

Adult

Form Approved
OMB NO. 0920-24EG
Exp. Date XX/XX/20XX

Public reporting burden of this collection of information is estimated to average 60 minutes, 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 collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS H21-8, Atlanta, Georgia 30333; ATTN: PRA (0920-24EG).

This survey asks about mental health and emotional well-being. If you answer that you have had suicidal thoughts or behaviors, or purposely tried to hurt yourself, we may inform your doctor or other clinic staff. This would be to ensure your safety and provide you with support and care. By completing this survey, you accept and consent to this protocol. If you have concerns or need immediate help, please tell the clinic staff. Completing the survey is voluntary. If you are not comfortable answering a question, just leave it blank.

Today's Date

Timestamp

What is your date of birth?

Age (autocalculated):

If you are under the age of 18, over the age of 26, or if you are filling this out for a child under the age of 18, please request an alternative form from the project staff.

Please answer the following questions about yourself.

What is your race and/or ethnicity? Select all that apply.

- American Indian or Alaska Native. For example, Navajo Nation, Blackfeet Tribe of the Blackfeet Indian Reservation of Montana, Native Village of Barrow Inupiat Traditional Government, Nome Eskimo Community, Aztec, Maya, etc.
- Asian. For example, Chinese, Asian Indian, Filipino, Vietnamese, Korean, Japanese, etc.
- Black or African American. For example, African American, Jamaican, Haitian, Nigerian, Ethiopian, Somali, etc.
- Hispanic or Latino. For example, Mexican, Puerto Rican, Salvadoran, Cuban, Dominican, Guatemalan, etc.
- Middle Eastern or North African. For example, Lebanese, Iranian, Egyptian, Syrian, Iraqi, Israeli, etc.
- Native Hawaiian or Pacific Islander. For example, Native Hawaiian, Samoan, Chamorro, Tongan, Fijian, Marshallese, etc.
- White. For example, English, German, Irish, Italian, Polish, Scottish, etc.

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things

- Not at all
- Several days
- More than half the days
- Nearly every day

Feeling down, depressed, or hopeless

- Not at all
- Several days
- More than half the days
- Nearly every day

Trouble falling or staying asleep, or sleeping too much

- Not at all
- Several days
- More than half the days
- Nearly every day

Feeling tired or having little energy

- Not at all
- Several days
- More than half the days
- Nearly every day

Poor appetite or overeating

- Not at all
- Several days
- More than half the days
- Nearly every day

Feeling bad about yourself - or that you are a failure or have let yourself or your family down

- Not at all
- Several days
- More than half the days
- Nearly every day

Trouble concentrating on things, such as reading the newspaper or watching television

- Not at all
- Several days
- More than half the days
- Nearly every day

Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual

- Not at all
 Several days
 More than half the days
 Nearly every day

Thoughts that you would be better off dead or of hurting yourself in some way

- Not at all
 Several days
 More than half the days
 Nearly every day

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all
 Somewhat difficult
 Very difficult
 Extremely difficult

During the past 12 months, how many times did you do something to purposely hurt yourself without wanting to die, such as cutting or burning yourself on purpose?

- 0 times
 1 time
 2 or 3 times
 4 or 5 times
 6 or more times

The next few questions are about thoughts of suicide. At any time in the past 12 months, did you seriously think about trying to kill yourself?

- Yes
 No

During the past 12 months, did you make any plans to kill yourself?

- Yes
 No

During the past 12 months, did you try to kill yourself?

- Yes
 No

During the past 12 months, did you get medical attention from a doctor or other health professional as a result of an attempt to kill yourself?

- Yes
 No

Did you stay in a hospital overnight or longer because you tried to kill yourself?

- Yes
 No

If you ever feel that you need to talk to someone about mental health struggles, emotional distress, alcohol or drug use concerns, you can call or text the 988 Suicide and Crisis Lifeline by dialing/texting 988. Counselors are available to talk at any time of the day or night and they can give you information about services in your area. Services are available in English and Spanish.

Please write down this number and website address.
988 (call or text)
<https://988lifeline.org/>

You skipped one or more questions on this page. Please review and complete the question(s) before going to the next page. If you intentionally skipped the question(s), you can go to the next page.

Co-occurring Conditions

Have you EVER been told by a doctor or other health professional that you had:

Any type of anxiety disorder?

- Yes
 No

Some common types of anxiety disorders include generalized anxiety disorder, social anxiety disorder, panic disorder, and phobias.

Do you currently have the condition?

- Yes
 No

Would you describe it as mild, moderate or severe?

- Mild
 Moderate
 Severe

Any type of depression?

- Yes
 No

Some common types of depression include major depression (or major depressive disorder), bipolar depression, dysthymia, post-partum depression, and seasonal affective disorder.

Do you currently have the condition?

- Yes
 No

Would you describe it as mild, moderate or severe?

- Mild
 Moderate
 Severe

Autism or Autism Spectrum Disorder?

