



Data Collection Worksheet

Please Note: The Data Collection Worksheet (DCW) is a tool to aid integration of a PhenX protocol into a study. The PhenX DCW is not designed to be a data collection instrument. Investigators will need to decide the best way to collect data for the PhenX protocol in their study. Variables captured in the DCW, along with variable names and unique PhenX variable identifiers, are included in the PhenX Data Dictionary (DD) files.

<p>1a. Now I'm going to ask you about some experiences that people have reported in connection with their use of medicines or drugs ON THEIR OWN. As I read each experience, please tell me if this has ever happened to you.</p> <p>In your entire life, did you EVER...(PAUSE)</p> <p>(Repeat phrase frequently)</p>	<p>b. Did this happen in the last 12 months?</p>	<p>c. During the last 12 months, which medicines or drugs did this happen with?</p> <p>(SHOW FLASHCARD)</p>	<p>d. Did this happen before 12 months ago, that is, before last (Month one year ago)?</p>	<p>e. Which medicines or drugs did this happen with before 12 months ago?</p> <p>(SHOW FLASHCARD)</p>																					
<p>(1) Find that your usual amount of a medicine or drug had much less effect on you than it once did?</p>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No - Go to next experience</p>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No - Mark "Yes" in column d</p>	<table border="1"> <tr> <td>1 <input type="checkbox"/> SED</td><td>2 <input type="checkbox"/> PAN</td></tr> <tr> <td>3 <input type="checkbox"/> MAR</td><td>4 <input type="checkbox"/> COC</td></tr> <tr> <td>5 <input type="checkbox"/> STIM</td><td>6 <input type="checkbox"/> CLB</td></tr> <tr> <td>7 <input type="checkbox"/> HAL</td><td>8 <input type="checkbox"/> SOLV</td></tr> <tr> <td>9 <input type="checkbox"/></td><td>10 <input type="checkbox"/></td></tr> </table>	1 <input type="checkbox"/> SED	2 <input type="checkbox"/> PAN	3 <input type="checkbox"/> MAR	4 <input type="checkbox"/> COC	5 <input type="checkbox"/> STIM	6 <input type="checkbox"/> CLB	7 <input type="checkbox"/> HAL	8 <input type="checkbox"/> SOLV	9 <input type="checkbox"/>	10 <input type="checkbox"/>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No - Go to next experience</p>	<table border="1"> <tr> <td>1 <input type="checkbox"/> SED</td><td>2 <input type="checkbox"/> PAN</td></tr> <tr> <td>3 <input type="checkbox"/> MAR</td><td>4 <input type="checkbox"/> COC</td></tr> <tr> <td>5 <input type="checkbox"/> STIM</td><td>6 <input type="checkbox"/> CLB</td></tr> <tr> <td>7 <input type="checkbox"/> HAL</td><td>8 <input type="checkbox"/> SOLV</td></tr> <tr> <td>9 <input type="checkbox"/></td><td>10 <input type="checkbox"/></td></tr> </table>	1 <input type="checkbox"/> SED	2 <input type="checkbox"/> PAN	3 <input type="checkbox"/> MAR	4 <input type="checkbox"/> COC	5 <input type="checkbox"/> STIM	6 <input type="checkbox"/> CLB	7 <input type="checkbox"/> HAL	8 <input type="checkbox"/> SOLV	9 <input type="checkbox"/>	10 <input type="checkbox"/>
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(2) Find that you had to use much more of a medicine or to get the effect you wanted?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Mark "Yes" in column d	1 <input type="checkbox"/> SED	2 <input type="checkbox"/> PAN	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> SED	2 <input type="checkbox"/> PAN
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			9 <input type="checkbox"/> HER	10 <input type="checkbox"/> OTH		9 <input type="checkbox"/> HER	10 <input type="checkbox"/> OTH
The next few questions are about the bad aftereffects that people may have when the effects of a medicine or drug are wearing off. This includes the morning after using it or in the first few days after stopping or cutting down on it. Did you EVER...							
(3) Sleep more than usual (when the effects of a medicine or drug were wearing off)?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Mark "Yes" in column d	1 <input type="checkbox"/> SED	2 <input type="checkbox"/> PAN	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> SED	2 <input type="checkbox"/> PAN
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(4) Feel weak or tired?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Mark "Yes" in column d	<div>1 <input type="checkbox"/> SED</div> <div>2 <input type="checkbox"/> PAN</div>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Go to next experience	<div>1 <input type="checkbox"/> SED</div> <div>2 <input type="checkbox"/> PAN</div>
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(5) Feel depressed?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Mark "Yes" in column d	<div>1 <input type="checkbox"/> SED</div> <div>2 <input type="checkbox"/> PAN</div>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Go to next experience	<div>1 <input type="checkbox"/> SED</div> <div>2 <input type="checkbox"/> PAN</div>
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<p>(6) Find your heart beating fast (when the effects of a medicine or drug were wearing off)?</p>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No - Go to next experience</p>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No - Mark "Yes" in column d</p>	<p>1 <input type="checkbox"/> SED</p>	<p>2 <input type="checkbox"/> PAN</p>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No - Go to next experience</p>	<p>1 <input type="checkbox"/> SED</p>	<p>2 <input type="checkbox"/> PAN</p>
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<p>(7) Have nausea or vomiting?</p>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No - Go to next experience</p>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No - Mark "Yes" in column d</p>	<p>1 <input type="checkbox"/> SED</p>	<p>2 <input type="checkbox"/> PAN</p>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No - Go to next experience</p>	<p>1 <input type="checkbox"/> SED</p>	<p>2 <input type="checkbox"/> PAN</p>
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<p>(8) Yawn a lot?</p>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No - Go to next experience</p>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No - Mark "Yes" in column d</p>	<p>1 <input type="checkbox"/> SED</p>	<p>2 <input type="checkbox"/> PAN</p>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No - Go to next experience</p>	<p>1 <input type="checkbox"/> SED</p>	<p>2 <input type="checkbox"/> PAN</p>
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<p>(9) Have runny eyes or a runny nose (when the effects of a medicine or drug were wearing off)?</p>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No - Go to next experience</p>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No - Mark "Yes" in column d</p>	<table border="1"> <tr> <td>1 <input type="checkbox"/> SED</td><td>2 <input type="checkbox"/> PAN</td></tr> <tr> <td>3 <input type="checkbox"/> MAR</td><td>4 <input type="checkbox"/> COC</td></tr> <tr> <td>5 <input type="checkbox"/> STIM</td><td>6 <input type="checkbox"/> CLB</td></tr> <tr> <td>7 <input type="checkbox"/> HAL</td><td>8 <input type="checkbox"/> SOLV</td></tr> <tr> <td>9 <input type="checkbox"/> HER</td><td>10 <input type="checkbox"/> OTH</td></tr> </table>	1 <input type="checkbox"/> SED	2 <input type="checkbox"/> PAN	3 <input type="checkbox"/> MAR	4 <input type="checkbox"/> COC	5 <input type="checkbox"/> STIM	6 <input type="checkbox"/> CLB	7 <input type="checkbox"/> HAL	8 <input type="checkbox"/> SOLV	9 <input type="checkbox"/> HER	10 <input type="checkbox"/> OTH	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No - Go to next experience</p>	<table border="1"> <tr> <td>1 <input type="checkbox"/> SED</td><td>2 <input type="checkbox"/> PAN</td></tr> <tr> <td>3 <input type="checkbox"/> MAR</td><td>4 <input type="checkbox"/> COC</td></tr> <tr> <td>5 <input type="checkbox"/> STIM</td><td>6 <input type="checkbox"/> CLB</td></tr> <tr> <td>7 <input type="checkbox"/> HAL</td><td>8 <input type="checkbox"/> SOLV</td></tr> <tr> <td>9 <input type="checkbox"/> HER</td><td>10 <input type="checkbox"/> OTH</td></tr> </table>	1 <input type="checkbox"/> SED	2 <input type="checkbox"/> PAN	3 <input type="checkbox"/> MAR	4 <input type="checkbox"/> COC	5 <input type="checkbox"/> STIM	6 <input type="checkbox"/> CLB	7 <input type="checkbox"/> HAL	8 <input type="checkbox"/> SOLV	9 <input type="checkbox"/> HER	10 <input type="checkbox"/> OTH
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9 <input type="checkbox"/> HER	10 <input type="checkbox"/> OTH																								
<p>(10) Eat more than usual or gain weight?</p>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No - Go to next experience</p>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No - Mark "Yes" in column d</p>	<table border="1"> <tr> <td>1 <input type="checkbox"/> SED</td><td>2 <input type="checkbox"/> PAN</td></tr> <tr> <td>3 <input type="checkbox"/> MAR</td><td>4 <input type="checkbox"/> COC</td></tr> <tr> <td>5 <input type="checkbox"/> STIM</td><td>6 <input type="checkbox"/> CLB</td></tr> </table>	1 <input type="checkbox"/> SED	2 <input type="checkbox"/> PAN	3 <input type="checkbox"/> MAR	4 <input type="checkbox"/> COC	5 <input type="checkbox"/> STIM	6 <input type="checkbox"/> CLB	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No - Go to next experience</p>	<table border="1"> <tr> <td>1 <input type="checkbox"/> SED</td><td>2 <input type="checkbox"/> PAN</td></tr> <tr> <td>3 <input type="checkbox"/> MAR</td><td>4 <input type="checkbox"/> COC</td></tr> <tr> <td>5 <input type="checkbox"/> STIM</td><td>6 <input type="checkbox"/> CLB</td></tr> </table>	1 <input type="checkbox"/> SED	2 <input type="checkbox"/> PAN	3 <input type="checkbox"/> MAR	4 <input type="checkbox"/> COC	5 <input type="checkbox"/> STIM	6 <input type="checkbox"/> CLB								
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1a. Did you EVER...(PAUSE) (Repeat phrase frequently)		b. Did this happen in the last 12 months?	c. During the last 12 months, which medicines or drugs did this happen with? <u>(SHOW FLASHCARD)</u>	d. Did this happen before 12 months ago, that is, before last (Month one year ago)?	e. Which medicines or drugs did this happen with before 12 months ago? <u>(SHOW FLASHCARD)</u>
(11) Feel anxious or nervous?	<div>1 <input type="checkbox"/> Yes</div> <div>2 <input type="checkbox"/> No - Go to next experience</div>	<div>1 <input type="checkbox"/> Yes</div> <div>2 <input type="checkbox"/> No - Mark "Yes" in column d</div>	<div>1 <input type="checkbox"/> SED</div> <div>2 <input type="checkbox"/> PAN</div> <div>3 <input type="checkbox"/> MAR</div> <div>4 <input type="checkbox"/> COC</div> <div>5 <input type="checkbox"/> STIM</div> <div>6 <input type="checkbox"/> CLB</div> <div>7 <input type="checkbox"/> HAL</div> <div>8 <input type="checkbox"/> SOLV</div> <div>9 <input type="checkbox"/> HER</div> <div>10 <input type="checkbox"/> OTH</div>	<div>1 <input type="checkbox"/> Yes</div> <div>2 <input type="checkbox"/> No - Go to next experience</div>	<div>1 <input type="checkbox"/> SED</div> <div>2 <input type="checkbox"/> PAN</div> <div>3 <input type="checkbox"/> MAR</div> <div>4 <input type="checkbox"/> COC</div> <div>5 <input type="checkbox"/> STIM</div> <div>6 <input type="checkbox"/> CLB</div> <div>7 <input type="checkbox"/> HAL</div> <div>8 <input type="checkbox"/> SOLV</div> <div>9 <input type="checkbox"/> HER</div> <div>10 <input type="checkbox"/> OTH</div>
(12) Have muscle aches or cramps (when the effects of a	<div>1 <input type="checkbox"/> Yes</div> <div>2 <input type="checkbox"/> No - Go to next experience</div>	<div>1 <input type="checkbox"/> Yes</div> <div>2 <input type="checkbox"/> No - Mark "Yes" in column</div>	<div>1 <input type="checkbox"/> SED</div> <div>2 <input type="checkbox"/> PAN</div> <div>3 <input type="checkbox"/></div> <div>4 <input type="checkbox"/></div>	<div>1 <input type="checkbox"/> Yes</div> <div>2 <input type="checkbox"/> No - Go to next experience</div>	<div>1 <input type="checkbox"/> SED</div> <div>2 <input type="checkbox"/> PAN</div> <div>3 <input type="checkbox"/></div> <div>4 <input type="checkbox"/></div>

