

**FIGS: GENERAL SCREENING QUESTIONS**

**INTERVIEW DATE:**

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Month Day Year

<b>SUBJECT ID</b>												
<b>SITE ID</b>				<b>FAMILY ID</b>					<b>INDIVIDUAL ID</b>			
			—					—				

Step 1: *Let's talk about your family. I want you to think about your parents and siblings, offspring, aunts, uncles, cousins, grandparents, as well as any other relatives you can recall.*

Step 2: *Now I am asking you to keep in mind all those in your family as I go through this list of questions.  
Was anyone adopted?*

*Was anyone mentally retarded?*

*Did anyone:*

*Have problems with their nerves or emotions? Take medicine or see a doctor for it? Take lithium?*

*Feel very low for a couple of weeks or more, or have a diagnosis of depression?*

*Attempt or complete suicide?*

*Seem overexcited (or manic) day and night, or have a diagnosis of mania?*

*Have visions, hear voices, or have beliefs that seem strange or unreal?*

*Have unusual or bizarre behavior, or have a diagnosis of schizophrenia?*

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*Have trouble with the police, with completing school, or with keeping a job?*

*Have alcohol or drug use that caused problems (with health, family, job, or police)? Go to AA or NA, or have treatment for this?*

*(Was anyone) hospitalized for psychiatric problems, or for drug or alcohol problems?*

*Have inherited medical diseases such as Huntington's disease or seizure disorder or any other disorders of the brain or nervous system?*

*(Did anyone) have few friends, or seem to be a loner?*

*(Did anyone) seem odd or eccentric in behavior or appearance?*

*(Was anyone) extremely jealous, or suspicious, or believe in magic, or see special meanings in things that no one else saw?*

*Step 3: Complete a Family Summary Sheet and then a Face Sheet for each of the informant's first-degree relatives. If he/she knows well other affected relatives, also complete a Face Sheet for them. In addition, for each of these given a positive response in the General Screening, complete the symptom checklist for any suspected: Depression/Mania, Alcohol/Drug Abuse, or Psychosis.*

**FIGS: FAMILY SUMMARY**

**INTERVIEWER:** Fill out a complete Family Summary for each family. If you need additional sheets, use the continuation page(s) and enter consecutive numbers to indicate which FIGS # is associated with each person.

SUBJECT ID									
SITE ID			FAMILY ID				INDIVIDUAL ID		
			—						

**FIGS #:** 2 **INTERVIEWER:** Use this number on all other pages of this person's FIGS information.

**RELATIONSHIP TO PROBAND (Check one only):**

Mother

**FIGS #:** 3 **INTERVIEWER:** Use this number on all other pages of this person's FIGS information.

**RELATIONSHIP TO PROBAND (Check one only):**

Father

**FIGS #:** 4 **INTERVIEWER:** Use this number on all other pages of this person's FIGS information.

**RELATIONSHIP TO PROBAND (Check one only):**

<input type="checkbox"/> Child	<input type="checkbox"/> Full Sibling	<input type="checkbox"/> Grandchild	<input type="checkbox"/> Niece / Nephew	
<input type="checkbox"/> Mother	<input type="checkbox"/> Maternal Half-Sibling	<input type="checkbox"/> Maternal Grandparent	<input type="checkbox"/> Maternal Aunt / Uncle	<input type="checkbox"/> Maternal First Cousin
<input type="checkbox"/> Father	<input type="checkbox"/> Paternal Half-Sibling	<input type="checkbox"/> Paternal Grandparent	<input type="checkbox"/> Paternal Aunt / Uncle	<input type="checkbox"/> Paternal First Cousin

	<u>No</u>	<u>Yes</u>	<u>Unk</u>
Is there more than one person <b>of this type</b> in the family?	0	1	9

If **YES**, enter a number in this box to differentiate this FIGS from others of the same type (e.g., Full Sibling 1 vs. Full Sibling 2):

**FIGS #:** 5 **INTERVIEWER:** Use this number on all other pages of this person's FIGS information.

**RELATIONSHIP TO PROBAND (Check one only):**

<input type="checkbox"/> Child	<input type="checkbox"/> Full Sibling	<input type="checkbox"/> Grandchild	<input type="checkbox"/> Niece / Nephew	
<input type="checkbox"/> Mother	<input type="checkbox"/> Maternal Half-Sibling	<input type="checkbox"/> Maternal Grandparent	<input type="checkbox"/> Maternal Aunt / Uncle	<input type="checkbox"/> Maternal First Cousin
<input type="checkbox"/> Father	<input type="checkbox"/> Paternal Half-Sibling	<input type="checkbox"/> Paternal Grandparent	<input type="checkbox"/> Paternal Aunt / Uncle	<input type="checkbox"/> Paternal First Cousin

	<u>No</u>	<u>Yes</u>	<u>Unk</u>
Is there more than one person <b>of this type</b> in the family?	0	1	9

If **YES**, enter a number in this box to differentiate this FIGS from others of the same type (e.g., Full Sibling 1 vs. Full Sibling 2):

