may have occurred upon awakening or when intoxicated) *stress_5*	1 ☐ YES	0 ☐ NO
24. felt a lot worse in situations that remind you of this event? *stress_6*	1 ☐ YES	0 ☐ NO
25. found yourself reacting physically to things that remind you of the trauma? Like breaking out in a sweat, breathing irregularly, or having your heart race or pound? *stress_7*	1 ☐ YES	0 ☐ NO
26. Is at least **one** of 21 – 25 coded **YES**? *Since ____ occurred, did you experience any of the following symptoms?*	1 ☐ YES	0 ☐ NO **STOP**
27. Have you tried to **avoid** thoughts, feelings, or conversations that remind you of this event? *symptom_1*	1 ☐ YES	0 ☐ NO
28. Have you tired to **avoid** activities, places, or people that bring back memories of this event? *symptom_2*	1 ☐ YES	0 ☐ NO
29. Are there any important aspects of the event that you are unable to remember? *symptom_3*	1 ☐ YES	0 ☐ NO
30. Do you find that you are now much less interested in participating in activities that are important to you? *symptom_4*	1 ☐ YES	0 ☐ NO
31. Have you felt distant and cut off from people? *symptom_5*	1 ☐ YES	0 ☐ NO
32. Have you felt numb or unable to have loving feelings for people close to you? *symptom_6*	1 ☐ YES	0 ☐ NO
33. Have you noticed a change in the way you think about or plan for the future like having a sense of foreshortened future? *symptom_7*	1 ☐ YES	0 ☐ NO
34. Are at least **three** of 27– 33 coded **YES**?	1 ☐ YES	0 ☐ NO **STOP**

Form 11	**Date Completed** *dtcomplete*							
	M	M	D	D	Y	Y	Y	Y

Assessment: 2 ☐ baseline

Since ____ occurred, did you experience any of the following"

35. Do you have difficulty falling or staying asleep? *experience_1*	1 ☐ YES	0 ☐ NO
36. Do you experience feelings of irritability or have angry outbursts (lose your temper)? *experience_2*	1 ☐ YES	0 ☐ NO
37. Do you have difficulty concentrating? *experience_3*	1 ☐ YES	0 ☐ NO
38. Do you find that you are overly watchful or hypervigilant to your surroundings? *experience_4*	1 ☐ YES	0 ☐ NO
39. Are you easily startled? *experience_5*	1 ☐ YES	0 ☐ NO
40. Are at least **two** of 35 – 39 coded **YES**?	1 ☐ YES	0 ☐ NO **STOP**
41. Have these problems lasted for **more than one month?** *problem_1*	1 ☐ YES	0 ☐ NO **STOP**
42. Have these problems often been very upsetting to you, or made it hard for you to do your work, take care of things at home, or get along with other people? *problem_2*	1 ☐ YES	0 ☐ NO **STOP**
43. Have they lasted **less than three months?**	1 ☐ YES **ACUTE PTSD STOP**	0 ☐ NO
44. Have they lasted **three months or more?**	1 ☐ YES **CHRONIC PTSD**	0 ☐ NO