medicine or drug were wearing off)?		d	MAR	COC		MAR	COC
			5 <input type="checkbox"/> STIM	6 <input type="checkbox"/> CLB		5 <input type="checkbox"/> STIM	6 <input type="checkbox"/> CLB
			7 <input type="checkbox"/> HAL	8 <input type="checkbox"/> SOLV		7 <input type="checkbox"/> HAL	8 <input type="checkbox"/> SOLV
			9 <input type="checkbox"/> HER	10 <input type="checkbox"/> OTH		9 <input type="checkbox"/> HER	10 <input type="checkbox"/> OTH
(13) Have a fever?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Mark "Yes" in column d	1 <input type="checkbox"/> SED	2 <input type="checkbox"/> PAN	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> SED	2 <input type="checkbox"/> PAN
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			7 <input type="checkbox"/> HAL	8 <input type="checkbox"/> SOLV		7 <input type="checkbox"/> HAL	8 <input type="checkbox"/> SOLV
			9 <input type="checkbox"/> HER	10 <input type="checkbox"/> OTH		9 <input type="checkbox"/> HER	10 <input type="checkbox"/> OTH
(14) Become so restless you fidgeted, paced or couldn't sit still?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Mark "Yes" in column d	1 <input type="checkbox"/> SED	2 <input type="checkbox"/> PAN	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> SED	2 <input type="checkbox"/> PAN
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			7 <input type="checkbox"/> HAL	8 <input type="checkbox"/> SOLV		7 <input type="checkbox"/> HAL	8 <input type="checkbox"/> SOLV
			9 <input type="checkbox"/> HER	10 <input type="checkbox"/> OTH		9 <input type="checkbox"/> HER	10 <input type="checkbox"/> OTH
(15) Move or talk much more slowly than usual (when the effects of a medicine or drug were wearing off)?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Mark "Yes" in column d	1 <input type="checkbox"/> SED	2 <input type="checkbox"/> PAN	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> SED	2 <input type="checkbox"/> PAN
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			9 <input type="checkbox"/> HER	10 <input type="checkbox"/> OTH		9 <input type="checkbox"/> HER	10 <input type="checkbox"/> OTH
(16) Find your pupils dilating or your hair standing up?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Mark "Yes" in column d	1 <input type="checkbox"/> SED	2 <input type="checkbox"/> PAN	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> SED	2 <input type="checkbox"/> PAN
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			9 <input type="checkbox"/>	10 <input type="checkbox"/>		9 <input type="checkbox"/>	10 <input type="checkbox"/>

			HER	OTH		HER	OTH
(17) Have unpleasant dreams that often seemed real?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Mark "Yes" in column d	1 <input type="checkbox"/> SED	2 <input type="checkbox"/> PAN	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> SED	2 <input type="checkbox"/> PAN
			3 <input type="checkbox"/> MAR	4 <input type="checkbox"/> COC		3 <input type="checkbox"/> MAR	4 <input type="checkbox"/> COC
			5 <input type="checkbox"/> STIM	6 <input type="checkbox"/> CLB		5 <input type="checkbox"/> STIM	6 <input type="checkbox"/> CLB
			7 <input type="checkbox"/> HAL	8 <input type="checkbox"/> SOLV		7 <input type="checkbox"/> HAL	8 <input type="checkbox"/> SOLV
			9 <input type="checkbox"/> HER	10 <input type="checkbox"/> OTH		9 <input type="checkbox"/> HER	10 <input type="checkbox"/> OTH
(18) See, feel or hear things that weren't really there (when the effects of a medicine or drug were wearing off)?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Mark "Yes" in column d	1 <input type="checkbox"/> SED	2 <input type="checkbox"/> PAN	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> SED	2 <input type="checkbox"/> PAN
			3 <input type="checkbox"/> MAR	4 <input type="checkbox"/> COC		3 <input type="checkbox"/> MAR	4 <input type="checkbox"/> COC
			5 <input type="checkbox"/> STIM	6 <input type="checkbox"/> CLB		5 <input type="checkbox"/> STIM	6 <input type="checkbox"/> CLB
			7 <input type="checkbox"/> HAL	8 <input type="checkbox"/> SOLV		7 <input type="checkbox"/> HAL	8 <input type="checkbox"/> SOLV
			9 <input type="checkbox"/> HER	10 <input type="checkbox"/> OTH		9 <input type="checkbox"/> HER	10 <input type="checkbox"/> OTH
(19) Feel shaky or have shaky or trembling	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Go to next	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Mark "Yes"	1 <input type="checkbox"/> SED	2 <input type="checkbox"/> PAN	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Go to next	1 <input type="checkbox"/> SED	2 <input type="checkbox"/> PAN