**FIGS #:** **6** **INTERVIEWER:** Use this number on all other pages of this person's FIGS information.

**RELATIONSHIP TO PROBAND (Check one only):**

- |                                 |   |  |  |  |
|---------------------------------|---|--|--|--|
| <input type="checkbox"/> Child  | <input type="checkbox"/> Full Sibling             | <input type="checkbox"/> Grandchild              | <input type="checkbox"/> Niece / Nephew        |  |
| <input type="checkbox"/> Mother | <input type="checkbox"/> Maternal<br>Half-Sibling | <input type="checkbox"/> Maternal<br>Grandparent | <input type="checkbox"/> Maternal Aunt / Uncle | <input type="checkbox"/> Maternal First Cousin |
| <input type="checkbox"/> Father | <input type="checkbox"/> Paternal<br>Half-Sibling | <input type="checkbox"/> Paternal<br>Grandparent | <input type="checkbox"/> Paternal Aunt / Uncle | <input type="checkbox"/> Paternal First Cousin |

	<u>No</u>	<u>Yes</u>	<u>Unk</u>
Is there more than one person <b>of this type</b> in the family?	0	1	9

If **YES**, enter a number in this box to differentiate this FIGS from others of the same type (e.g., Full Sibling 1 vs. Full Sibling 2):

**FIGS #:** **7** **INTERVIEWER:** Use this number on all other pages of this person's FIGS information.

- |                                 |   |  |  |  |
|---------------------------------|---|--|--|--|
| <input type="checkbox"/> Child  | <input type="checkbox"/> Full Sibling             | <input type="checkbox"/> Grandchild              | <input type="checkbox"/> Niece / Nephew        |  |
| <input type="checkbox"/> Mother | <input type="checkbox"/> Maternal<br>Half-Sibling | <input type="checkbox"/> Maternal<br>Grandparent | <input type="checkbox"/> Maternal Aunt / Uncle | <input type="checkbox"/> Maternal First Cousin |
| <input type="checkbox"/> Father | <input type="checkbox"/> Paternal<br>Half-Sibling | <input type="checkbox"/> Paternal<br>Grandparent | <input type="checkbox"/> Paternal Aunt / Uncle | <input type="checkbox"/> Paternal First Cousin |

	<u>No</u>	<u>Yes</u>	<u>Unk</u>
Is there more than one person <b>of this type</b> in the family?	0	1	9

If **YES**, enter a number in this box to differentiate this FIGS from others of the same type (e.g., Full Sibling 1 vs. Full Sibling 2):

**FIGS #:** **8** **INTERVIEWER:** Use this number on all other pages of this person's FIGS information.

- |                                 |   |  |  |  |
|---------------------------------|---|--|--|--|
| <input type="checkbox"/> Child  | <input type="checkbox"/> Full Sibling             | <input type="checkbox"/> Grandchild              | <input type="checkbox"/> Niece / Nephew        |  |
| <input type="checkbox"/> Mother | <input type="checkbox"/> Maternal<br>Half-Sibling | <input type="checkbox"/> Maternal<br>Grandparent | <input type="checkbox"/> Maternal Aunt / Uncle | <input type="checkbox"/> Maternal First Cousin |
| <input type="checkbox"/> Father | <input type="checkbox"/> Paternal<br>Half-Sibling | <input type="checkbox"/> Paternal<br>Grandparent | <input type="checkbox"/> Paternal Aunt / Uncle | <input type="checkbox"/> Paternal First Cousin |

	<u>No</u>	<u>Yes</u>	<u>Unk</u>
Is there more than one person <b>of this type</b> in the family?	0	1	9

If **YES**, enter a number in this box to differentiate this FIGS from others of the same type (e.g., Full Sibling 1 vs. Full Sibling 2):

**FIGS: FAMILY SUMMARY CONTINUATION**

**INTERVIEWER:** Use continuation pages and enter consecutive numbers to indicate which FIGS # is associated with each person.

SUBJECT ID									
SITE ID			FAMILY ID				INDIVIDUAL ID		
			—						

**FIGS #:**  **INTERVIEWER:** Use this number on all other pages of this person's FIGS information.

**RELATIONSHIP TO PROBAND (Check one only):**

<input type="checkbox"/> Child	<input type="checkbox"/> Full Sibling	<input type="checkbox"/> Grandchild	<input type="checkbox"/> Niece / Nephew	<input type="checkbox"/> Maternal First Cousin
<input type="checkbox"/> Mother	<input type="checkbox"/> Maternal Half-Sibling	<input type="checkbox"/> Maternal Grandparent	<input type="checkbox"/> Maternal Aunt / Uncle	<input type="checkbox"/> Maternal First Cousin
<input type="checkbox"/> Father	<input type="checkbox"/> Paternal Half-Sibling	<input type="checkbox"/> Paternal Grandparent	<input type="checkbox"/> Paternal Aunt / Uncle	<input type="checkbox"/> Paternal First Cousin

<u>No</u>	<u>Yes</u>	<u>Unk</u>
0	1	9

If **YES**, enter a number in this box to differentiate this FIGS from others of the same type (e.g., Full Sibling 1 vs. Full Sibling 2):