- Yes
 No

This includes diagnoses of Asperger's Disorder or Pervasive Developmental Disorder (PDD).

Do you currently have the condition?

- Yes
 No

Would you describe it as mild, moderate or severe?

- Mild
 Moderate
 Severe

Attention Deficit Disorder or Attention-Deficit/Hyperactivity Disorder, that is, ADD or ADHD?

- Yes
 No

Do you currently have the condition?

- Yes
 No

Would you describe it as mild, moderate or severe?

- Mild
 Moderate
 Severe

Obsessive-compulsive disorder or OCD?

- Yes
 No

Do you currently have the condition?

- Yes
 No

Would you describe it as mild, moderate or severe?

- Mild
 Moderate
 Severe

Post-traumatic stress disorder or PTSD?

- Yes
 No

Do you currently have the condition?

- Yes
 No

Would you describe it as mild, moderate or severe?

- Mild
 Moderate
 Severe

Substance use disorder?

- Yes
 No

Do you currently have the condition?

- Yes
 No

Would you describe it as mild, moderate or severe?

- Mild
 Moderate
 Severe

Frequent or severe headaches, including migraine?

- Yes
 No

Do you currently have the condition?

- Yes
 No

Would you describe it as mild, moderate or severe?

- Mild
 Moderate
 Severe

A sleep disorder?

- Yes
 No

Examples of sleep disorders include sleep apnea, insomnia, and narcolepsy.

Do you currently have the condition?

- Yes
 No

Would you describe it as mild, moderate or severe?

- Mild
 Moderate
 Severe

Eating disorder?

- Yes
 No

Do you currently have the condition?

- Yes
 No

Would you describe it as mild, moderate or severe?

Mild
 Moderate
 Severe

Self-injurious behavior?

Yes
 No

Do you currently have the condition?

Yes
 No

Would you describe it as mild, moderate or severe?

Mild
 Moderate
 Severe

A concussion or brain injury?

Yes
 No

A concussion or brain injury is when a blow or jolt to the head causes problems such as headaches, dizziness, being dazed or confused, difficulty remembering or concentrating, vomiting, blurred vision, changes in mood or behavior, or being knocked out.

Have you EVER been told by a doctor or educator that you had:

Examples of educators are teachers and school nurses.

Behavioral or conduct problems?

Yes
 No

Do you currently have the condition?

Yes
 No

Would you describe it as mild, moderate or severe?

Mild
 Moderate
 Severe

Developmental delay?

Yes
 No

Do you currently have the condition?

Yes
 No

Would you describe it as mild, moderate or severe?

Mild
 Moderate
 Severe

Intellectual disability (formerly known as mental retardation)?

Yes
 No

Do you currently have the condition?

Yes
 No

Would you describe it as mild, moderate or severe?

Mild
 Moderate
 Severe

Speech disorder? Yes
 No

Do you currently have the condition? Yes
 No

Would you describe it as mild, moderate or severe? Mild
 Moderate
 Severe

Language disorder? Yes
 No

Do you currently have the condition? Yes
 No

Would you describe it as mild, moderate or severe? Mild
 Moderate
 Severe

Learning disability? Yes
 No

Do you currently have the condition? Yes
 No

Would you describe it as mild, moderate or severe? Mild
 Moderate
 Severe

Has a doctor or other health care provider told you that you currently have:

Allergies (such as food, drug, insect, seasonal, or other)? Yes
 No

Asthma? Yes
 No

Autoimmune disease (such as Type 1 Diabetes, Celiac, or Juvenile Idiopathic Arthritis)? Yes
 No

Type 2 Diabetes? Yes
 No

Epilepsy or Seizure Disorder? Yes
 No

Have you ever shown extreme expression of anger, often to the point of uncontrollable rage that is disproportionate to the situation at hand? Yes
 No

Do you currently show extreme expression of anger? Yes
 No

Would you describe it as mild, moderate or severe?

- Mild
 Moderate
 Severe

Have you ever had sensory processing problems?

- Yes
 No

For example, being hypersensitive (over-responsive) to certain sensations (like certain lights, sounds, touch, tastes, or smells) or hyposensitive (under-responsive) and seek out sensory input, to the point that it causes distress.

You skipped one or more questions on this page. Please review and complete the question(s) before going to the next page. If you intentionally skipped the question(s), you can go to the next page.

Treatment for Tic Disorders and Related Conditions

The next questions ask about medications you may be taking for a tic disorder or related conditions.

Related conditions include things like ADHD, OCD, anxiety, depression, behavior issues, or other mental health conditions.

Have you ever taken medication for a tic disorder or related conditions? Yes
 No

At what age did you first start taking medication for a tic disorder or related conditions? _____

Are you currently taking medication for a tic disorder or related conditions? Yes
 No

What medications do you currently take for a tic disorder or related conditions? _____

Please list all.

Who usually makes sure you take your medication for a tic disorder or related conditions? I do
 A parent or guardian
 Another family member or adult
 Other person (Please specify relationship of other person) _____

The next questions ask about other treatments for a tic disorder or related conditions.