hands?	experience	in column d	3 <input type="checkbox"/> MAR	4 <input type="checkbox"/> COC	experience	3 <input type="checkbox"/> MAR	4 <input type="checkbox"/> COC
			5 <input type="checkbox"/> STIM	6 <input type="checkbox"/> CLB		5 <input type="checkbox"/> STIM	6 <input type="checkbox"/> CLB
			7 <input type="checkbox"/> HAL	8 <input type="checkbox"/> SOLV		7 <input type="checkbox"/> HAL	8 <input type="checkbox"/> SOLV
			9 <input type="checkbox"/> HER	10 <input type="checkbox"/> OTH		9 <input type="checkbox"/> HER	10 <input type="checkbox"/> OTH
(20) Have trouble falling asleep or staying asleep?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Mark "Yes" in column d					
1a. Did you EVER...(PAUSE) (Repeat phrase frequently)		b. Did this happen in the last 12 months?	c. During the last 12 months, which medicines or drugs did this happen with? (SHOW FLASHCARD)		d. Did this happen before 12 months ago, that is, before last (Month one year ago)?	e. Which medicines or drugs did this happen with before 12 months ago? (SHOW FLASHCARD)	
(21) Have fits or seizures (when the effects of a medicine or drug were wearing off)?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Mark "Yes" in column d	1 <input type="checkbox"/> SED	2 <input type="checkbox"/> PAN	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> SED	2 <input type="checkbox"/> PAN
			3 <input type="checkbox"/> MAR	4 <input type="checkbox"/> COC		3 <input type="checkbox"/> MAR	4 <input type="checkbox"/> COC
			5 <input type="checkbox"/>	6 <input type="checkbox"/>		5 <input type="checkbox"/>	6 <input type="checkbox"/>

			<div>STIM</div> <div>CLB</div> <div>7 <input type="checkbox"/> HAL</div> <div>8 <input type="checkbox"/> SOLV</div> <div>9 <input type="checkbox"/> HER</div> <div>10 <input type="checkbox"/> OTH</div>		<div>STIM</div> <div>CLB</div> <div>7 <input type="checkbox"/> HAL</div> <div>8 <input type="checkbox"/> SOLV</div> <div>9 <input type="checkbox"/> HER</div> <div>10 <input type="checkbox"/> OTH</div>
(22) Become more irritable than usual?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Mark "Yes" in column d	<div>1 <input type="checkbox"/> SED</div> <div>2 <input type="checkbox"/> PAN</div> <div>3 <input type="checkbox"/> MAR</div> <div>4 <input type="checkbox"/> COC</div> <div>5 <input type="checkbox"/> STIM</div> <div>6 <input type="checkbox"/> CLB</div> <div>7 <input type="checkbox"/> HAL</div> <div>8 <input type="checkbox"/> SOLV</div> <div>9 <input type="checkbox"/> HER</div> <div>10 <input type="checkbox"/> OTH</div>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Go to next experience	<div>1 <input type="checkbox"/> SED</div> <div>2 <input type="checkbox"/> PAN</div> <div>3 <input type="checkbox"/> MAR</div> <div>4 <input type="checkbox"/> COC</div> <div>5 <input type="checkbox"/> STIM</div> <div>6 <input type="checkbox"/> CLB</div> <div>7 <input type="checkbox"/> HAL</div> <div>8 <input type="checkbox"/> SOLV</div> <div>9 <input type="checkbox"/> HER</div> <div>10 <input type="checkbox"/> OTH</div>
(23) Eat less than usual or lose weight?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Mark "Yes" in column d	<div>1 <input type="checkbox"/> SED</div> <div>2 <input type="checkbox"/> PAN</div> <div>3 <input type="checkbox"/> MAR</div> <div>4 <input type="checkbox"/> COC</div> <div>5 <input type="checkbox"/> STIM</div> <div>6 <input type="checkbox"/> CLB</div> <div>7 <input type="checkbox"/> HAL</div> <div>8 <input type="checkbox"/> SOLV</div>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Go to next experience	<div>1 <input type="checkbox"/> SED</div> <div>2 <input type="checkbox"/> PAN</div> <div>3 <input type="checkbox"/> MAR</div> <div>4 <input type="checkbox"/> COC</div> <div>5 <input type="checkbox"/> STIM</div> <div>6 <input type="checkbox"/> CLB</div> <div>7 <input type="checkbox"/> HAL</div> <div>8 <input type="checkbox"/> SOLV</div>

			9 <input type="checkbox"/> HER	10 <input type="checkbox"/> OTH		9 <input type="checkbox"/> HER	10 <input type="checkbox"/> OTH
(24) Feel angry, combative or aggressive (when the effects of a medicine or drug were wearing off)?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Mark "Yes" in column d	1 <input type="checkbox"/> SED	2 <input type="checkbox"/> PAN	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> SED	2 <input type="checkbox"/> PAN
			3 <input type="checkbox"/> MAR	4 <input type="checkbox"/> COC		3 <input type="checkbox"/> MAR	4 <input type="checkbox"/> COC
			5 <input type="checkbox"/> STIM	6 <input type="checkbox"/> CLB		5 <input type="checkbox"/> STIM	6 <input type="checkbox"/> CLB
			7 <input type="checkbox"/> HAL	8 <input type="checkbox"/> SOLV		7 <input type="checkbox"/> HAL	8 <input type="checkbox"/> SOLV
			9 <input type="checkbox"/> HER	10 <input type="checkbox"/> OTH		9 <input type="checkbox"/> HER	10 <input type="checkbox"/> OTH
(25) Have a headache?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Mark "Yes" in column d	1 <input type="checkbox"/> SED	2 <input type="checkbox"/> PAN	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> SED	2 <input type="checkbox"/> PAN
			3 <input type="checkbox"/> MAR	4 <input type="checkbox"/> COC		3 <input type="checkbox"/> MAR	4 <input type="checkbox"/> COC
			5 <input type="checkbox"/> STIM	6 <input type="checkbox"/> CLB		5 <input type="checkbox"/> STIM	6 <input type="checkbox"/> CLB
			7 <input type="checkbox"/> HAL	8 <input type="checkbox"/> SOLV		7 <input type="checkbox"/> HAL	8 <input type="checkbox"/> SOLV
			9 <input type="checkbox"/> HER	10 <input type="checkbox"/> OTH		9 <input type="checkbox"/> HER	10 <input type="checkbox"/> OTH
(26) Find yourself	1 <input type="checkbox"/> Yes	1 <input type="checkbox"/> Yes	1 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/> Yes	1 <input type="checkbox"/>	2 <input type="checkbox"/>

sweating?	2 <input type="checkbox"/> No - Go to next experience	2 <input type="checkbox"/> No - Mark "Yes" in column d	SED	PAN	2 <input type="checkbox"/> No - Go to next experience	SED	PAN
			3 <input type="checkbox"/> MAR	4 <input type="checkbox"/> COC		3 <input type="checkbox"/> MAR	4 <input type="checkbox"/> COC
			5 <input type="checkbox"/> STIM	6 <input type="checkbox"/> CLB		5 <input type="checkbox"/> STIM	6 <input type="checkbox"/> CLB
			7 <input type="checkbox"/> HAL	8 <input type="checkbox"/> SOLV		7 <input type="checkbox"/> HAL	8 <input type="checkbox"/> SOLV
			9 <input type="checkbox"/> HER	10 <input type="checkbox"/> OTH		9 <input type="checkbox"/> HER	10 <input type="checkbox"/> OTH
(27) Have chills (when the effects of a medicine or drug were wearing off)?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Mark "Yes" in column d	1 <input type="checkbox"/> SED	2 <input type="checkbox"/> PAN	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> SED	2 <input type="checkbox"/> PAN
			3 <input type="checkbox"/> MAR	4 <input type="checkbox"/> COC		3 <input type="checkbox"/> MAR	4 <input type="checkbox"/> COC
			5 <input type="checkbox"/> STIM	6 <input type="checkbox"/> CLB		5 <input type="checkbox"/> STIM	6 <input type="checkbox"/> CLB
			7 <input type="checkbox"/> HAL	8 <input type="checkbox"/> SOLV		7 <input type="checkbox"/> HAL	8 <input type="checkbox"/> SOLV
			9 <input type="checkbox"/> HER	10 <input type="checkbox"/> OTH		9 <input type="checkbox"/> HER	10 <input type="checkbox"/> OTH
(28) Have stomach pain?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Mark "Yes" in column d	1 <input type="checkbox"/> SED	2 <input type="checkbox"/> PAN	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> SED	2 <input type="checkbox"/> PAN
			3 <input type="checkbox"/> MAR	4 <input type="checkbox"/> COC		3 <input type="checkbox"/> MAR	4 <input type="checkbox"/> COC