**FIGS #:**  **INTERVIEWER:** Use this number on all other pages of this person's FIGS information.

**RELATIONSHIP TO PROBAND (Check one only):**

<input type="checkbox"/> Child	<input type="checkbox"/> Full Sibling	<input type="checkbox"/> Grandchild	<input type="checkbox"/> Niece / Nephew	<input type="checkbox"/> Maternal First Cousin
<input type="checkbox"/> Mother	<input type="checkbox"/> Maternal Half-Sibling	<input type="checkbox"/> Maternal Grandparent	<input type="checkbox"/> Maternal Aunt / Uncle	<input type="checkbox"/> Maternal First Cousin
<input type="checkbox"/> Father	<input type="checkbox"/> Paternal Half-Sibling	<input type="checkbox"/> Paternal Grandparent	<input type="checkbox"/> Paternal Aunt / Uncle	<input type="checkbox"/> Paternal First Cousin

<u>No</u>	<u>Yes</u>	<u>Unk</u>
0	1	9

If **YES**, enter a number in this box to differentiate this FIGS from others of the same type (e.g., Full Sibling 1 vs. Full Sibling 2):

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<input type="checkbox"/> Father	<input type="checkbox"/> Paternal Half-Sibling	<input type="checkbox"/> Paternal Grandparent	<input type="checkbox"/> Paternal Aunt / Uncle	<input type="checkbox"/> Paternal First Cousin

<u>No</u>	<u>Yes</u>	<u>Unk</u>
0	1	9

If **YES**, enter a number in this box to differentiate this FIGS from others of the same type (e.g., Full Sibling 1 vs. Full Sibling 2):

**FIGS: FAMILY SUMMARY CONTINUATION**

FIGS 4.0 / BP  
15-Feb-2005

**FIGS #:**  **INTERVIEWER:** Use this number on all other pages of this person's FIGS information.

**RELATIONSHIP TO PROBAND** (Check one only):

- |                                 |   |  |  |  |
|---------------------------------|---|--|--|--|
| <input type="checkbox"/> Child  | <input type="checkbox"/> Full Sibling             | <input type="checkbox"/> Grandchild              | <input type="checkbox"/> Niece / Nephew        |  |
| <input type="checkbox"/> Mother | <input type="checkbox"/> Maternal<br>Half-Sibling | <input type="checkbox"/> Maternal<br>Grandparent | <input type="checkbox"/> Maternal Aunt / Uncle | <input type="checkbox"/> Maternal First Cousin |
| <input type="checkbox"/> Father | <input type="checkbox"/> Paternal<br>Half-Sibling | <input type="checkbox"/> Paternal<br>Grandparent | <input type="checkbox"/> Paternal Aunt / Uncle | <input type="checkbox"/> Paternal First Cousin |

	<u>No</u>	<u>Yes</u>	<u>Unk</u>
Is there more than one person <b>of this type</b> in the family?	0	1	9

If **YES**, enter a number in this box to differentiate this FIGS from others of the same type (e.g., Full Sibling 1 vs. Full Sibling 2):

**FIGS #:**  **INTERVIEWER:** Use this number on all other pages of this person's FIGS information.

**RELATIONSHIP TO PROBAND** (Check one only):

- |                                 |   |  |  |  |
|---------------------------------|---|--|--|--|
| <input type="checkbox"/> Child  | <input type="checkbox"/> Full Sibling             | <input type="checkbox"/> Grandchild              | <input type="checkbox"/> Niece / Nephew        |  |
| <input type="checkbox"/> Mother | <input type="checkbox"/> Maternal<br>Half-Sibling | <input type="checkbox"/> Maternal<br>Grandparent | <input type="checkbox"/> Maternal Aunt / Uncle | <input type="checkbox"/> Maternal First Cousin |
| <input type="checkbox"/> Father | <input type="checkbox"/> Paternal<br>Half-Sibling | <input type="checkbox"/> Paternal<br>Grandparent | <input type="checkbox"/> Paternal Aunt / Uncle | <input type="checkbox"/> Paternal First Cousin |

	<u>No</u>	<u>Yes</u>	<u>Unk</u>
Is there more than one person <b>of this type</b> in the family?	0	1	9

If **YES**, enter a number in this box to differentiate this FIGS from others of the same type (e.g., Full Sibling 1 vs. Full Sibling 2):

**FIGS #:**  **INTERVIEWER:** Use this number on all other pages of this person's FIGS information.

**RELATIONSHIP TO PROBAND** (Check one only):

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	<u>No</u>	<u>Yes</u>	<u>Unk</u>
Is there more than one person <b>of this type</b> in the family?	0	1	9

If **YES**, enter a number in this box to differentiate this FIGS from others of the same type (e.g., Full Sibling 1 vs. Full Sibling 2):

**FIGS: FACE SHEET**

**FAMILY INTERVIEW FOR GENETIC STUDIES  
(FIGS)**

**INTERVIEW DATE:**

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Month Day Year

<b>FIGS ID</b>											
<b>SITE ID</b>			—	<b>FAMILY ID</b>				—	<b>FIGS # (* see footnote)</b>		

Year when last seen or known about, or died: 

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Year

Is person being described living? 0 1 9

If deceased, cause of death: \_\_\_\_\_

Suicide? 0 1 9

**INTERVIEWER:** Refer to General Screening Questions if necessary.

1. **(Probe:** has he/she had any psychiatric or personality problems like those we mentioned earlier?) 0 1 9  
 Write narrative:

\* Use the FIGS # from the Family Summary Sheet to indicate which person is being reported in this FIGS

Continue Narrative:



**FIGS: DEPRESSION CHECKLIST**

FIGS ID											
SITE ID			—	FAMILY ID				—	FIGS # (* see footnote)		

Code for a single episode (best recalled, worst episode if possible).

