PREDICTORS STUDY 2

Study ID: C J M P _ _ _ _ _ Date: _ _/_ _/_ _ _ _

Name: _____ Interviewer:_____

Time: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 - 11 - 12 - 13 - 14 - 15 - 16 - 17 - 18 - 19 - 20

FORM PP. CURRENT PSYCHIATRIC STATUS

PSYCHOSIS (Persistent > 3x or more/week; Transient < 3x/week)

1. Delusions (past month)

General

In the past month, has the patient talked about any strange ideas or unusual beliefs? No 0
Yes 1

If "Yes", can you describe them for me? _____

_____

Was this the case some of the time or most of the time? Persistent 0
Transient 1
N/A 2

Will the patient accept the truth if corrected? No 0
Yes 1
N/A 2

Paranoid delusions (past month)

(a) Has the patient felt that others are stealing things from him/her? No 0
Yes 1

Was this the case some of the time or most of the time? Persistent 0
Transient 1
N/A 2

Will the patient accept the truth if corrected? No 0
Yes 1
N/A 2

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(b) Has the patient suspected that his/her wife/husband is unfaithful? [Circle N/A if patient is single or widowed.]

No 0
Yes 1
N/A 2

Was this the case some of the time or most of the time?

Persistent 0
Transient 1
N/A 2

Will the patient accept the truth if corrected?

No 0
Yes 1
N/A 2

(c) Has the patient had any other unfounded suspicions?

No 0
Yes 1

If "Yes", can you describe them? _____

_____

_____

Was this the case some of the time or most of the time?

Persistent 0
Transient 1
N/A 2

Will the patient accept the truth if corrected?

No 0
Yes 1
N/A 2

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Global Severity Rating for Paranoid Delusions:

To what extent would you say these behaviors have affected the *patient's* daily activities and functioning?

0 No effect
1 Minimal effect
2 Mild effect
3 Moderate effect
4 Severe effect
9 Not applicable

How difficult or disturbing do *you* find these behaviors to manage or deal with?

0 No difficulty
1 Minimally difficult
2 Mildly difficult
3 Moderately difficult
4 Extremely difficult
9 Not applicable

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Delusions of Abandonment (past month)

Has the patient suspected or accused the caregiver of plotting to leave him/her? No 0 Yes 1

Was this the case some of the time or most of the time? Persistent 0 Transient 1 N/A 2

Will the patient accept the truth if corrected? No 0 Yes 1 N/A 2

Somatic delusions (past month)

Has the patient had any false beliefs that he/she has cancer or another physical illness? No 0 Yes 1

Was this the case some of the time or most of the time? Persistent 0 Transient 1 N/A 2

Will the patient accept the truth if corrected? No 0 Yes 1 N/A 2

Misidentification syndromes (past month)

(a) Has the patient stated that people are in the house/home when nobody is there? No 0 Yes 1

Was this the case some of the time or most of the time? Persistent 0 Transient 1 N/A 2

Will the patient accept the truth if corrected? No 0 Yes 1 N/A 2

(b) Has the patient looked into the mirror and said it is someone else? No 0 Yes 1

Was this the case some of the time or most of the time? Persistent 0 Transient 1 N/A 2

Will the patient accept the truth if corrected? No 0 Yes 1 N/A 2

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(c) Has the patient misidentified people, for example, said that the spouse/caregiver is an imposter? No 0 Yes 1

Was this the case some of the time or most of the time? Persistent 0 Transient 1 N/A 2

Will the patient accept the truth if corrected? No 0 Yes 1 N/A 2

(d) Has the patient said that his/her house or home is not his/her home? No 0 Yes 1

Was this the case some of the time or most of the time? Persistent 0 Transient 1 N/A 2

Will the patient accept the truth if corrected? No 0 Yes 1 N/A 2

(e) Has the patient believed that the characters on television are real or in the room? [circle N/A if the patient has no access to a television] No 0 Yes 1 N/A 2

Was this the case some of the time or most of the time? Persistent 0 Transient 1 N/A 2

Will the patient accept the truth if corrected? No 0 Yes 1 N/A 2

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Global Severity Rating for Misidentification Delusions:

To what extent would you say these behaviors have affected the *patient's* daily activities and functioning?

0	No effect
1	Minimal effect
2	Mild effect
3	Moderate effect
4	Severe effect
9	Not applicable

How difficult or disturbing do *you* find these behaviors to manage or deal with?