			<div>5 <input type="checkbox"/> STIM</div> <div>6 <input type="checkbox"/> CLB</div> <div>7 <input type="checkbox"/> HAL</div> <div>8 <input type="checkbox"/> SOLV</div> <div>9 <input type="checkbox"/> HER</div> <div>10 <input type="checkbox"/> OTH</div>		<div>5 <input type="checkbox"/> STIM</div> <div>6 <input type="checkbox"/> CLB</div> <div>7 <input type="checkbox"/> HAL</div> <div>8 <input type="checkbox"/> SOLV</div> <div>9 <input type="checkbox"/> HER</div> <div>10 <input type="checkbox"/> OTH</div>
Check Item 1. Are at least 2 items marked "Yes" in 1c(3)-1c(28)?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>Go to Check Item 2</i>				
(28-1) You just mentioned that you had SOME bad aftereffects when stopping or cutting down on your use of medicines or drugs in the last 12 months. Did at least 2 of these experiences happen around the same time DURING the last 12 months?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>Go to Check Item 2</i>			
Check Item 2. Are at least 2 items marked "Yes" in 1e(3)-	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>Skip to 1a(29)</i>				

1e(28)?							
(28-2) You (just/also) mentioned that you had SOME bad aftereffects when stopping or cutting down on your use of medicines or drugs BEFORE 12 months ago. Did at least 2 of these experiences happen around HT1 the same time BEFORE 12 months ago?							
1a. In your entire life, did you EVER... <i>(Repeat phrase frequently)</i>	b. Did this happen in the last 12 months?	c. During the last 12 months, which medicines or drugs did this happen with? <i>(SHOW FLASHCARD)</i>	d. Did this happen before 12 months ago, that is, before last <i>(Month one year ago)?</i>	e. Which medicines or drugs did this happen with before 12 months ago? <i>(SHOW FLASHCARD)</i>			
(29) Take more of the same or a similar medicine or drug to get over or avoid any of these bad aftereffects?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Mark "Yes" in column d	1 <input type="checkbox"/> SED 2 <input type="checkbox"/> PAN		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> SED 2 <input type="checkbox"/> PAN	
			3 <input type="checkbox"/> MAR 4 <input type="checkbox"/> COC			3 <input type="checkbox"/> MAR 4 <input type="checkbox"/> COC	
			5 <input type="checkbox"/> STIM 6 <input type="checkbox"/> CLB			5 <input type="checkbox"/> STIM 6 <input type="checkbox"/> CLB	
			7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV			7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV	
			9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH			9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH	

<p>(30) More than once WANT to stop or cut down on using any of these medicines or drugs?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Go to next experience</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Mark "Yes" in column d</p>	<p>1 <input type="checkbox"/> SED 3 <input type="checkbox"/> MAR 5 <input type="checkbox"/> STIM 7 <input type="checkbox"/> HAL 9 <input type="checkbox"/> HER</p>	<p>2 <input type="checkbox"/> PAN 4 <input type="checkbox"/> COC 6 <input type="checkbox"/> CLB 8 <input type="checkbox"/> SOLV 10 <input type="checkbox"/> OTH</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Go to next experience</p>	<p>1 <input type="checkbox"/> SED 3 <input type="checkbox"/> MAR 5 <input type="checkbox"/> STIM 7 <input type="checkbox"/> HAL 9 <input type="checkbox"/> HER</p>	<p>2 <input type="checkbox"/> PAN 4 <input type="checkbox"/> COC 6 <input type="checkbox"/> CLB 8 <input type="checkbox"/> SOLV 10 <input type="checkbox"/> OTH</p>
<p>(31) More than once TRY to stop or cut down on using any of these medicines or drugs but found you couldn't do it?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Go to next experience</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Mark "Yes" in column d</p>	<p>1 <input type="checkbox"/> SED 3 <input type="checkbox"/> MAR 5 <input type="checkbox"/> STIM 7 <input type="checkbox"/> HAL 9 <input type="checkbox"/> HER</p>	<p>2 <input type="checkbox"/> PAN 4 <input type="checkbox"/> COC 6 <input type="checkbox"/> CLB 8 <input type="checkbox"/> SOLV 10 <input type="checkbox"/> OTH</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Go to next experience</p>	<p>1 <input type="checkbox"/> SED 3 <input type="checkbox"/> MAR 5 <input type="checkbox"/> STIM 7 <input type="checkbox"/> HAL 9 <input type="checkbox"/> HER</p>	<p>2 <input type="checkbox"/> PAN 4 <input type="checkbox"/> COC 6 <input type="checkbox"/> CLB 8 <input type="checkbox"/> SOLV 10 <input type="checkbox"/> OTH</p>
<p>(32) Often use a medicine or drug in larger amounts or for a much longer period than you</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Go to next experience</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Mark "Yes" in column d</p>	<p>1 <input type="checkbox"/> SED 3 <input type="checkbox"/></p>	<p>2 <input type="checkbox"/> PAN 4 <input type="checkbox"/></p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Go to next experience</p>	<p>1 <input type="checkbox"/> SED 3 <input type="checkbox"/></p>	<p>2 <input type="checkbox"/> PAN 4 <input type="checkbox"/></p>

meant to?			<div>MAR</div> <div>COC</div> <div>5 <input type="checkbox"/> STIM</div> <div>6 <input type="checkbox"/> CLB</div> <div>7 <input type="checkbox"/> HAL</div> <div>8 <input type="checkbox"/> SOLV</div> <div>9 <input type="checkbox"/> HER</div> <div>10 <input type="checkbox"/> OTH</div>		<div>MAR</div> <div>COC</div> <div>5 <input type="checkbox"/> STIM</div> <div>6 <input type="checkbox"/> CLB</div> <div>7 <input type="checkbox"/> HAL</div> <div>8 <input type="checkbox"/> SOLV</div> <div>9 <input type="checkbox"/> HER</div> <div>10 <input type="checkbox"/> OTH</div>
(33) Have a period when you spent a lot of time using a medicine or drug or getting over its bad aftereffects?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Mark "Yes" in column d	<div>1 <input type="checkbox"/> SED</div> <div>2 <input type="checkbox"/> PAN</div> <div>3 <input type="checkbox"/> MAR</div> <div>4 <input type="checkbox"/> COC</div> <div>5 <input type="checkbox"/> STIM</div> <div>6 <input type="checkbox"/> CLB</div> <div>7 <input type="checkbox"/> HAL</div> <div>8 <input type="checkbox"/> SOLV</div> <div>9 <input type="checkbox"/> HER</div> <div>10 <input type="checkbox"/> OTH</div>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Go to next experience	<div>1 <input type="checkbox"/> SED</div> <div>2 <input type="checkbox"/> PAN</div> <div>3 <input type="checkbox"/> MAR</div> <div>4 <input type="checkbox"/> COC</div> <div>5 <input type="checkbox"/> STIM</div> <div>6 <input type="checkbox"/> CLB</div> <div>7 <input type="checkbox"/> HAL</div> <div>8 <input type="checkbox"/> SOLV</div> <div>9 <input type="checkbox"/> HER</div> <div>10 <input type="checkbox"/> OTH</div>
(34) Have a period when you spent a lot of time making sure you always had enough of a medicine or drug available?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Mark "Yes" in column d	<div>1 <input type="checkbox"/> SED</div> <div>2 <input type="checkbox"/> PAN</div> <div>3 <input type="checkbox"/> MAR</div> <div>4 <input type="checkbox"/> COC</div> <div>5 <input type="checkbox"/> STIM</div> <div>6 <input type="checkbox"/> CLB</div>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Go to next experience	<div>1 <input type="checkbox"/> SED</div> <div>2 <input type="checkbox"/> PAN</div> <div>3 <input type="checkbox"/> MAR</div> <div>4 <input type="checkbox"/> COC</div> <div>5 <input type="checkbox"/> STIM</div> <div>6 <input type="checkbox"/> CLB</div>

