



45447



South Carolina PLAY
Project to Learn about ADHD in Youth

ID Number

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OMB No: 0920-0747; Exp Date: 7/31/2010

Parent Questionnaire (Version P)

Many people have emotional problems at one time or another. We want to ask you about your own experience with emotional and behavioral problems and then about your child's history. Remember that your answers are confidential. Your name does not appear on this form and no one outside the research team will know what you say. Please begin now. Thank you.

1. Have you ever had a period of time that lasted at least 2 weeks when you felt depressed (or down or blue)? Multiple symptoms of depression may include sadness, low energy, poor sleep (too little or too much), no appetite or too much appetite, not enjoying activities, or suicidal thoughts.		<input type="radio"/> Yes	<input type="radio"/> No		
If Yes:	1a. How old were you when it first occurred?	<table border="1"><tr><td></td><td></td></tr></table>			year(s)
	1b. How many episodes have you had?	<table border="1"><tr><td></td><td></td></tr></table>			
1c. How long ago was the last episode?	<input type="radio"/> < 1 month <input type="radio"/> 1-6 months <input type="radio"/> 7-12 months	OR <table border="1"><tr><td></td><td></td></tr></table> year(s)			
1d. Have you ever been told by a doctor or other health professional that you have depression?	<input type="radio"/> Yes	<input type="radio"/> No			
2. Have you ever had serious anxiety symptoms, such as:					
2a. Panic attacks (shortness of breath, chest pain, numbness, tingling, sweating)?		<input type="radio"/> Yes	<input type="radio"/> No		
2b. Feeling generally anxious for 6 months or more (excessive worrying, tension, feeling keyed up)?		<input type="radio"/> Yes	<input type="radio"/> No		
3. Have you ever been told by a doctor or other health professional that you have:					
3a. Post-Traumatic Stress Disorder (PTSD)?		<input type="radio"/> Yes	<input type="radio"/> No		
3b. Obsessive Compulsive Disorder (OCD)?		<input type="radio"/> Yes	<input type="radio"/> No		
4. Have you ever been told by a doctor or other health professional that you have Bipolar or Manic-Depressive Disorder?		<input type="radio"/> Yes	<input type="radio"/> No		
5. Have you ever been told by a doctor or other health professional that you have Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD)?		<input type="radio"/> Yes	<input type="radio"/> No		

Public reporting burden of this collection of information is estimated to average 5 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this information, including suggestions for reducing this burden to CDC/ATSDR Information Clearance Officer, 1600 Clifton Road NE, MS D-24, Atlanta, Georgia 30333: ATTN: PRA (OMB No: 0920-0747).



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6. Have you ever heard voices talking to you or seen things other people could not hear or see?		<input type="radio"/> Yes	<input type="radio"/> No
7. Have you ever been treated by a psychiatrist or other mental health professional, such as a psychologist?		<input type="radio"/> Yes	<input type="radio"/> No
7a. If yes, what diagnosis did that person make?		<input type="radio"/> Depression <input type="radio"/> Bipolar or Manic Depressive Disorder <input type="radio"/> Generalized Anxiety <input type="radio"/> Panic Disorder <input type="radio"/> Obsessive-Compulsive Disorder (OCD) <input type="radio"/> Post-traumatic Stress Disorder (PTSD) <input type="radio"/> Attention-Deficit/Hyperactivity Disorder <input type="radio"/> Oppositional Defiant Disorder <input type="radio"/> Conduct Disorder <input type="radio"/> Borderline Personality Disorder <input type="radio"/> Schizophrenia or Schizoaffective Disorder <input type="radio"/> Other (please specify) _____ <input type="radio"/> No diagnosis <input type="radio"/> Don't Know	
8. Have you ever received counseling for an emotional or behavioral problem?		<input type="radio"/> Yes	<input type="radio"/> No
8a. If yes, what was the problem?			
9. Have you ever taken medication for an emotional problem?		<input type="radio"/> Yes	<input type="radio"/> No
9a. If yes, what is the name of the medication(s)?	<input type="radio"/> Prozac <input type="radio"/> Paxil <input type="radio"/> Zoloft <input type="radio"/> Effexor <input type="radio"/> Wellbutrin <input type="radio"/> Remeron <input type="radio"/> Lithium <input type="radio"/> Depakote <input type="radio"/> Tegretol <input type="radio"/> Neurontin <input type="radio"/> Topamax <input type="radio"/> Trileptal <input type="radio"/> Zyprexa	<input type="radio"/> Seroquel <input type="radio"/> Risperdol <input type="radio"/> Geodon <input type="radio"/> Haldol <input type="radio"/> Ritalin <input type="radio"/> Adderall <input type="radio"/> Concerta <input type="radio"/> Cylert <input type="radio"/> Clonidine <input type="radio"/> Strattera <input type="radio"/> Tenex <input type="radio"/> Other <input type="radio"/> Don't Know	