Related conditions include things like ADHD, OCD, anxiety, depression, behavior issues, or other mental health conditions.

Have you ever received comprehensive behavioral intervention for tics (CBIT) or habit reversal therapy for a tic disorder? Yes
 No
 Don't know

Are you currently receiving comprehensive behavior intervention for tics (CBIT) or habit reversal therapy for a tic disorder? Yes
 No
 Don't know

Have you ever received school-based behavioral treatment, support, or accommodation for a tic disorder or related conditions? Yes
 No
 Don't know

Do not include CBIT or habit reversal therapy.

Are you currently receiving school-based behavioral treatment, support, or accommodation for a tic disorder or related conditions? Yes
 No
 Don't know
 Not currently in school

Do not include CBIT or habit reversal therapy.

Have you ever received behavioral treatment based outside of school for a tic disorder or related conditions? Yes
 No
 Don't know

Do not include CBIT or habit reversal therapy.

Are you currently receiving behavior treatment based outside of school for a tic disorder or related conditions?

- Yes
 No
 Don't know

Do not include CBIT or habit reversal therapy.

Have you ever received any other treatment for a tic disorder or related conditions?

- Yes
 No
 Don't know

Please specify any other treatment you have ever received for a tic disorder or related conditions:

Are you currently receiving any other treatment for a tic disorder or related conditions?

- Yes
 No
 Don't know

Please specify any other treatment you are currently receiving for a tic disorder or related conditions:

Overall, how satisfied are you with your tic disorder treatment and management?

- Very satisfied
 Somewhat satisfied
 Somewhat dissatisfied
 Very dissatisfied

In the past year, have you received any of the following for any mental, emotional, or behavioral problem, across settings (school, doctor's office)?

Select all that apply.

- Social skills training
 Cognitive behavioral therapy
 Counseling (for example, talk therapy or psychotherapy)
 Other (Please specify) _____
 None of these

You skipped one or more questions on this page. Please review and complete the question(s) before going to the next page. If you intentionally skipped the question(s), you can go to the next page.

Healthcare Transition (from Pediatric to Adult Health Care)

SINCE TURNING 18, have you made the transfer to a primary care provider who treats adults?

- I already saw a primary care provider who treats adults before I turned 18
 Yes
 No

How satisfied were you with the health care providers' help to transfer your care to adult health care?

- Very satisfied
 Somewhat satisfied
 Somewhat dissatisfied
 Very dissatisfied

Has a doctor or other health care provider talked with you about the process of transferring to adult care?

- Yes
 No

Have any of your doctors or other health care providers helped with finding a new primary care provider who treats adults?

- Yes, and I have seen a primary care provider who treats adults
 Yes, but I have not been able to see a primary care provider who treats adults
 No

Examples of assistance include suggesting names of adult providers, making introductions, or sending a letter to the new provider.

SINCE TURNING 18, have you needed to see a mental health professional?

- Yes
 No

Mental health professionals include psychiatrists, psychologists, psychiatric nurses, and clinical social workers.

Did your doctors or other health care providers help with finding mental health professionals who care for adults?

- Yes, and I have seen a mental health provider who cares for adults
 Yes, but I have not been able to see a mental health provider who cares for adults
 No

SINCE TURNING 18, have you needed to see a specialist other than a mental health professional?

- Yes
 No

Examples of specialists include doctors like surgeons, heart doctors, allergy doctors, skin doctors, and others who specialize in one area of health care. Do not include dentists or other oral health care providers.

Did your doctors or other health care providers help with finding specialists who care for adults (other than mental health professionals)?

- Yes, and I have seen a specialist who cares for adults
 Yes, but I have not been able to see a specialist who cares for adults
 No

SINCE TURNING 18, did you need to find a new health professional for care related to your tic disorder?

- Yes
 No

Did your doctors or other health care providers help with finding a health professional who cares for adults with tic disorders?

Examples of assistance include suggesting names of adult providers, making introductions, or sending a letter to the new provider.

- Yes, and I have seen a health professional who cares for adults with tic disorders
- Yes, but I have not been able to see a health professional who cares for adults with tic disorders
- No

SINCE TURNING 18, have you had any of the following challenges in finding a health professional who treats tic disorders in adults?

Select all that apply.

Providers in my area that treat tic disorders in adults...

- are not accepting new patients
- do not take my health insurance
- do not have appointments in the next 6 months
- do not have appointments that fit my schedule
- do not offer in-person appointments
- do not offer telehealth/virtual appointments
- there are no providers that treat tic disorders in adults in my area
- I have had a different problem
- I haven't had any problems finding a health professional who treats tic disorders in adults

What other challenges (not listed above) have you faced in finding a health professional who treats tic disorders in adults?

You skipped one or more questions on this page. Please review and complete the question(s) before going to the next page. If you intentionally skipped the question(s), you can go to the next page.

Employment and Service Use

LAST WEEK, did you work for pay at a job or business?