	<u>No</u>	<u>Yes</u>	<u>Unk</u>
1. <i>During depression...</i>			
1.a) <i>...was he/she depressed most of the day, nearly every day, for as long as a week or more?</i>	0	1	9
1.b) <i>...did he/she lose interest in things or become unable to enjoy most things, for as long as a week?</i>	0	1	9
1.c) <i>...did he/she have a change in appetite or weight without trying to?</i>	0	1	9
1.d) <i>...did he/she have a change in sleep patterns (either too much or too little)?</i>	0	1	9
1.e) <i>...did he/she become unable to work, go to school, or take care of household responsibilities?</i>	0	1	9
<b>If yes:</b> Describe: _____ _____			
<b>If all NO, discontinue this checklist</b>			
1.f) <i>...did he/she move or speak more slowly than usual?</i>	0	1	9
1.g) <i>...did he/she pace or wring his/her hands?</i>	0	1	9
1.h) <i>...did he/she have less energy or feel tired out?</i>	0	1	9
1.i) <i>...did he/she feel guilty, worthless or blame himself/herself?</i>	0	1	9
1.j) <i>...did he/she have trouble concentrating or making decisions?</i>	0	1	9
1.k) <i>...did he/she talk of death or suicide? Or try suicide?</i>	0	1	9
1.l) <i>...did he/she have visions, or hear voices, or have beliefs or behavior that seem strange or unusual, at the same time as (symptoms above)? (If YES, complete a Psychosis Checklist after this one.)</i>	0	1	9

\* Use the FIGS # from the Family Summary Sheet to indicate which person is being reported in this FIGS

		Code Response					
2.	Code and describe professional treatment (code all that apply):	0	1	2	3	4	9
	0. None						
	1. Inpatient: _____						
	2. Outpatient: _____						
	3. ECT: _____						
	4. Medication: _____						
	9. Unknown						
3.	Age of onset					Age	<input style="width: 100px; height: 20px;" type="text"/>
4.	Number of episodes					Episodes	<input style="width: 100px; height: 20px;" type="text"/>
5.	Duration of longest episode in weeks					Weeks	<input style="width: 100px; height: 20px;" type="text"/>
						Code	<input style="width: 100px; height: 20px;" type="text"/>
						Response	<hr style="width: 100%;"/>
6.	Rate and code impairment or incapacitation:	0	1	2	9		
	0. None						
	1. Impairment						
	2. Incapacitation						
	9. Unknown						
7.	Interviewer judgement on reliability of this information:					1	2
	1. Good					3	
	2. Fair						
	3. Poor						

<b>FIGS ID</b>											
<b>SITE ID</b>				<b>FAMILY ID</b>					<b>FIGS # (* see footnote)</b>		
			—					—			

	<u>No</u>	<u>Yes</u>	<u>Unk</u>
1. <i>For most of the time day and night over several days, did he/she (more than usual)...</i>			
1.a) <i>...seem too happy/high/excited?</i>	0	1	9
1.b) <i>...become so excited or agitated it was impossible to converse with him/her?</i>	0	1	9
1.c) <i>...act very irritable or angry?</i>	0	1	9
1.d) <i>...need less sleep without feeling tired?</i>	0	1	9
1.e) <i>...show poor judgement (e.g., spending sprees, sexual indiscretions?)</i>	0	1	9
<b>If yes:</b> Describe: _____ _____			
<b>If all NO, discontinue this checklist</b>			
1.f) <i>...behave in such a way as to cause difficulty for those around him/her (obnoxious/manipulative)?</i>	0	1	9
1.g) <i>...feel that he/she had special gifts or powers?</i>	0	1	9
1.h) <i>...become more talkative than usual?</i>	0	1	9
1.i) <i>...jump from one idea to another?</i>	0	1	9
1.j) <i>...become easily distracted?</i>	0	1	9
1.k) <i>...get involved in too many activities at work or school?</i>	0	1	9
1.l) <i>...have visions? hear voices? have beliefs or behavior that seem strange or unusual? at the same time as (above symptoms)? (If YES, complete a Psychosis Checklist after this one.)</i>	0	1	9

\* Use the FIGS # from the Family Summary Sheet to indicate which person is being reported in this FIGS

		Code Response					
2.	Code and describe professional treatment (code all that apply):	0	1	2	3	4	9
	0. None						
	1. Inpatient: _____						
	2. Outpatient: _____						
	3. ECT: _____						
	4. Medication: _____						
	9. Unknown						
3.	Age of onset						Age [ ]
4.	Number of episodes						Episodes [ ]
5.	Duration of longest episode in weeks						Weeks [ ]
							Code Response
6.	Rate and code impairment or incapacitation:	0	1	2	3	4	9
	0. None						
	1. Mild impairment						
	2. Marked impairment (in occupation or other role)						
	3. Incapacitated (e.g., hospitalized)						
	4. Improvement in function (hypomania)						
	9. Unknown						
7.	Interviewer judgement on reliability of this information:						
	1. Good						
	2. Fair						
	3. Poor						