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10. In general, you would say your health is:

- ☐ Excellent
☐ Very Good
☐ Good
☐ Fair
☐ Poor

CHILD'S SIBLINGS**Now we would like to ask about your other children:****(Please complete this section for each of your children who are NOT in the study. If you only have one child, skip this section.)****Child #2:** Age: years Sex: ☐ M ☐ F**Please answer 11a, b, and c about child #2**

11a. Has your child ever been treated by a psychiatrist or other mental health professional, such as a psychologist?

☐ Yes☐ No11b. **If yes**, what diagnosis did that person make?

- ☐ Depression
☐ Bipolar or Manic Depressive Disorder
☐ Generalized Anxiety
☐ Panic Disorder
☐ Obsessive-Compulsive Disorder (OCD)
☐ Post-traumatic Stress Disorder (PTSD)
☐ Attention-Deficit/Hyperactivity Disorder
☐ Oppositional Defiant Disorder
☐ Conduct Disorder
☐ Borderline Personality Disorder
☐ Schizophrenia or Schizoaffective Disorder
☐ Other (please specify)
☐ No diagnosis
☐ Don't Know

11c. Has your child ever received counseling for an emotional or behavioral problem?

☐ Yes☐ NoID
Number

Parents' Questionnaire

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Child #3: Age: years Sex: ☐ M ☐ F

Please answer 12a, b, and c about child #3

12a. Has your child ever been treated by a psychiatrist or other mental health professional, such as a psychologist?

☐ Yes

☐ No

12b. **If yes**, what diagnosis did that person make?

- ☐ Depression
- ☐ Bipolar or Manic Depressive Disorder
- ☐ Generalized Anxiety
- ☐ Panic Disorder
- ☐ Obsessive-Compulsive Disorder (OCD)
- ☐ Post-traumatic Stress Disorder (PTSD)
- ☐ Attention-Deficit/Hyperactivity Disorder
- ☐ Oppositional Defiant Disorder
- ☐ Conduct Disorder
- ☐ Borderline Personality Disorder
- ☐ Schizophrenia or Schizoaffective Disorder
- ☐ Other (please specify)
- ☐ No diagnosis
- ☐ Don't Know

12c. Has your child ever received counseling for an emotional or behavioral problem?

☐ Yes

☐ No

Questionnaire is continued on next page →



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Child #4: Age: years Sex: ☐ M ☐ F

Please answer 16a, b, and c about child #4

13a. Has your child ever been treated by a psychiatrist or other mental health professional, such as a psychologist?

☐ Yes

☐ No

13b. **If yes**, what diagnosis did that person make?

☐ Depression

☐ Bipolar or Manic Depressive Disorder

☐ Generalized Anxiety

☐ Panic Disorder

☐ Obsessive-Compulsive Disorder (OCD)

☐ Post-traumatic Stress Disorder (PTSD)

☐ Attention-Deficit/Hyperactivity Disorder

☐ Oppositional Defiant Disorder

☐ Conduct Disorder

☐ Borderline Personality Disorder

☐ Schizophrenia or Schizoaffective Disorder

☐ Other (please specify)

☐ No diagnosis

☐ Don't Know

13c. Has your child ever received counseling for an emotional or behavioral problem?

☐ Yes

☐ No

Questionnaire is continued on back —>



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Child #5: Age: years Sex: ☐ M ☐ F

Please answer 14a, b, and c about child #5

14a. Has your child ever been treated by a psychiatrist or other mental health professional, such as a psychologist?

☐ Yes☐ No

14b. If yes, what diagnosis did that person make?

☐ Depression☐ Bipolar or Manic Depressive Disorder☐ Generalized Anxiety☐ Panic Disorder☐ Obsessive-Compulsive Disorder (OCD)☐ Post-traumatic Stress Disorder (PTSD)☐ Attention-Deficit/Hyperactivity Disorder☐ Oppositional Defiant Disorder☐ Conduct Disorder☐ Borderline Personality Disorder☐ Schizophrenia or Schizoaffective Disorder☐ Other (please specify) ☐ No diagnosis☐ Don't Know

14c. Has your child ever received counseling for an emotional or behavioral problem?

☐ Yes☐ No

FOR STUDY USE ONLY

ID Number

Interviewed By

Date Interviewed

Month

Day

Year