			<div>7 <input type="checkbox"/> HAL</div> <div>8 <input type="checkbox"/> SOLV</div> <div>9 <input type="checkbox"/> HER</div> <div>10 <input type="checkbox"/> OTH</div>		<div>7 <input type="checkbox"/> HAL</div> <div>8 <input type="checkbox"/> SOLV</div> <div>9 <input type="checkbox"/> HER</div> <div>10 <input type="checkbox"/> OTH</div>
(35) Give up or cut down on activities that were important to you in order to use a medicine or drug-like work, school, or associating with friends or relatives?	<div>1 <input type="checkbox"/> Yes</div> <div>2 <input type="checkbox"/> No - Go to next experience</div>	<div>1 <input type="checkbox"/> Yes</div> <div>2 <input type="checkbox"/> No - Mark "Yes" in column d</div>	<div>1 <input type="checkbox"/> SED</div> <div>2 <input type="checkbox"/> PAN</div> <div>3 <input type="checkbox"/> MAR</div> <div>4 <input type="checkbox"/> COC</div> <div>5 <input type="checkbox"/> STIM</div> <div>6 <input type="checkbox"/> CLB</div> <div>7 <input type="checkbox"/> HAL</div> <div>8 <input type="checkbox"/> SOLV</div> <div>9 <input type="checkbox"/> HER</div> <div>10 <input type="checkbox"/> OTH</div>	<div>1 <input type="checkbox"/> Yes</div> <div>2 <input type="checkbox"/> No - Go to next experience</div>	<div>1 <input type="checkbox"/> SED</div> <div>2 <input type="checkbox"/> PAN</div> <div>3 <input type="checkbox"/> MAR</div> <div>4 <input type="checkbox"/> COC</div> <div>5 <input type="checkbox"/> STIM</div> <div>6 <input type="checkbox"/> CLB</div> <div>7 <input type="checkbox"/> HAL</div> <div>8 <input type="checkbox"/> SOLV</div> <div>9 <input type="checkbox"/> HER</div> <div>10 <input type="checkbox"/> OTH</div>
(36) Give up or cut down on activities that you were interested in or that gave you pleasure in order to use a medicine or drug?	<div>1 <input type="checkbox"/> Yes</div> <div>2 <input type="checkbox"/> No - Go to next experience</div>	<div>1 <input type="checkbox"/> Yes</div> <div>2 <input type="checkbox"/> No - Mark "Yes" in column d</div>	<div>1 <input type="checkbox"/> SED</div> <div>2 <input type="checkbox"/> PAN</div> <div>3 <input type="checkbox"/> MAR</div> <div>4 <input type="checkbox"/> COC</div> <div>5 <input type="checkbox"/> STIM</div> <div>6 <input type="checkbox"/> CLB</div> <div>7 <input type="checkbox"/> HAL</div> <div>8 <input type="checkbox"/> SOLV</div> <div>9 <input type="checkbox"/></div> <div>10 <input type="checkbox"/></div>	<div>1 <input type="checkbox"/> Yes</div> <div>2 <input type="checkbox"/> No - Go to next experience</div>	<div>1 <input type="checkbox"/> SED</div> <div>2 <input type="checkbox"/> PAN</div> <div>3 <input type="checkbox"/> MAR</div> <div>4 <input type="checkbox"/> COC</div> <div>5 <input type="checkbox"/> STIM</div> <div>6 <input type="checkbox"/> CLB</div> <div>7 <input type="checkbox"/> HAL</div> <div>8 <input type="checkbox"/> SOLV</div> <div>9 <input type="checkbox"/></div> <div>10 <input type="checkbox"/></div>

			HER	OTH		HER	OTH
(37) Continue to use a medicine or drug even though you knew it was making you feel depressed, uninterested in things, or suspicious or distrustful of other people?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Mark "Yes" in column d	1 <input type="checkbox"/> SED	2 <input type="checkbox"/> PAN	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> SED	2 <input type="checkbox"/> PAN
			3 <input type="checkbox"/> MAR	4 <input type="checkbox"/> COC		3 <input type="checkbox"/> MAR	4 <input type="checkbox"/> COC
			5 <input type="checkbox"/> STIM	6 <input type="checkbox"/> CLB		5 <input type="checkbox"/> STIM	6 <input type="checkbox"/> CLB
			7 <input type="checkbox"/> HAL	8 <input type="checkbox"/> SOLV		7 <input type="checkbox"/> HAL	8 <input type="checkbox"/> SOLV
			9 <input type="checkbox"/> HER	10 <input type="checkbox"/> OTH		9 <input type="checkbox"/> HER	10 <input type="checkbox"/> OTH
1a. In your entire life, did you EVER...(PAUSE) (Repeat phrase frequently)	b. Did this happen in the last 12 months?	c. During the last 12 months, which medicines or drugs did this happen with? (SHOW FLASHCARD)	d. Did this happen before 12 months ago, that is, before last (Month one year ago)?	e. Which medicines or drugs did this happen with before 12 months ago? (SHOW FLASHCARD)			
(38) Continue to use a medicine or drug even though you knew it was causing you a health problem or making a health problem	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Mark "Yes" in column d	1 <input type="checkbox"/> SED	2 <input type="checkbox"/> PAN	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> SED	2 <input type="checkbox"/> PAN
			3 <input type="checkbox"/> MAR	4 <input type="checkbox"/> COC		3 <input type="checkbox"/> MAR	4 <input type="checkbox"/> COC
			5 <input type="checkbox"/> STIM	6 <input type="checkbox"/> CLB		5 <input type="checkbox"/> STIM	6 <input type="checkbox"/> CLB

worse?			<div>7 <input type="checkbox"/> HAL</div> <div>8 <input type="checkbox"/> SOLV</div> <div>9 <input type="checkbox"/> HER</div> <div>10 <input type="checkbox"/> OTH</div>		<div>7 <input type="checkbox"/> HAL</div> <div>8 <input type="checkbox"/> SOLV</div> <div>9 <input type="checkbox"/> HER</div> <div>10 <input type="checkbox"/> OTH</div>
(39) Feel a very strong urge or desire to use a medicine or drug?	<div>1 <input type="checkbox"/> Yes</div> <div>2 <input type="checkbox"/> No - Go to next experience</div>	<div>1 <input type="checkbox"/> Yes</div> <div>2 <input type="checkbox"/> No - Mark "Yes" in column d</div>	<div>1 <input type="checkbox"/> SED</div> <div>2 <input type="checkbox"/> PAN</div> <div>3 <input type="checkbox"/> MAR</div> <div>4 <input type="checkbox"/> COC</div> <div>5 <input type="checkbox"/> STIM</div> <div>6 <input type="checkbox"/> CLB</div> <div>7 <input type="checkbox"/> HAL</div> <div>8 <input type="checkbox"/> SOLV</div> <div>9 <input type="checkbox"/> HER</div> <div>10 <input type="checkbox"/> OTH</div>	<div>1 <input type="checkbox"/> Yes</div> <div>2 <input type="checkbox"/> No - Go to next experience</div>	<div>1 <input type="checkbox"/> SED</div> <div>2 <input type="checkbox"/> PAN</div> <div>3 <input type="checkbox"/> MAR</div> <div>4 <input type="checkbox"/> COC</div> <div>5 <input type="checkbox"/> STIM</div> <div>6 <input type="checkbox"/> CLB</div> <div>7 <input type="checkbox"/> HAL</div> <div>8 <input type="checkbox"/> SOLV</div> <div>9 <input type="checkbox"/> HER</div> <div>10 <input type="checkbox"/> OTH</div>
(40) Want a medicine or drug so badly that you couldn't think of anything else?	<div>1 <input type="checkbox"/> Yes</div> <div>2 <input type="checkbox"/> No - Go to next experience</div>	<div>1 <input type="checkbox"/> Yes</div> <div>2 <input type="checkbox"/> No - Mark "Yes" in column d</div>	<div>1 <input type="checkbox"/> SED</div> <div>2 <input type="checkbox"/> PAN</div> <div>3 <input type="checkbox"/> MAR</div> <div>4 <input type="checkbox"/> COC</div> <div>5 <input type="checkbox"/> STIM</div> <div>6 <input type="checkbox"/> CLB</div> <div>7 <input type="checkbox"/> HAL</div> <div>8 <input type="checkbox"/> SOLV</div> <div>9 <input type="checkbox"/></div> <div>10 <input type="checkbox"/></div>	<div>1 <input type="checkbox"/> Yes</div> <div>2 <input type="checkbox"/> No - Go to next experience</div>	<div>1 <input type="checkbox"/> SED</div> <div>2 <input type="checkbox"/> PAN</div> <div>3 <input type="checkbox"/> MAR</div> <div>4 <input type="checkbox"/> COC</div> <div>5 <input type="checkbox"/> STIM</div> <div>6 <input type="checkbox"/> CLB</div> <div>7 <input type="checkbox"/> HAL</div> <div>8 <input type="checkbox"/> SOLV</div> <div>9 <input type="checkbox"/></div> <div>10 <input type="checkbox"/></div>