- Yes
 No

Did you have a job or business LAST WEEK, but were temporarily absent due to illness, vacation, family or maternity leave, or some other reason?

- Yes
 No

What is the MAIN reason you were not working for pay at a job or business last week?

- Unemployed, laid off, looking for work
 Seasonal/contract work
 Retired
 Unable to work for health reasons/disabled
 Taking care of house or family
 Going to school
 Working at a family-owned job or business not for pay
 Other

When was the last time you worked for pay at a job or business, even if only for a few days?

- Within the past 12 months
 1-5 years ago
 Over 5 years ago
 Never worked

How many hours per week do you USUALLY work in total at ALL jobs or businesses?

When you work do you USUALLY work 35 hours or more per week in total at ALL jobs or businesses?

- Yes
 No

During the past 12 months, about how many days of work did you miss because you had an illness, injury, or disability?

Do not include family or paternity/maternity leave.

Last year, how much was paid out-of-pocket for your OWN medical care, such as copays for doctor and dentist visits, diagnostic tests, prescription medicine, glasses and contacts, and medical supplies?

- \$0 (No medical or health-related expenses)
 \$1-\$249
 \$250-\$499
 \$500-\$999
 \$1,000-\$5,000
 More than \$5,000

Include any amount paid out-of-pocket on your behalf by anyone in this household.

Last year, how much was paid out-of-pocket for your non-prescription healthcare products such as vitamins, allergy and cold medicine, pain relievers, quit smoking aids, AND anything else not yet reported?

- \$0 (No medical or health-related expenses)
 \$1-\$249
 \$250-\$499
 \$500-\$999
 \$1,000-\$5,000
 More than \$5,000

Include any amount paid out-of-pocket on your behalf by anyone in this household.

Last year, how much was paid out-of-pocket for your OWN mental health care, including copays for doctor visits, prescription medicine, and therapy or counseling?

- \$0 (No medical or health-related expenses)
 \$1-\$249
 \$250-\$499
 \$500-\$999
 \$1,000-\$5,000
 More than \$5,000

Include any amount paid out-of-pocket on your behalf by anyone in this household.

During the past 12 months, have you DELAYED getting counseling or therapy from a mental health professional because of the cost?

- Yes
 No

During the past 12 months, was there any time when you needed counseling or therapy from a mental health professional, but DID NOT GET IT because of the cost?

- Yes
 No

During the past 12 months, have you DELAYED getting care from a mental health professional because you couldn't get an appointment?

- Yes
 No

If yes, how long was the delay?

- Less than 3 months
 3-6 months
 7-12 months
 More than 12 months

The next questions are about your medical bills. Include bills for doctors, dentists, hospitals, therapists, medication, equipment, and nursing home or home care.

In the past 12 months, did you have problems paying or were unable to pay any medical bills?

- Yes
 No

Do you currently have any medical bills that you are unable to pay at all?

- Yes
 No

If you get sick or have an accident, how worried are you that you will be able to pay your medical bills?

- Very worried
 Somewhat worried
 Not at all worried

During the past 12 months, have you DELAYED getting medical care because of the cost?

- Yes
 No

During the past 12 months, was there any time when you needed medical care, but DID NOT GET IT because of the cost?

- Yes
 No

At any time in the past 12 months, did you take prescription medication?

- Yes
 No

During the past 12 months, were any of the following true for you?

You skipped medication doses to save money.

- Yes
 No

You took less medication to save money.

- Yes
 No

You DELAYED filling a prescription to save money.

- Yes
 No

During the past 12 months, was there any time when you needed prescription medication, but DID NOT GET IT because of the cost?

- Yes
 No

During the past 12 months, how many times have you gone to a hospital emergency room about your health?

During the past 12 months, have you been hospitalized overnight?

- Yes
 No

You skipped one or more questions on this page. Please review and complete the question(s) before going to the next page. If you intentionally skipped the question(s), you can go to the next page.

Additional Questions About You

Which of the following best represents how you think of yourself?

- Gay (lesbian or gay)
 Straight, this is not gay (or lesbian or gay)
 Bisexual
 Something else
 I don't know the answer

What is your sex?

- Male
 Female

What is the HIGHEST level of school you have completed or the highest degree you have received?

- Never attended/kindergarten only
 Grade 1-11
 12th grade, no diploma
 GED or equivalent
 High school graduate
 Some college, no degree
 Associate degree: occupational, technical, or vocational program
 Associate degree: academic program
 Bachelor's degree (Example: BA, AB, BS, BBA)
 Master's degree (Example: MA, MS, MEng, MEd, MBA)
 Professional school degree (Example: MD, DDS, DVM, JD)
 Doctoral degree (Example: PhD, EdD)

Are you now married, living with a partner together as an unmarried couple, or neither?

- Married
 Living with a partner together as an unmarried couple
 Neither

The next questions are about health insurance. Include health insurance obtained through employment or purchased directly as well as government programs like Medicare, Medicaid, and the Children's Health Insurance Program that provide medical care or help pay medical bills.