FIGS ID											
SITE ID			—	FAMILY ID				—	FIGS # (* see footnote)		

**ALCOHOLISM**

**INTERVIEWER:** Code for a single episode (best recalled, worst episode if possible).

*I am going to ask you a series of questions about alcohol and drug use. I will use the word “often” in some of these questions; by often, we mean three or more times.*

	<u>No</u>	<u>Yes</u>	<u>Unk</u>
1. <i>Has his/her drinking or being hung over <u>often</u> kept him/her from working or taking care of household responsibilities?</i>	0	1	9
2. <i>Has he/she <u>often</u> been high from drinking in a situation where it increased his/her chances of getting hurt—for instance, when driving, using machinery or guns, or during sports?</i>	0	1	9
3. <i>Did his/her alcohol use more than once cause him/her to have legal problems, such as arrests for drunk driving or disorderly conduct or drunken behavior?</i>	0	1	9
4. <i>Did his/her drinking <u>often</u> cause him/her to have problems at work, school or at home?</i>	0	1	9

**Alcohol Dependence**

**Loss of Control / Compulsive Use**

5. <i>Has he/she <u>often</u> kept on drinking when they promised that he/she would not, or has he/she often drunk more than he/she intended to?</i>	0	1	9
6. <i>Has he/she <u>often</u> wanted or tried to stop or cut down on drinking?</i>	0	1	9
7. <i>Did he/she ever try to stop or cut down on drinking and find he/she could not?</i>	0	1	9
8. <i>Has there ever been a period when he/she spent so much time drinking or recovering from the effects of alcohol that he/she had little time for anything else?</i>	0	1	9
9. <i>Has he/she <u>often</u> given up or greatly reduced important activities because of his/her drinking—like sports, work, or associating with friends or relatives?</i>	0	1	9

**Tolerance**

10. <i>Did he/she ever need to drink a lot more in order to get an effect, or find that he/she could no longer get high or drunk on the amount they used to drink?</i>	0	1	9
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**Psychological and Physical problems**

11. <i>Has he/she more than once had blackouts, when he/she did not pass out, but he/she drank enough so that the next day he/she could not remember things he/she said or did?</i>	0	1	9
11.a) <b>If yes:</b> <i>Did he/she continue to drink after he/she knew it caused him/her any of these problems?</i>	0	1	9
12. <i>While drinking, did he/she more than once have psychological problems start or get worse such as feeling depressed, feeling paranoid, trouble thinking clearly, hearing, smelling or seeing things, or feeling jumpy?</i>	0	1	9
12.a) <b>If yes:</b> <i>Did he/she continue to drink after he/she knew it caused him/her any of these problems?</i>	0	1	9

\* Use the FIGS # from the Family Summary Sheet to indicate which person is being reported in this FIGS

	<u>No</u>	<u>Yes</u>	<u>Unk</u>
13. <i>There are several other health problems that can result from long stretches of heavy drinking. Did he/she more than once have a serious health problem such as liver disease, pancreatitis, or stomach disease from drinking?</i>	0	1	9
13.a) <b>If yes:</b> <i>Did he/she continue to drink knowing that drinking caused him/her to have health problems?</i>	0	1	9
14. <i>Has he/she ever continued to drink when he/she knew he/she had any (other) serious physical illness that might be made worse by drinking?</i>	0	1	9

**Withdrawal**

15. <i>Did he/she ever have times when he/she stopped or cut down on drinking and had withdrawal problems such as shaking hands, nausea and vomiting, sweating, anxiety, or trouble sleeping?</i>	0	1	9
15.a) <b>If yes:</b> <i>Has he/she more than once taken a drink to keep from having any of these symptoms or to make them go away?</i>	0	1	9

Code Response

16. <i>Did he/she go to AA or have any kind of treatment? (Code and describe all that apply)</i>	0	1	2	3	4	9
0. None						
1. Inpatient: _____						
2. Outpatient: _____						
3. AA or other self-help: _____						
4. Medication: _____						
9. Unknown						

Describe details and/or other treatment:

17. <i>Does he/she currently have a problem with alcohol?</i>	<u>No</u> 0	<u>Yes</u> 1	<u>Unk</u> 9
18. Record age he/she began to have alcohol-related problems.			Ons Age <input type="text"/>
19. Record age he/she stopped drinking heavily.			Rec Age <input type="text"/>

**DRUG ABUSE/DEPENDENCE**20. *Which drugs did he/she have trouble with?*

Specify: \_\_\_\_\_

	<u>No</u>	<u>Yes</u>	<u>Unk</u>
<b><u>Drug Abuse</u></b>			
21. <i>Has he/she <u>often</u> been high on (Drug) or suffering its after-effects while in school, working, or taking care of household responsibilities?</i>	0	1	9
22. <i>Has he/she <u>often</u> been under the effects of (Drug) in a situation where it increased their chances of getting hurt—for instance, when driving, using knives or machinery or guns, or during sports?</i>	0	1	9
23. <i>Did his/her use of (Drug) more than once cause them to have legal problems such as arrests for disorderly conduct, possession or selling?</i>	0	1	9
24. <i>Did his/her (Drug) use <u>often</u> cause him/her to have problems at work, school, or at home?</i>	0	1	9

