Adult

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

This survey asks questions about your mental health and emotions. If you say that you have thought about hurting yourself or have tried to do so, we may inform your doctor or clinic staff. This is to make sure you are safe and to help you get support and care.

By filling out this survey, you agree to this process. If you have any worries or need help right away, please talk to the clinic staff.

You do not have to complete the survey if you don't want to. If you feel uncomfortable with a question, you can 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 like you need to talk about mental health issues, emotional pain, or problems with alcohol or drugs, you can call or text the 988 Suicide and Crisis Lifeline at 988. Counselors are available 24/7 to listen and help you find services in your area. They can speak with you in English or Spanish.

Please save this number and website:

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.

The next questions ask about any other conditions you might have along with your tic disorder.

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

Any type of anxiety disorder? Some common types of anxiety disorders include generalized anxiety disorder, social anxiety disorder, panic disorder, and phobias.	◯ Yes ◯ No
Do you currently have the condition?	◯ Yes ◯ No
Would you describe it as mild, moderate or severe?	◯ Mild ◯ Moderate ◯ Severe
Any type of depression? Some common types of depression include major depression (or major depressive disorder), bipolar depression, dysthymia, post-partum depression, and seasonal affective disorder.	◯ Yes ◯ No
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? This includes diagnoses of Asperger's Disorder or Pervasive Developmental Disorder (PDD).	◯ Yes ◯ No
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? Examples of sleep disorders include sleep apnea, insomnia, and narcolepsy.	◯ Yes ◯ No
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? 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.	◯ Yes ◯ No

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?

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.

◯ 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.

The next questions ask about 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?

Do not include CBIT or habit reversal therapy.
- ◯ Yes
- ◯ No
- ◯ Don't know

Are you currently receiving school-based behavioral treatment, support, or accommodation for a tic disorder or related conditions?

Do not include CBIT or habit reversal therapy.
- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Not currently in school

Have you ever received behavioral treatment based outside of school for a tic disorder or related conditions?

Do not include CBIT or habit reversal therapy.
- ◯ Yes
- ◯ No
- ◯ Don't know

Are you currently receiving behavior treatment based outside of school for a tic disorder or related conditions? Do not include CBIT or habit reversal therapy.	◯ Yes ◯ No ◯ Don't know
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.

The next questions ask about the 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?

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

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

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

- ◯ Yes
- ◯ No

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?

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.

- ◯ Yes
- ◯ No

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.

The next questions ask about employment and use of health care services.

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?

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

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

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?

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

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

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? Include any amount paid out-of-pocket on your behalf by anyone in this household.	◯ $0 (No medical or health-related expenses) ◯ $1-$249 ◯ $250-$499 ◯ $500-$999 ◯ $1,000-$5,000 ◯ More than $5,000
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
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- ◯ 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.

The final questions ask about problems that may have bothered you over the past 2 weeks, followed by two additional questions about you.

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

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

◯ Current
◯ Ever

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

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

◯ Current
◯ Ever

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 touching the shoulder with the chin or lifting the chin up.	◯ Current ◯ Ever
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 jerking a shoulder.	◯ Current ◯ Ever
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 quickly flexing the arms or extending them, nail biting, poking with fingers, or popping knuckles.	◯ Current ◯ Ever
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 kicking, skipping, knee-bending, flexing or extension of the ankles; shaking, stomping or tapping the foot.	◯ Current ◯ Ever

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

tensing the abdomen, tensing the buttocks.

◯ Current
◯ Ever

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

touching

◯ Current
◯ Ever

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)