			HER	OTH		HER	OTH
(41) Have arguments with your spouse or partner or family or friends as a result of your medicine or drug use?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Mark "Yes" in column d	1 <input type="checkbox"/> SED	2 <input type="checkbox"/> PAN	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> SED	2 <input type="checkbox"/> PAN
			3 <input type="checkbox"/> MAR	4 <input type="checkbox"/> COC		3 <input type="checkbox"/> MAR	4 <input type="checkbox"/> COC
			5 <input type="checkbox"/> STIM	6 <input type="checkbox"/> CLB		5 <input type="checkbox"/> STIM	6 <input type="checkbox"/> CLB
			7 <input type="checkbox"/> HAL	8 <input type="checkbox"/> SOLV		7 <input type="checkbox"/> HAL	8 <input type="checkbox"/> SOLV
			9 <input type="checkbox"/> HER	10 <input type="checkbox"/> OTH		9 <input type="checkbox"/> HER	10 <input type="checkbox"/> OTH
(42) Continue to use a medicine or drug even though it was causing you trouble with your family or friends?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Mark "Yes" in column d	1 <input type="checkbox"/> SED	2 <input type="checkbox"/> PAN	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> SED	2 <input type="checkbox"/> PAN
			3 <input type="checkbox"/> MAR	4 <input type="checkbox"/> COC		3 <input type="checkbox"/> MAR	4 <input type="checkbox"/> COC
			5 <input type="checkbox"/> STIM	6 <input type="checkbox"/> CLB		5 <input type="checkbox"/> STIM	6 <input type="checkbox"/> CLB
			7 <input type="checkbox"/> HAL	8 <input type="checkbox"/> SOLV		7 <input type="checkbox"/> HAL	8 <input type="checkbox"/> SOLV
			9 <input type="checkbox"/> HER	10 <input type="checkbox"/> OTH		9 <input type="checkbox"/> HER	10 <input type="checkbox"/> OTH
(43) Get into physical fights while under the	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Go to next	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Mark "Yes"	1 <input type="checkbox"/> SED	2 <input type="checkbox"/> PAN	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Go to next	1 <input type="checkbox"/> SED	2 <input type="checkbox"/> PAN

influence of a medicine or drug?	experience	in column d	3 <input type="checkbox"/> MAR	4 <input type="checkbox"/> COC	experience	3 <input type="checkbox"/> MAR	4 <input type="checkbox"/> COC
			5 <input type="checkbox"/> STIM	6 <input type="checkbox"/> CLB		5 <input type="checkbox"/> STIM	6 <input type="checkbox"/> CLB
			7 <input type="checkbox"/> HAL	8 <input type="checkbox"/> SOLV		7 <input type="checkbox"/> HAL	8 <input type="checkbox"/> SOLV
			9 <input type="checkbox"/> HER	10 <input type="checkbox"/> OTH		9 <input type="checkbox"/> HER	10 <input type="checkbox"/> OTH
(44) Have job or school troubles as a result of your medicine or drug use-like missing too much work, not doing your work well, being demoted or losing a job, or being suspended, expelled or dropping out of school?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Mark "Yes" in column d	1 <input type="checkbox"/> SED	2 <input type="checkbox"/> PAN	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> SED	2 <input type="checkbox"/> PAN
			3 <input type="checkbox"/> MAR	4 <input type="checkbox"/> COC		3 <input type="checkbox"/> MAR	4 <input type="checkbox"/> COC
			5 <input type="checkbox"/> STIM	6 <input type="checkbox"/> CLB		5 <input type="checkbox"/> STIM	6 <input type="checkbox"/> CLB
			7 <input type="checkbox"/> HAL	8 <input type="checkbox"/> SOLV		7 <input type="checkbox"/> HAL	8 <input type="checkbox"/> SOLV
			9 <input type="checkbox"/> HER	10 <input type="checkbox"/> OTH		9 <input type="checkbox"/> HER	10 <input type="checkbox"/> OTH
(45) Continue to use a medicine or drug even though it was causing you problems at school or work?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Mark "Yes" in column d	1 <input type="checkbox"/> SED	2 <input type="checkbox"/> PAN	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> SED	2 <input type="checkbox"/> PAN
			3 <input type="checkbox"/> MAR	4 <input type="checkbox"/> COC		3 <input type="checkbox"/> MAR	4 <input type="checkbox"/> COC
			5 <input type="checkbox"/>	6 <input type="checkbox"/>		5 <input type="checkbox"/>	6 <input type="checkbox"/>

			<div>STIM</div> <div>CLB</div> <div>7 <input type="checkbox"/> HAL</div> <div>8 <input type="checkbox"/> SOLV</div> <div>9 <input type="checkbox"/> HER</div> <div>10 <input type="checkbox"/> OTH</div>		<div>STIM</div> <div>CLB</div> <div>7 <input type="checkbox"/> HAL</div> <div>8 <input type="checkbox"/> SOLV</div> <div>9 <input type="checkbox"/> HER</div> <div>10 <input type="checkbox"/> OTH</div>
<p>(46) Have a period when your medicine or drug use or your being sick from medicine or drug use often interfered with taking care of your home or family?</p>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No - Go to next experience</p>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No - Mark "Yes" in column d</p>	<div>1 <input type="checkbox"/> SED</div> <div>2 <input type="checkbox"/> PAN</div> <div>3 <input type="checkbox"/> MAR</div> <div>4 <input type="checkbox"/> COC</div> <div>5 <input type="checkbox"/> STIM</div> <div>6 <input type="checkbox"/> CLB</div> <div>7 <input type="checkbox"/> HAL</div> <div>8 <input type="checkbox"/> SOLV</div> <div>9 <input type="checkbox"/> HER</div> <div>10 <input type="checkbox"/> OTH</div>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No - Go to next experience</p>	<div>1 <input type="checkbox"/> SED</div> <div>2 <input type="checkbox"/> PAN</div> <div>3 <input type="checkbox"/> MAR</div> <div>4 <input type="checkbox"/> COC</div> <div>5 <input type="checkbox"/> STIM</div> <div>6 <input type="checkbox"/> CLB</div> <div>7 <input type="checkbox"/> HAL</div> <div>8 <input type="checkbox"/> SOLV</div> <div>9 <input type="checkbox"/> HER</div> <div>10 <input type="checkbox"/> OTH</div>
<p>(47) More than once drive a car, motorcycle, truck, boat, or other vehicle when you were under the influence of a medicine or drug?</p>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No - Go to next experience</p>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No - Mark "Yes" in column d</p>	<div>1 <input type="checkbox"/> SED</div> <div>2 <input type="checkbox"/> PAN</div> <div>3 <input type="checkbox"/> MAR</div> <div>4 <input type="checkbox"/> COC</div> <div>5 <input type="checkbox"/> STIM</div> <div>6 <input type="checkbox"/> CLB</div> <div>7 <input type="checkbox"/> HAL</div> <div>8 <input type="checkbox"/> SOLV</div>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No - Go to next experience</p>	<div>1 <input type="checkbox"/> SED</div> <div>2 <input type="checkbox"/> PAN</div> <div>3 <input type="checkbox"/> MAR</div> <div>4 <input type="checkbox"/> COC</div> <div>5 <input type="checkbox"/> STIM</div> <div>6 <input type="checkbox"/> CLB</div> <div>7 <input type="checkbox"/> HAL</div> <div>8 <input type="checkbox"/> SOLV</div>

			9 <input type="checkbox"/> HER	10 <input type="checkbox"/> OTH		9 <input type="checkbox"/> HER	10 <input type="checkbox"/> OTH
(48) Find yourself under the influence of a medicine or drug or feeling its aftereffects in situations that increased your chances of getting hurt-like swimming; using heavy machinery or equipment; or walking in a dangerous area or around heavy traffic?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Mark "Yes" in column d	1 <input type="checkbox"/> SED	2 <input type="checkbox"/> PAN	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - Go to next experience	1 <input type="checkbox"/> SED	2 <input type="checkbox"/> PAN
			3 <input type="checkbox"/> MAR	4 <input type="checkbox"/> COC		3 <input type="checkbox"/> MAR	4 <input type="checkbox"/> COC
			5 <input type="checkbox"/> STIM	6 <input type="checkbox"/> CLB		5 <input type="checkbox"/> STIM	6 <input type="checkbox"/> CLB
			7 <input type="checkbox"/> HAL	8 <input type="checkbox"/> SOLV		7 <input type="checkbox"/> HAL	8 <input type="checkbox"/> SOLV
			9 <input type="checkbox"/> HER	10 <input type="checkbox"/> OTH		9 <input type="checkbox"/> HER	10 <input type="checkbox"/> OTH
Check Item 3. Are at least 2 boxes in Box 1, (2 or 3), 4-12 marked "Yes" in 1a, column e? 1 <input type="checkbox"/> Yes - see below 2 <input type="checkbox"/> No - <i>SKIP to Check Item 6</i> <i>For <input type="checkbox"/> 1 Mark corresponding category below and ask 2 a-g for each marked category.</i>	2a. You just mentioned some experience you had with <i>(Name of drug category)</i> in the past, that is, before 12 months ago. Before last <i>(Month one year ago)</i> was there ever a period when SOME of these experiences with <i>(Name of drug category)</i> were happening around the same time most days for at least a month	b. About how old were you the FIRST time SOME of these experiences with <i>(Name of drug category)</i> BEGAN to happen around the same time?	c. In your ENTIRE LIFE how many separate periods like this did you have when some of these experiences with <i>(Name of drug category)</i> were happening around the same time? By separate periods, I mean times separated by at least a year when you EITHER STOPPED using <i>(Name of drug category)</i> entirely				