**Drug Dependence****Loss of Control / Compulsive Use**

25. <i>Has he/she <u>often</u> used (Drug) more days or in larger amounts than he/she intended to?</i>	0	1	9
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- |     |   |   |   |   |
|-----|---|---|---|---|
| 26. | <i>Has he/she <u>often</u> wanted to or tried to cut down on (Drug)?</i>  | 0 | 1 | 9 |
| 27. | <i>Did he/she ever try to cut down on (Drug) and find that he/she could not?</i>  | 0 | 1 | 9 |
| 28. | <i>Has there ever been a period of a month or more when a great deal of his/her time was spent using (Drug), getting (Drug), or getting over effects?</i> | 0 | 1 | 9 |
| 29. | <i>Has he/she <u>often</u> given up or greatly reduced important activities with friends or relatives or at work in order to use (Drug)?</i>              | 0 | 1 | 9 |

**Tolerance**

- |     |   |   |   |   |
|-----|---|---|---|---|
| 30. | <i>Did he/she ever need larger amounts of (Drug) to get an effect, or find that he/she could no longer get high on the amount he/she used to use?</i> | 0 | 1 | 9 |
|-----|---|---|---|---|

**Psychological and Physical problems**

- |       |  |   |   |   |
|-------|--|---|---|---|
| 31.   | <i>While using (Drug), did he/she more than once have psychological problems start or get worse, such as feeling depressed, feeling paranoid, trouble thinking clearly, hearing, smelling, or seeing things, or feeling jumpy?</i> | 0 | 1 | 9 |
| 31.a) | <b>If yes:</b> <i>Did he/she continue to use (Drug) after he/she knew it caused these problems?</i>  | 0 | 1 | 9 |
| 32.   | <i>Did using (Drug) cause him/her more than once to have any physical health problem (other than withdrawal)?</i>  | 0 | 1 | 9 |
| 31.a) | <b>If yes:</b> <i>Did he/she continue to use (Drug) after he/she knew it caused these problems?</i>  | 0 | 1 | 9 |

**Withdrawal**

- |     |   |   |   |   |
|-----|---|---|---|---|
| 33. | <i>Did he/she ever have times when he/she stopped or cut down on his/her (Drug) use and had withdrawal problems such as irritability, depression, fatigue, or trouble sleeping?</i> | 0 | 1 | 9 |
| 34. | <b>If yes:</b> <i>Did he/she use (Drug) to prevent these symptoms?</i>  | 0 | 1 | 9 |

Code Response

- |     |  |   |   |   |   |   |   |
|-----|--|---|---|---|---|---|---|
| 35. | <i>Did he/she go to NA or have any kind of treatment? (Code and describe all that apply)</i> | 0 | 1 | 2 | 3 | 4 | 9 |
|     | 0. None  |   |   |   |   |   |   |
|     | 1. Inpatient: _____  |   |   |   |   |   |   |
|     | 2. Outpatient: _____   |   |   |   |   |   |   |
|     | 3. NA or other self-help: _____  |   |   |   |   |   |   |
|     | 4. Medication: _____   |   |   |   |   |   |   |
|     | 9. Unknown   |   |   |   |   |   |   |

Describe details and/or other treatment:

- |     |   |                |                 |                                 |
|-----|---|----------------|-----------------|---------------------------------|
| 36. | <i>Does he/she currently have a problem with drugs?</i> | <u>No</u><br>0 | <u>Yes</u><br>1 | <u>Unk</u><br>9                 |
| 37. | Record age he/she began to have drug-related problems.  |                |                 | Ons Age<br><input type="text"/> |
| 38. | Record age he/she stopped using drugs heavily.          |                |                 | Rec Age<br><input type="text"/> |
|     |   |                |                 | Code Response                   |

- |     |  |   |   |   |
|-----|--|---|---|---|
| 39. | Interviewer judgment on reliability of this information: | 1 | 2 | 3 |
|     | 1. Good  |   |   |   |
|     | 2. Fair  |   |   |   |
|     | 3. Poor  |   |   |   |





<b>FIGS ID</b>											
<b>SITE ID</b>			—	<b>FAMILY ID</b>				—	<b>FIGS # (* see footnote)</b>		

**PSYCHOSIS**

Code for a single episode (best recalled, worst episode if possible).

1. *What were his/her unusual beliefs or experiences?*

Specify: \_\_\_\_\_  
\_\_\_\_\_

<i>Did he/she ever...</i>	<u>No</u>	<u>Yes</u>	<u>Unk</u>
1.a) <i>...believe people were following him/her, or that someone was trying to hurt or poison him/her?</i>	0	1	9
1.b) <i>...believe someone was reading his/her mind?</i>	0	1	9
1.c) <i>...believe he/she was under the control of some outside person or power or force?</i>	0	1	9
1.d) <i>...believe his/her thoughts were broadcast, or that an outside force took away his/her thoughts or put thoughts into his/her head?</i>	0	1	9
1.e) <i>...have any other strange or unusual beliefs?</i>	0	1	9