Are you covered by any kind of health insurance or some other kind of health care plan?

- Yes
 No

What kinds of health insurance or health care coverage do you have?

Select all that apply.

- Private health insurance
 Medicare
 Medigap
 Medicaid
 Children's Health Insurance Program (CHIP)
 Military related health care: TRICARE (CHAMPUS) / VA health care / CHAMP-VA
 Indian Health Service
 State-sponsored health plan
 Other government program
 No coverage of any type

Health insurance plans are usually obtained in one person's name even if other family members are covered by that plan. That person is called the policyholder. Are you the policyholder for your health insurance plan?

- Yes
 No

How are you related to the policyholder for your health insurance? Are you the policyholder's child, spouse, former spouse, or are you related in some other way?

- Child
 Spouse
 Former spouse
 Some other relationship

The following questions are about the address where you currently live.

What is your current street address?

Example: 123 Main Street

What is the apartment or unit number (skip if none)?

Example: Apt. 5a

In what city do you currently live?

In what state do you currently live?

- Alabama
- Alaska
- Arizona
- Arkansas
- California
- Colorado
- Connecticut
- District of Columbia
- Delaware
- Florida
- Georgia
- Hawaii
- Idaho
- Illinois
- Indiana
- Iowa
- Kansas
- Kentucky
- Louisiana
- Maine
- Maryland
- Massachusetts
- Michigan
- Minnesota
- Mississippi
- Missouri
- Montana
- Nebraska
- Nevada
- New Hampshire
- New Jersey
- New Mexico
- New York
- North Carolina
- North Dakota
- Ohio
- Oklahoma
- Oregon
- Pennsylvania
- Rhode Island
- South Carolina
- South Dakota
- Tennessee
- Texas
- Utah
- Vermont
- Virginia
- Washington
- West Virginia
- Wisconsin
- Wyoming
- Other (Please specify)

Specify other place (not US state) you live

What is your current zip code (for address above)?

How many people are living or staying at this address?

Include everyone who usually lives or stays at this address. Do NOT include anyone who is living somewhere else for more than two months, such as a college student living away or someone in the Armed Forces on deployment.

What is your best estimate of your total family income from all sources, before taxes, in the last year?

- < \$15,000
- \$15,000-\$24,999
- \$25,000-49,999
- \$50,000-74,999
- \$75,000-99,999
- \$100,000-149,999
- \$150,000-199,999
- \$200,000 or higher

Some people who are deaf or have serious difficulty hearing use assistive devices to communicate by phone. Are you deaf or do you have serious difficulty hearing?

- Yes
- No

Are you blind or do you have serious difficulty seeing, even when wearing glasses?

- Yes
- No

Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?

- Yes
- No

Do you have serious difficulty walking or climbing stairs?

- Yes
- No

Do you have difficulty dressing or bathing?

- Yes
- No

Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?

- Yes
- No

You skipped one or more questions on this page. Please review and complete the question(s) before going to the next page. If you intentionally skipped the question(s), you can go to the next page.

Over the last 2 weeks, how often have you been bothered by the following problems?

Feeling nervous, anxious or on edge

- Not at all
 Several days
 More than half the days
 Nearly every day

Not being able to stop or control worrying

- Not at all
 Several days
 More than half the days
 Nearly every day

Worrying too much about different things

- Not at all
 Several days
 More than half the days
 Nearly every day

Trouble relaxing

- Not at all
 Several days
 More than half the days
 Nearly every day

Being so restless that it is hard to sit still

- Not at all
 Several days
 More than half the days
 Nearly every day

Becoming easily annoyed or irritable

- Not at all
 Several days
 More than half the days
 Nearly every day

Feeling afraid as if something awful might happen

- Not at all
 Several days
 More than half the days
 Nearly every day

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all
 Somewhat difficult
 Very difficult
 Extremely difficult

Did anyone help you complete this survey?

- Yes, someone helped me, but I completed most of the survey on my own.
 Yes, someone helped me with all or most of the survey.
 No, I completed the survey on my own.

If you are interested in receiving project updates in the future, please enter your email address.

You may decline to be re-contacted now or at any time in the future.

You skipped one or more questions on this page. Please review and complete the question(s) before going to the next page. If you intentionally skipped the question(s), you can go to the next page.

ASQ

Please complete the survey below. Thank you!

Medical Record Number _____

Timestamp _____

Please ask the following questions only for those ages 9 and up.

Note to person administering the ASQ: Please provide the following information to the respondent before asking the questions.

This survey asks about mental health and emotional well-being. If you answer that you have had suicidal thoughts or behaviors, or purposely tried to hurt yourself, we may inform your doctor or other clinic staff. This would be to ensure your safety and provide you with support and care.

By completing this survey, you accept and consent to this protocol. If you have concerns or need immediate help, please tell the clinic staff.