	(PAUSE), on and off for a few months or longer (PAUSE) or within the same 1-year period?		(PAUSE) OR you didn't have any of the experiences you just mentioned with (Name of drug category).
1 <input type="checkbox"/> Sedatives or Tranquilizers	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - SKIP to next drug category	_____ Age	_____ Number
2 <input type="checkbox"/> Painkillers	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - SKIP to next drug category	_____ Age	_____ Number
3 <input type="checkbox"/> Marijuana	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - SKIP to next drug category	_____ Age	_____ Number
4 <input type="checkbox"/> Cocaine or Crack	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - SKIP to next drug category	_____ Age	_____ Number
5 <input type="checkbox"/> Stimulants	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - SKIP to next drug category	_____ Age	_____ Number
6 <input type="checkbox"/> Club drugs	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - SKIP to next drug category	_____ Age	_____ Number
7 <input type="checkbox"/> Hallucinogens	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - SKIP to next drug category	_____ Age	_____ Number

8 <input type="checkbox"/> Inhalants/Solvents	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to next drug category</i>	_____ Age	_____ Number
9 <input type="checkbox"/> Heroin	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to next drug category</i>	_____ Age	_____ Number
10 <input type="checkbox"/> Other	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 6</i>	_____ Age	_____ Number
Check Item 4. Is number in 2c, 2 or more or unknown?	d. In your ENTIRE LIFE what was the LONGEST period you had when SOME of these experiences with (<i>Name of drug category</i>) were happening around the same time?	e. About how old were you the MOST RECENT time when some of these experiences BEGAN to happen around the same time?	f. How long did this period last when some of these experiences with (<i>Name of drug category</i>) were happening around the same time?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 2f</i>	_____ Month(s) OR _____ Year(s)	_____ Age - <i>Go to Check Item 5</i>	_____ Month(s) OR _____ Year(s)
Check Item 5. Is at least 1 item marked in 1, column c, items (1)-(38) or (41)-(48)?	g. About how old were you when you FINALLY STOPPED having these problems with (<i>Name of drug category</i>)? By finally stopped, I mean they never started happening again.		
1 <input type="checkbox"/> Yes - <i>Go to next drug category</i> 2 <input type="checkbox"/> No	_____ Age - <i>SKIP to next drug category</i>		

1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 2f</i>	_____ Month(s) OR _____ Year(s)	_____ Age - Go to Check Item 5	_____ Month(s) OR _____ Year(s)	1 <input type="checkbox"/> Yes - Go to next drug category 2 <input type="checkbox"/> No	_____ Age - <i>SKIP to next drug category</i>
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 2f</i>	_____ Month(s) OR _____ Year(s)	_____ Age - Go to Check Item 5	_____ Month(s) OR _____ Year(s)	1 <input type="checkbox"/> Yes - Go to next drug category 2 <input type="checkbox"/> No	_____ Age - <i>SKIP to next drug category</i>
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 2f</i>	_____ Month(s) OR _____ Year(s)	_____ Age - Go to Check Item 5	_____ Month(s) OR _____ Year(s)	1 <input type="checkbox"/> Yes - Go to next drug category 2 <input type="checkbox"/> No	_____ Age - <i>SKIP to next drug category</i>
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 2f</i>	_____ Month(s) OR _____ Year(s)	_____ Age - Go to Check Item 5	_____ Month(s) OR _____ Year(s)	1 <input type="checkbox"/> Yes - Go to next drug category 2 <input type="checkbox"/> No	_____ Age - <i>SKIP to next drug category</i>
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 2f</i>	_____ Month(s) OR _____ Year(s)	_____ Age - Go to Check Item 5	_____ Month(s) OR _____ Year(s)	1 <input type="checkbox"/> Yes - Go to next drug category 2 <input type="checkbox"/> No	_____ Age - <i>SKIP to next drug category</i>

1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 2f</i>	_____ Month(s) OR _____ Year(s)	_____ Age - <i>Go to Check Item 5</i>	_____ Month(s) OR _____ Year(s)	1 <input type="checkbox"/> Yes - <i>Go to next drug category</i> 2 <input type="checkbox"/> No	_____ Age - <i>SKIP to next drug category</i>
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 2f</i>	_____ Month(s) OR _____ Year(s)	_____ Age - <i>Go to Check Item 5</i>	_____ Month(s) OR _____ Year(s)	1 <input type="checkbox"/> Yes - <i>Go to next drug category</i> 2 <input type="checkbox"/> No	_____ Age - <i>SKIP to next drug category</i>
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 2f</i>	_____ Month(s) OR _____ Year(s)	_____ Age - <i>Go to Check Item 5</i>	_____ Month(s) OR _____ Year(s)	1 <input type="checkbox"/> Yes - <i>Go to next drug category</i> 2 <input type="checkbox"/> No	_____ Age - <i>SKIP to next drug category</i>
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 2f</i>	_____ Month(s) OR _____ Year(s)	_____ Age - <i>Go to Check Item 5</i>	_____ Month(s) OR _____ Year(s)	1 <input type="checkbox"/> Yes - <i>Go to next drug category</i> 2 <input type="checkbox"/> No	_____ Age - <i>SKIP to next drug category</i>
Check Item 6. Are at least 2 Boxes, Box 1, (2 or 3), 4-12, marked in 1a, column c for Sedatives/Tranquilizers?			1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check item 7</i>		
3. You just mentioned SOME experiences you had with sedatives or tranquilizers in the last 12 months.			1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		

<p>(a) When you had SOME of these experiences with sedatives or tranquilizers in the last 12 months, were you using them without a prescription?</p> <p>(b) During the last 12 months when you had some of these experiences with sedatives or tranquilizers, were you using them in LARGER AMOUNTS, MORE FREQUENTLY or LONGER than prescribed or for a reason other than prescribed by a doctor?</p>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p>
<p>Check Item 7. Are at least 2 Boxes, Box 1, (2 or 3), 4-12, marked in 1a, column e for sedatives/tranquilizers?</p>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No - <i>SKIP to Check item 8</i></p>
<p>4. You just mentioned SOME experience you had with sedatives or tranquilizers around the same time BEFORE 12 months ago, that is, BEFORE last (<i>Month one year ago</i>).</p> <p>(a) During ANY of these times when you had SOME of these experiences with sedatives or tranquilizers BEFORE 12 months ago, were you using them without a prescription?</p> <p>(b) Did ALL of these times BEFORE 12 months ago ONLY happen when you were using sedatives or tranquilizers without a prescription?</p> <p>(c) During ANY of these times when you had SOME of those experiences with sedatives or tranquilizers BEFORE 12 months ago, were you using them in GREATER AMOUNTS, MORE FREQUENTLY, or LONGER than prescribed or for a reason other than prescribed by a doctor?</p>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No - <i>SKIP to 4c</i></p> <p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No - <i>SKIP to Check Item 8</i></p> <p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No - <i>SKIP to Check Item 8</i></p>

<p>5. Did ALL of those times BEFORE 12 months ago ONLY happen when you were using sedatives or tranquilizers in LARGER AMOUNTS, MORE FREQUENTLY, or LONGER than prescribed or for a reason other than prescribed by a doctor?</p>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p>
<p>Check Item 8. Are at least 2 Boxes, Box 1, (2 or 3), 4-12 marked in 1a, column c for painkillers?</p>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No - <i>SKIP to Check Item 9</i></p>
<p>6. You just mentioned SOME experiences you had with painkillers in the last 12 months.</p> <p>(a) When you had SOME of these experiences with painkillers in the last 12 months, were you using them without a prescription?</p> <p>(b) During the last 12 months when you had some of these experiences with painkillers, were you using them in LARGER AMOUNTS, MORE FREQUENTLY or LONGER than prescribed or for a reason other than prescribed by a doctor?</p>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p> <p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p>
<p>Check Item 9. Are at least 2 Boxes, Box 1, (2 or 3), 4-12, marked in 1a, column e for painkillers?</p>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No - <i>SKIP to Check item 10</i></p>
<p>7. You just mentioned SOME experience you had with painkillers around the same time BEFORE 12 months ago, that is, BEFORE last (<i>Month one year ago</i>).</p> <p>(d) During ANY of these times when you had SOME of these experiences with painkillers BEFORE 12 months ago, were you using them without a prescription?</p>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No - <i>SKIP to 7c</i></p> <p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No - <i>SKIP to Check Item 10</i></p> <p>1 <input type="checkbox"/> Yes</p>