**If yes:** Describe: \_\_\_\_\_  
\_\_\_\_\_

1.f) <i>...see things that were not really there?</i>	0	1	9
1.g) <i>...hear voices or other sounds that were not real?</i>	0	1	9

**If yes:** Describe: \_\_\_\_\_  
\_\_\_\_\_

**Skip to question 1.h**

	<u>No</u>	<u>Yes</u>	<u>Unk</u>
1.g.1) (Code <b>YES</b> if: voice with content having no relation to depression or elation, or voice keeping up running commentary on subject's behavior or thoughts, or two or more voices conversing.)	0	1	9

\* Use the FIGS # from the Family Summary Sheet to indicate which person is being reported in this FIGS

**FIGS: PSYCHOSIS CHECKLIST**

1.h) ... *speak in a way that was difficult to make sense of?* 0    1    9

**If yes:** Describe: \_\_\_\_\_  
\_\_\_\_\_

1.i) ... *seem to be physically stuck in one position, or move around excitedly without any purpose?* 0    1    9

1.j) ... *appear to have no emotions, or inappropriate emotions?* 0    1    9

2. How long did the longest of these experiences last?

Weeks

**INTERVIEWER: If less than 1 week (unless successfully treated), STOP HERE. Otherwise continue, if informant is knowledgeable about this person.**

**INTERVIEWER: If subject did NOT have any episode of Major Depression or Mania (by FIGS checklists from this informant), skip to question 6.**

3. When any (SX above) happened, did he/she also have the mood disturbance we discussed before, at the same time? 

<u>No</u>	<u>Yes</u>	<u>Unk</u>
0	1	9

**Skip to question 6**

**INTERVIEWER:** For the rest of this checklist, “illness duration” refers to total time of illness, including active and prodromal and/or residual symptoms and/or treatment (include time on medication).

4. (Probe and code **YES** if mania and/or depression lasted at least 30% of total duration of illness described above, or medication for it.) 

<u>No</u>	<u>Yes</u>	<u>Unk</u>
0	1	9

5. (Probe and code **YES** if illness described above, or medication for it, was ever present for as long as one week, without depression and/or mania.) 

<u>No</u>	<u>Yes</u>	<u>Unk</u>
0	1	9

**Skip to question 6**

5.a) (Code **YES** if the above was true for as long as two weeks.) 0    1    9

- |  | Code Response  |   |  |       |   |    |   |               |  |  |
|--|--|---|--|-------|---|----|---|---------------|--|--|
| 6. Code and describe professional treatment (Code and describe all that apply):  | 0 1 2 3 4 9  |   |  |       |   |    |   |               |  |  |
| 0. None  |  |   |  |       |   |    |   |               |  |  |
| 1. Inpatient: _____  |  |   |  |       |   |    |   |               |  |  |
| 2. Outpatient: _____   |  |   |  |       |   |    |   |               |  |  |
| 3. ECT: _____  |  |   |  |       |   |    |   |               |  |  |
| 4. Medication: _____   |  |   |  |       |   |    |   |               |  |  |
| 9. Unknown   |  |   |  |       |   |    |   |               |  |  |
| Describe details and/or other treatment:   |  |   |  |       |   |    |   |               |  |  |
|  |  |   |  |       |   |    |   |               |  |  |
| 7. Age of onset  | Age<br><input style="width: 100px; height: 20px;" type="text"/>  |   |  |       |   |    |   |               |  |  |
| 8. Number of episodes (Code <b>001</b> if chronic symptoms and/or treatment since onset)   | Episodes<br><input style="width: 100px; height: 20px;" type="text"/>   |   |  |       |   |    |   |               |  |  |
| 9. <u>Total</u> illness duration ( <u>all</u> episodes, includes active and prodromal and/or residual symptoms and/or treatment. | <table style="margin: auto;"> <tr> <td style="text-align: center;">Weeks</td> <td></td> <td style="text-align: center;">Years</td> </tr> <tr> <td style="text-align: center;"><input style="width: 80px; height: 20px;" type="text"/></td> <td style="text-align: center;">OR</td> <td style="text-align: center;"><input style="width: 80px; height: 20px;" type="text"/></td> </tr> <tr> <td colspan="3" style="text-align: center;">Code Response</td> </tr> </table> | Weeks   |  | Years | <input style="width: 80px; height: 20px;" type="text"/> | OR | <input style="width: 80px; height: 20px;" type="text"/> | Code Response |  |  |
| Weeks  |  | Years   |  |       |   |    |   |               |  |  |
| <input style="width: 80px; height: 20px;" type="text"/>  | OR   | <input style="width: 80px; height: 20px;" type="text"/> |  |       |   |    |   |               |  |  |
| Code Response  |  |   |  |       |   |    |   |               |  |  |
| 10. Rate and code impairment or incapacitation:  | 0 1 2 9  |   |  |       |   |    |   |               |  |  |
| 0. None  |  |   |  |       |   |    |   |               |  |  |
| 1. Impaired  |  |   |  |       |   |    |   |               |  |  |
| 2. Incapacitated   |  |   |  |       |   |    |   |               |  |  |
| 9. Unknown   |  |   |  |       |   |    |   |               |  |  |
| 11. Interviewer judgement on reliability of this information:  | 1 2 3  |   |  |       |   |    |   |               |  |  |
| 1. Good  |  |   |  |       |   |    |   |               |  |  |
| 2. Fair  |  |   |  |       |   |    |   |               |  |  |
| 3. Poor  |  |   |  |       |   |    |   |               |  |  |

**INTERVIEWER: If informant apparently does not know subject well enough to give information on Prodromal/Residual symptoms, STOP HERE.**

**If duration criterion for DSM III-R Schizophrenia, Chronic Type, already met, (question 9, total illness duration > 2 years), STOP HERE.**

**FIGS: PSYCHOSIS CHECKLIST**

**INTERVIEWER:** Use this page only if Schizo-affective is ruled out (by questions 3 to 5 above), or if the psychosis symptoms lasted at least one week (or shorter duration if successfully treated).