1) In the past few weeks, have you wished you were dead? Yes
 No
 Refused to answer

2) In the past few weeks, have you felt that you or your family would be better off if you were dead? Yes
 No
 Refused to answer

3) In the past week, have you been having thoughts about killing yourself? Yes
 No
 Refused to answer

4) Have you ever tried to kill yourself? Yes
 No
 Refused to answer

4a) How? _____

4b) When? _____

The patient answered "No" to questions 1 through 4; therefore, screening is complete, and it is not necessary to ask question #5. No intervention is necessary; however, clinical judgment can always override a negative screen.

Do you want to ask the patient question #5 (Are you having thoughts of killing yourself right now?) or finish the ASQ? Ask question #5
 Finish the ASQ

This patient is considered a positive screen. Ask question #5 to assess acuity.

5) Are you having thoughts of killing yourself right now? Yes
 No

5b) Please describe:

Patient is acute positive screen (imminent risk identified)

Patient requires a STAT safety/full mental health evaluation. Patient cannot leave until evaluated for safety.

Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient's care.

Provide resources to all patients: 988 Suicide and Crisis Lifeline, 988 (call, text),
<https://988lifeline.org/>

Patient is non-acute positive screen (potential risk identified).

Patient requires a brief suicide safety assessment to determine if a full mental health evaluation is needed. If a patient (or parent/guardian) refuses the brief assessment, this should be treated as an "against medical advice" (AMA) discharge.

Alert physician or clinician responsible for patient's care.

Provide resources to all patients: 988 Suicide and Crisis Lifeline, 988 (call, text),

<https://988lifeline.org/>

Initials of person (staff/professional) completing ASQ

Optional: Provide any comments on clinical information entered on this form. Please do not use any patient identifiers.

Overview of ASQ - this information is included above, within skip logic, and only included here for reference.

If patient answers "No" to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary (*Note: Clinical judgment can always override a negative screen).

If patient answers "Yes" to any of questions 1 through 4, or refuses to answer, they are considered a positive screen. Ask question #5 to assess acuity.

"Yes" to question #5 = acute positive screen (imminent risk identified)

Patient requires a STAT safety/full mental health evaluation. Patient cannot leave until evaluated for safety.

Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient's care.

"No" to question #5 (but "Yes" or "Refused" to one of questions 1-4) = non-acute positive screen (potential risk identified)

Patient requires a brief suicide safety assessment to determine if a full mental health evaluation is needed. If a patient (or parent/guardian) refuses the brief assessment, this should be treated as an "against medical advice" (AMA) discharge.

Alert physician or clinician responsible for patient's care.

Provide Resources to All Patients:

- 988 Suicide and Crisis Lifeline, Call or Text 988
- Visit https://988lifeline.org to chat

YGTSS

Please complete the survey below. Thank you!

Medical Record Number _____

Timestamp _____

This instrument to be completed by trained professional.

Motor Tics

Age of first motor tics, in years _____

Describe first motor tic: _____

Was tic onset sudden or gradual? _____

Age of worst motor tics, in years? _____

Motor Tic Symptom Checklist

Please select if the patient currently (during the past week) has each tic OR if they ever (but not currently) had the tic. State age of onset (in years) if patient has had this behavior.

The patient has experienced, or others have noticed, involuntary and apparently purposeless bouts of:

eye movements

- Current
 Ever

eye blinking, squinting, a quick turning of the eyes, rolling of the eyes to one side, or opening eyes wide very briefly.

What was the age of onset of this behavior? _____

eye gestures such as looking surprised or quizzical, or looking to one side for a brief period of time, as if s/he heard a noise.

- Current
 Ever

What was the age of onset of this behavior? _____

nose, mouth, tongue movements, or facial grimacing

- Current
 Ever

nose twitching, biting the tongue, chewing on the lip or licking the lip, lip pouting, teeth baring, or teeth grinding.

What was the age of onset of this behavior? _____

broadening the nostrils as if smelling something, smiling, or other gestures involving the mouth, holding funny expressions, or sticking out the tongue.

- Current
 Ever

What was the age of onset of this behavior?

head jerks/movements

- Current
 Ever

touching the shoulder with the chin or lifting the chin up.

What was the age of onset of this behavior?

throwing the head back, as if to get hair out of the eyes.

- Current
 Ever

What was the age of onset of this behavior?

shoulder jerks/movements

- Current
 Ever

jerking a shoulder.

What was the age of onset of this behavior?

shrugging the shoulder as if to say "I don't know."

- Current
 Ever

What was the age of onset of this behavior?

arm or hand movements

- Current
 Ever

quickly flexing the arms or extending them, nail biting, poking with fingers, or popping knuckles.

What was the age of onset of this behavior?

passing hand through the hair in a combing like fashion, or touching objects or others, pinching, or counting with fingers for no purpose, or writing tics, such as writing over and over the same letter or word, or pulling back on the pencil while writing.

- Current
 Ever

What was the age of onset of this behavior?

leg, foot, or toe movements

- Current
 Ever

kicking, skipping, knee-bending, flexing or extension of the ankles; shaking, stomping or tapping the foot.