<p>(e) Did ALL of these times BEFORE 12 months ago ONLY happen when you were using painkillers without a prescription?</p> <p>(f) During ANY of these times when you had SOME of those experiences with painkillers BEFORE 12 months ago, were you using them in GREATER AMOUNTS, MORE FREQUENTLY, or LONGER than prescribed or for a reason other than prescribed by a doctor?</p>	<p>2 <input type="checkbox"/> No - <i>SKIP to Check Item 10</i></p>
<p>8. Did ALL of those times BEFORE 12 months ago ONLY happen when you were using painkillers in LARGER AMOUNTS, MORE FREQUENTLY, or LONGER than prescribed or for a reason other than prescribed by a doctor?</p>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p>
<p>Check Item 10. Are at least 2 Boxes, Box 1, (2 or 3), 4-12 marked in 1a, column c for stimulants?</p>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No - <i>SKIP to Check Item 11</i></p>
<p>9. You just mentioned SOME experiences you had with stimulants in the last 12 months.</p> <p>(c) When you had SOME of these experiences with stimulants in the last 12 months, were you using them without a prescription?</p> <p>(d) During the last 12 months when you had some of these experiences with stimulants, were you using them in LARGER AMOUNTS, MORE FREQUENTLY or LONGER than prescribed or for a reason other than prescribed by a doctor?</p>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p> <p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p>
<p>Check Item 11. Are at least 2 Boxes, Box 1, (2 or 3), 4-12, marked in 1a, column e</p>	<p>1 <input type="checkbox"/> Yes</p>

for stimulants?	2 <input type="checkbox"/> No - <i>SKIP to 12a</i>	
<p>10. You just mentioned SOME experience you had with stimulants around the same time BEFORE 12 months ago, that is, BEFORE last (<i>Month one year ago</i>).</p> <p>(g) During ANY of these times when you had SOME of these experiences with stimulants BEFORE 12 months ago, were you using them without a prescription?</p> <p>(h) Did ALL of these times BEFORE 12 months ago ONLY happen when you were using stimulants without a prescription?</p> <p>(i) During ANY of these times when you had SOME of those experiences with stimulants BEFORE 12 months ago, were you using them in GREATER AMOUNTS, MORE FREQUENTLY, or LONGER than prescribed or for a reason other than prescribed by a doctor?</p>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No - <i>SKIP to 10c</i></p> <p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No - <i>SKIP to 12a</i></p> <p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No - <i>SKIP to 12a</i></p>	
<p>11. Did ALL of those times BEFORE 12 months ago ONLY happen when you were using stimulants in LARGER AMOUNTS, MORE FREQUENTLY, or LONGER than prescribed or for a reason other than prescribed by a doctor?</p>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No - <i>SKIP to 12a</i></p>	
<p>12a. In the last 12 months, did you more than once get arrested, held at a police station or have any other legal problems because of your medicine or drug use?</p>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No - <i>SKIP to 12c</i></p>	
<p>12b. During the last 12 months, which medicines or drugs did this happen with?</p> <p><i>(SHOW FLASHCARD)</i></p>	<p>1 <input type="checkbox"/> SED</p> <p>3 <input type="checkbox"/> MAR</p>	<p>2 <input type="checkbox"/> PAN</p> <p>4 <input type="checkbox"/> COC</p>

	<table border="1"> <tr> <td data-bbox="906 161 1157 268">5 <input type="checkbox"/> STIM</td> <td data-bbox="1166 161 1417 268">6 <input type="checkbox"/> CLB</td> </tr> <tr> <td data-bbox="906 279 1157 386">7 <input type="checkbox"/> HAL</td> <td data-bbox="1166 279 1417 386">8 <input type="checkbox"/> SOLV</td> </tr> <tr> <td data-bbox="906 396 1157 504">9 <input type="checkbox"/> HER</td> <td data-bbox="1166 396 1417 504">10 <input type="checkbox"/> OTH</td> </tr> </table>	5 <input type="checkbox"/> STIM	6 <input type="checkbox"/> CLB	7 <input type="checkbox"/> HAL	8 <input type="checkbox"/> SOLV	9 <input type="checkbox"/> HER	10 <input type="checkbox"/> OTH				
5 <input type="checkbox"/> STIM	6 <input type="checkbox"/> CLB										
7 <input type="checkbox"/> HAL	8 <input type="checkbox"/> SOLV										
9 <input type="checkbox"/> HER	10 <input type="checkbox"/> OTH										
12c. Did this happen before 12 months ago, that is before last (<i>Month one year ago</i>)?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 13a</i>										
12d. Which medicines or drugs did this happen with before 12 months ago? (SHOW FLASHCARD)	<table border="1"> <tr> <td data-bbox="906 720 1157 827">1 <input type="checkbox"/> SED</td> <td data-bbox="1166 720 1417 827">2 <input type="checkbox"/> PAN</td> </tr> <tr> <td data-bbox="906 837 1157 945">3 <input type="checkbox"/> MAR</td> <td data-bbox="1166 837 1417 945">4 <input type="checkbox"/> COC</td> </tr> <tr> <td data-bbox="906 955 1157 1062">5 <input type="checkbox"/> STIM</td> <td data-bbox="1166 955 1417 1062">6 <input type="checkbox"/> CLB</td> </tr> <tr> <td data-bbox="906 1073 1157 1180">7 <input type="checkbox"/> HAL</td> <td data-bbox="1166 1073 1417 1180">8 <input type="checkbox"/> SOLV</td> </tr> <tr> <td data-bbox="906 1190 1157 1297">9 <input type="checkbox"/> HER</td> <td data-bbox="1166 1190 1417 1297">10 <input type="checkbox"/> OTH</td> </tr> </table>	1 <input type="checkbox"/> SED	2 <input type="checkbox"/> PAN	3 <input type="checkbox"/> MAR	4 <input type="checkbox"/> COC	5 <input type="checkbox"/> STIM	6 <input type="checkbox"/> CLB	7 <input type="checkbox"/> HAL	8 <input type="checkbox"/> SOLV	9 <input type="checkbox"/> HER	10 <input type="checkbox"/> OTH
1 <input type="checkbox"/> SED	2 <input type="checkbox"/> PAN										
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7 <input type="checkbox"/> HAL	8 <input type="checkbox"/> SOLV										
9 <input type="checkbox"/> HER	10 <input type="checkbox"/> OTH										
13a. In the last 12 months, did you use any medicine or drug to make you more alert or to enhance your mental performance, skills or abilities at work or in school?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 13c</i>										
13b. During the last 12 months, which medicines or drugs did this happen with? (SHOW FLASHCARD)	<table border="1"> <tr> <td data-bbox="906 1570 1157 1677">1 <input type="checkbox"/> SED</td> <td data-bbox="1166 1570 1417 1677">2 <input type="checkbox"/> PAN</td> </tr> <tr> <td data-bbox="906 1688 1157 1795">3 <input type="checkbox"/> MAR</td> <td data-bbox="1166 1688 1417 1795">4 <input type="checkbox"/> COC</td> </tr> <tr> <td data-bbox="906 1806 1157 1913">5 <input type="checkbox"/> STIM</td> <td data-bbox="1166 1806 1417 1913">6 <input type="checkbox"/> CLB</td> </tr> </table>	1 <input type="checkbox"/> SED	2 <input type="checkbox"/> PAN	3 <input type="checkbox"/> MAR	4 <input type="checkbox"/> COC	5 <input type="checkbox"/> STIM	6 <input type="checkbox"/> CLB				
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	7 <input type="checkbox"/> HAL	8 <input type="checkbox"/> SOLV
	9 <input type="checkbox"/> HER	10 <input type="checkbox"/> OTH
13c. Did this happen before 12 months ago, that is before last (<i>Month one year ago</i>)?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>END QUESTIONS</i>	
13d. During the last 12 months, which medicines or drugs did this happen with? (SHOW FLASHCARD)	1 <input type="checkbox"/> SED	2 <input type="checkbox"/> PAN
	3 <input type="checkbox"/> MAR	4 <input type="checkbox"/> COC
	5 <input type="checkbox"/> STIM	6 <input type="checkbox"/> CLB
	7 <input type="checkbox"/> HAL	8 <input type="checkbox"/> SOLV
	9 <input type="checkbox"/> HER	10 <input type="checkbox"/> OTH

Protocol source: <https://www.phenxtoolkit.org/protocols/view/31402>