**Establishing the Prodromal Period:**

12. Now I would like to ask you about the year before his/her **(psychotic symptoms)** started. During that time did he/she...

(Ask after completing question 16.a-1 for the Prodromal period:)

**Establishing the Residual Period:**

Now I would like to ask you about the year after his/her **(psychotic symptoms)** stopped. During that time did he/she...

	<b>Prodromal Period</b>			<b>Residual Period</b>		
	<u>No</u>	<u>Yes</u>	<u>Unk</u>	<u>No</u>	<u>Yes</u>	<u>Unk</u>
12.a) ...stay away from family and friends, become socially isolated?	0	1	9	0	1	9
12.b) ...have trouble doing his/her job, going to school, or doing work at home?	0	1	9	0	1	9
12.c) ...do something peculiar like talking to self in public?	0	1	9	0	1	9
12.d) ...neglect hygiene and grooming?	0	1	9	0	1	9
12.e) ...appear to have no emotions or inappropriate emotions?	0	1	9	0	1	9
12.f) ...speak in a way that was hard to understand, or was he/she at a loss for words?	0	1	9	0	1	9
12.g) ...have unusual beliefs or ideas?	0	1	9	0	1	9
12.h) ...have unusual perceptions, like sensing the presence of a person not actually present?	0	1	9	0	1	9
12.i) ...have no interests, no energy?	0	1	9	0	1	9
12.j) ...find special meaning in TV, radio, or newspaper articles?	0	1	9	0	1	9
12.k) ...feel nervous with other people?	0	1	9	0	1	9
12.l) ...worry that people were out to get him/her?	0	1	9	0	1	9
13.a) How long did he/she have these experiences?	Weeks					

**INTERVIEWER:** Return to top of question 12 to establish the Residual period and code in Residual Column.

13.b) How long did he/she have these experiences after his/her **(Active psychotic features)** stopped?

Weeks

No   Yes   Unk

14. Was he/she always this way?

0   1   9

<b>FIGS ID</b>											
<b>SITE ID</b>			—	<b>FAMILY ID</b>				—	<b>FIGS # (* see footnote)</b>		

Code based on Informant's Report:

Did person being described have:		<u>No</u>	<u>Yes</u>	<u>Unk</u>
<b>1.</b>	<b>Depression</b>	0	1	9
	1.a) Single	0	1	9
	1.b) Recurrent	0	1	9
	1.c) Impaired/Incapacitated	0	1	9
	1.d) Treatment	0	1	9
	1.e) Age of onset		Age	<input style="width: 50px; height: 20px;" type="text"/>
<b>2.</b>	<b>Mania</b>	0	1	9
	2.a) Single	0	1	9
	2.b) Recurrent	0	1	9
	2.c) Impaired/Incapacitated	0	1	9
	2.d) Treatment	0	1	9
	2.e) Age of onset		Age	<input style="width: 50px; height: 20px;" type="text"/>
<b>3.</b>	<b>Psychosis</b>	0	1	9
	3.a) (1) Chronic or (2) acute?	1	2	
	3.b) Outside of mood disorder	0	1	9
	3.c) Treatment	0	1	9
	3.d) Age of onset		Age	<input style="width: 50px; height: 20px;" type="text"/>
<b>4.</b>	<b>Alcohol</b>	<u>No</u>	<u>Yes</u>	<u>Unk</u>
	4.a) Dependence	0	1	9
	4.b) Treatment	0	1	9
	4.c) Age of onset		Age	<input style="width: 50px; height: 20px;" type="text"/>
<b>5.</b>	<b>Drugs</b>	0	1	9
	5.a) Specify: _____			

\* Use the FIGS # from the Family Summary Sheet to indicate which person is being reported in this FIGS

<b>FIGS: COMPOSITE SHEET</b>
------------------------------

		<u>No</u>	<u>Yes</u>	<u>Unk</u>
5.b)	Dependence	0	1	9
5.c)	Treatment	0	1	9
5.d)	Age of onset	Age		
6.	<b>Other</b>	0	1	9
6.a)	Specify: _____			
6.a.1)	DX Code	_ _ _ . _ _		
6.a.2)	Treatment	0	1	9
6.b)	Specify: _____			
6.b.1)	DX Code	_ _ _ . _ _		
6.b.2)	Treatment	0	1	9
6.c)	Specify: _____			
6.c.1)	DX Code	_ _ _ . _ _		
6.c.2)	Treatment	0	1	9
7.	<b>NMI</b>	0	1	9