What was the age of onset of this behavior?

taking a step forward and two steps backward, squatting, or deep knee-bending.

- Current
- Ever

What was the age of onset of this behavior?

abdominal/trunk/pelvis movements

- Current
- Ever

tensing the abdomen, tensing the buttocks.

What was the age of onset of this behavior?

other simple motor tics.

- Current
- Ever

Please write example(s):

What was the age of onset of this behavior?

Other complex motor tics

- Current
- Ever

touching

What was the age of onset of this behavior?

tapping

- Current
- Ever

What was the age of onset of this behavior?

picking

- Current
- Ever

What was the age of onset of this behavior?

evening-up

- Current
- Ever

What was the age of onset of this behavior?

reckless behaviors

- Current
- Ever

What was the age of onset of this behavior?

stimulus-dependent tics (a tic which follows, for example, hearing a particular word or phrase, seeing a specific object, smelling a particular odor).

- Current
- Ever

What was the age of onset of this behavior?

Please write example(s):

rude/obscene gestures; obscene finger/hand gestures.

- Current
- Ever

What was the age of onset of this behavior?

unusual postures.

- Current
- Ever

What was the age of onset of this behavior?

bending or gyrating, such as bending over.

- Current
- Ever

What was the age of onset of this behavior?

rotating or spinning on one foot.

- Current
- Ever

What was the age of onset of this behavior?

copying the action of another (echopraxia)

- Current
- Ever

What was the age of onset of this behavior?

sudden tic-like impulsive behaviors.

- Current
- Ever

What was the age of onset of this behavior?

Please describe this behavior.

tic-like behaviors that could injure/mutilate others.

- Current
- Ever

What was the age of onset of this behavior?

Please describe this behavior.

self-injurious tic-like behavior(s).

- Current
- Ever

What was the age of onset of this behavior?

Please describe this behavior.

other involuntary and apparently purposeless motor tics (that do not fit in any previous categories).

Please describe any other patterns or sequences of motor tic behaviors:

Phonic (Vocal) Tics

Age of first vocal tics, in years

Describe first vocal tic:

Was tic onset sudden or gradual?

Age of worst vocal tics, in years

Phonic Tic Symptom Checklist

Please select if the patient currently (during the past week) has each tic OR if they ever (but not currently) had the tic. State age of onset (in years) if patient has had this behavior.

The patient has experienced, or others have noticed, involuntary and apparently purposeless bouts of:

coughing.

- Current
- Ever

What was the age of onset of this behavior?

throat clearing.

- Current
- Ever

What was the age of onset of this behavior?

sniffing.

- Current
- Ever

What was the age of onset of this behavior?

whistling.

- Current
- Ever

What was the age of onset of this behavior?

animal or bird noises.

- Current
- Ever

What was the age of onset of this behavior?

other simple phonic tics.

- Current
- Ever

What was the age of onset of this behavior?

Please list:

syllables.

- Current
- Ever

What was the age of onset of this behavior?

Please list:

words.

- Current
- Ever

What was the age of onset of this behavior?

Please list:

rude or obscene words or phrases.

- Current
- Ever

What was the age of onset of this behavior?

Please list:

repeating what someone else said, either sounds, single words or sentences. Perhaps repeating what's said on TV (echolalia).

- Current
- Ever

What was the age of onset of this behavior?

repeating something the patient said over and over again (palilalia).

- Current
- Ever

What was the age of onset of this behavior?

other tic-like speech problems, such as sudden changes in volume or pitch.

- Current
- Ever

What was the age of onset of this behavior?

Please describe:

Describe any other patterns or sequences of phonic tic behaviors:

What was the age of onset of this behavior?

Severity Ratings: Number (Past 7-10 days)

Current Motor Number

Current Phonic Number

Rating Scale

(0) None (no tics)

(1) Single tic

(2) Multiple discrete tics (2-5)

(3) Multiple discrete tics (>5)

(4) Multiple discrete tics plus at least one orchestrated pattern of multiple simultaneous or sequential tics where it is difficult to distinguish discrete tics.

(5) Multiple discrete tics plus several (>2) orchestrated paroxysms of multiple simultaneous or sequential tics where it is difficult to distinguish discrete tics.

Severity Ratings: Frequency (Past 7-10 days)

Current Motor Frequency

Current Phonic Frequency

Rating Scale

(0) None: No evidence of specific tic behaviors.

(1) Rarely: Specific tic behaviors have been present during previous week. These behaviors occur infrequently, often not on a daily basis. If bouts of tics occur, they are brief and uncommon.

(2) Occasionally: Specific tic behaviors are usually present on a daily basis, but there are long tic-free intervals during the day. Bouts of tics may occur on occasion and are not sustained for more than a few minutes at a time.

(3) Frequently: Specific tic behaviors are present on a daily basis. Tic free intervals as long as 3 hours are not uncommon. Bouts of tics occur regularly but may be limited to a single setting.

(4) Almost Always: Specific tic behaviors are present virtually every waking hour of every day, and periods of sustained tic behaviors occur regularly. Bouts of tics are common and are not limited to a single setting.