0	No difficulty
1	Minimally difficult
2	Mildly difficult
3	Moderately difficult
4	Extremely difficult
9	Not applicable

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Other delusions (past month)

Has the patient had any false beliefs or other strange ideas that I have not not asked you about? No 0 Yes 1

If "Yes", can you describe them? _____

_____

_____

Was this the case some of the time or most of the time? Persistent 0 Transient 1 N/A 2

Will the patient accept the truth if corrected? No 0 Yes 1 N/A 2

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2. Hallucinations (past month)

(a) Has the patient heard voices or sounds when no one is there? [Auditory]

No 0
Yes: Vague 1
Clear 2

If "yes", can you describe them? _____

_____

_____

(b) Has the patient seen visions? [Visual]

No 0
Yes: Vague 1
Clear 2

If "Yes", can you describe them? _____

_____

_____

(c) Has the patient reported unusual smells like burning rubber, gas or rotten eggs? [Olfactory]

No 0
Yes: Vague 1
Clear 2

If "Yes", can you describe them? _____

_____

_____

(d) Has the patient felt that things are crawling under his/her skin? [Tactile]

No 0
Yes: Vague 1
Clear 2

If "Yes", can you describe them? _____

_____

_____

(e) Has the patient reported any other hallucinations?

No 0
Yes: Vague 1
Clear 2

If "Yes", can you describe them? _____

_____

_____

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Global Severity Rating for Hallucinations:

To what extent would you say these behaviors have affected the *patient's* daily activities and functioning?

0	No effect
1	Minimal effect
2	Mild effect
3	Moderate effect
4	Severe effect
9	Not applicable

How difficult or disturbing do *you* find these behaviors to manage or deal with?

0	No difficulty
1	Minimally difficult
2	Mildly difficult
3	Moderately difficult
4	Extremely difficult
9	Not applicable

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3. Illusions (past month)

Has the patient reported that one thing is something else, for example, saying that a pillow looks like a person or a light bulb looks like a fire starting?

No 0
Yes: Vague 1
Clear 2

If "Yes", can you describe them? _____

_____

_____

Global Severity Rating for Illusions:

To what extent would you say these behaviors have affected the *patient's* daily activities and functioning?

0	No effect
1	Minimal effect
2	Mild effect
3	Moderate effect
4	Severe effect
9	Not applicable

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How difficult or disturbing do *you* find these behaviors to manage or deal with?

0 No difficulty
1 Minimally difficult
2 Mildly difficult
3 Moderately difficult
4 Extremely difficult
9 Not applicable

4. Behavioral Disturbances (past month)

(a) Has the patient wandered away from home or from the caregiver? No 0 Yes 1

(b) Has the patient made verbal outbursts? No 0 Yes 1

(c) Has the patient used physical threats and/or violence? No 0 Threatening behavior 1 Physical violence 2

(d) Has the patient shown agitation or restlessness? No 0 Yes 1

(e) Has the patient been more confused at night or during evening, compared to the day? No 0 Yes 1

Global Severity Rating for Behavioral Disturbances:

To what extent would you say these behaviors have affected the *patient's* daily activities and functioning?

0 No effect
1 Minimal effect
2 Mild effect
3 Moderate effect
4 Severe effect
9 Not applicable

How difficult or disturbing do *you* find these behaviors to manage or deal with?

0 No difficulty
1 Minimally difficult
2 Mildly difficult
3 Moderately difficult
4 Extremely difficult
9 Not applicable

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5. Depression (past month)

If the answer to items (a) to (c) below is "Yes", circle the appropriate level of severity.
If the answer is "No", circle "N/A".

(a) Has the patient been sad, depressed, blue or down in the dumps?

No 0
Yes 1

If "Yes", how do you know they are sad, e.g. do they cry or complain that they feel sad?

Write down details: _____

_____

_____

Was he/she depressed:

N/A 0
occasionally 1
some of the time 2
most of the time 3
all of the time 4

(b) Has the patient had difficulty sleeping?

No 0
Yes 1

If "Yes", is there:

N/A 0
slight difficulty 1
at least 2 hours sleep at night 2
less than 2 hours sleep at night 3
excessive sleep/sleepiness 4

(c) Has the patient's appetite changed?

No 0
Yes 1

If "Yes", circle one:

N/A 0
slightly decreased 1
No appetite. Food is tasteless 2
Need persuasion to eat at all 3
excessive appetite 4

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Global Severity Rating for Depression:

To what extent would you say these behaviors have affected the *patient's* daily activities and functioning?

0	No effect
1	Minimal effect
2	Mild effect
3	Moderate effect
4	Severe effect
9	Not applicable

How difficult or disturbing do *you* find these behaviors to manage or deal with?

0	No difficulty
1	Minimally difficult
2	Mildly difficult
3	Moderately difficult
4	Extremely difficult
9	Not applicable

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