(5) Always: Specific tic behaviors are present virtually all the time. Tic free intervals are difficult to identify and do not last more than 5 to 10 minutes at most.

Severity Ratings: Intensity (Past 7-10 days)

Current Motor Intensity

Current Phonic Intensity

Rating Scale

(0) Absent: Tics are not present at all

(1) Minimal: Tics are not visible or audible (based solely on patient's private experience) or tics are less forceful than comparable voluntary actions and are typically not noticed because of their intensity.

(2) Mild: Tics are not more forceful than comparable voluntary actions or utterances and are typically not noticed because of their intensity.

(3) Moderate: Tics are more forceful than comparable voluntary actions, but are not outside the range of normal expression for comparable voluntary actions or utterances. They may call attention to the individual because of their forceful character.

(4) Marked: Tics are more forceful than comparable voluntary actions or utterances and typically have an "exaggerated" character. Such tics frequently call attention to the individual because of their forceful and exaggerated character.

(5) Severe: Tics are extremely forceful and exaggerated in expression. These tics call attention to the individual and may result in risk of physical injury (accidental, provoked, or self-inflicted) because of their forceful expression.

Severity Ratings: Complexity (Past 7-10 days)

Current Motor Complexity

Current Phonic Complexity

Rating Scale

(0) None: Tics are not present OR if present, all tics are clearly "simple" (sudden, brief, purposeless) in character.

(1) Borderline: Some tics are not clearly "simple" in character.

(2) Mild: Some tics are clearly "complex" (purposeful in appearance) and mimic brief "automatic" behaviors, such as grooming, syllables, or brief meaningful utterances such as "ah huh", or "hi", that could be readily camouflaged.

(3) Moderate: Some tics are more "complex" (more purposeful and sustained in appearance) and may occur in orchestrated bouts that would be difficult to camouflage, but could be rationalized or "explained" as normal behavior or speech (picking, tapping, saying "you bet" or "honey", brief echolalia).

(4) Marked: Some tics are very "complex" in character and tend to occur in sustained orchestrated bouts that would be difficult to camouflage and could not be easily rationalized as normal behavior or speech because of their duration and/or their unusual, inappropriate, bizarre or obscene character (a lengthy facial contortion, touching genitals, echolalia, speech atypicalities, longer bouts of saying "what do you mean" repeatedly or saying "fu" or "sh").

(5) Severe: Some tics involve lengthy bouts of orchestrated behavior or speech that would be impossible to camouflage or successfully rationalize as normal because of their duration and/or extremely unusual, inappropriate, bizarre or obscene character (lengthy displays or utterances often involving copropraxia, self-abusive behavior, or coprolalia).

Severity Ratings: Interference (Past 7-10 days)

Current Motor Interference

Current Phonic Interference

Rating Scale

(0) None: This means there are no tics present at all.

(1) Minimal: When tics are present, they do not interrupt the flow of behavior or speech.

(2) Mild: When tics are present, they occasionally interrupt the flow of behavior or speech.

(3) Moderate: When tics are present, they frequently interrupt the flow of behavior or speech.

(4) Marked: When tics are present, they frequently interrupt the flow of behavior or speech, and they occasionally disrupt intended action or communication.

(5) Severe: When tics are present, they frequently disrupt intended action or communication.

Severity Ratings: Impairment (Past 7-10 days)

Current Motor Impairment

Current Phonic Impairment

Rating Scale

(0) None

(10) Minimal: Tics associated with subtle difficulties in self-esteem, family life, social acceptance or school/job functioning (infrequent upset or concern about tics vis a vis the future, periodic, slight increase in family tensions because of tics; friend or acquaintances may occasionally notice or comment about tics in an upsetting way.

(20) Mild: Tics associated with minor difficulties in self-esteem, family life, social acceptance, or school/job functioning.

(30) Moderate: Tics associated with some clear problems in self-esteem, family life, social acceptance, or school/job functioning (episodes of dysphoria, periodic distress and upheaval in the family, frequent teasing by peers or episodic social avoidance, periodic interference in school/job performance because of tics).

(40) Marked: Tics associated with major difficulties in self-esteem, family life, social acceptance, or school/job functioning.

(50) Severe: Tics associated with extreme difficulties in self-esteem, family life, social acceptance, or school/job functioning (severe depression with suicidal ideation, disruption of the family [separation/divorce, residential placement], disruption of social ties, severely restricted life because of social stigma and social avoidance, removal from school/job).

Initials of person completing this form.

Optional: Provide any comments on clinical information entered on this form. Please do not use any patient identifiers.

For the person conducting the assessment: How familiar are you with this individual (being assessed with YGTSS)?

- Not familiar (for example: this was my first encounter with this individual, or previous encounters were very brief)
- Somewhat familiar (for example: I have interacted with this individual on more than one occasion and for more than just a brief encounter)
- Very familiar (I have interacted with this individual on several occasions AND am very familiar with their tic symptoms)