

Name: Megan Petersen _____ Age: 33 _____ ID #: _____

4/18/23 _____ Date: Gender: Male Female Education (Years Completed): 16 _____

Ethnicity: Asian Black/African American Hispanic/Latino Native American Native Hawaiian/Other Pacific Islander White Other

PDSQ™

TEST BOOKLET

Mark Zimmerman, M.D.



This form asks you about emotions, moods, thoughts, and behaviors. For each question, check the box in the *Yes* column if it describes how you have been acting, feeling, or thinking. If the item does not apply to you, check the box in the *No* column. Please answer every question.

- | Yes | No | DURING THE PAST 2 WEEKS... |
|-------------------------------------|-------------------------------------|---|
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 1. ...did you feel sad or depressed? |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 2. ...did you feel sad or depressed for most of the day, nearly every day? |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 3. ...did you get less joy or pleasure from almost all of the things you normally enjoy? |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 4. ...were you less interested in almost all of the activities you are usually interested in? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 5. ...was your appetite significantly <i>smaller</i> than usual nearly every day? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 6. ...was your appetite significantly <i>greater</i> than usual nearly every day? |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 7. ...did you sleep at least 1 to 2 hours <i>less</i> than usual nearly every day? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 8. ...did you sleep at least 1 to 2 hours <i>more</i> than usual nearly every day? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 9. ...did you feel very jumpy and physically restless, and have a lot of trouble sitting calmly in a chair, nearly every day? |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 10. ...did you feel tired out nearly every day? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 11. ...did you frequently feel guilty about things you have done? |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 12. ...did you put yourself down and have negative thoughts about yourself nearly every day? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 13. ...did you feel like a failure nearly every day? |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 14. ...did you have problems concentrating nearly every day? |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 15. ...was decision making more difficult than normal nearly every day? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 16. ...did you frequently think of dying in passive ways like going to sleep and not waking up? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 17. ...did you wish you were dead? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 18. ...did you think you'd be better off dead? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 19. ...did you have thoughts of suicide, even though you would not really do it? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 20. ...did you seriously consider taking your life? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 21. ...did you think about a specific way to take your life? |
-
- | | | |
|--------------------------|-------------------------------------|--|
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 22. Have you <i>ever experienced</i> a traumatic event such as combat, rape, assault, sexual abuse, or any other extremely upsetting event? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 23. Have you <i>ever witnessed</i> a traumatic event such as rape, assault, someone dying in an accident, or any other extremely upsetting incident? |
- DURING THE PAST 2 WEEKS...**
- | | | |
|-------------------------------------|-------------------------------------|---|
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 24. ...did thoughts about a traumatic event frequently pop into your mind? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 25. ...did you frequently get upset because you were thinking about a traumatic event? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 26. ...were you frequently bothered by memories or dreams of a traumatic event? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 27. ...did reminders of a traumatic event cause you to feel intense distress? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 28. ...did you try to block out thoughts or feelings related to a traumatic event? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 29. ...did you try to avoid activities, places, or people that reminded you of a traumatic event? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 30. ...did you have flashbacks, where it felt like you were reliving a traumatic event? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 31. ...did reminders of a traumatic event make you shake, break out into a sweat, or have a racing heart? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 32. ...did you feel distant and cutoff from other people because of having experienced a traumatic event? |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | 33. ...did you feel emotionally numb because of having experienced a traumatic event? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 34. ...did you give up on goals for the future because of having experienced a traumatic event? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 35. ...did you keep your guard up because of having experienced a traumatic event? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 36. ...were you jumpy and easily startled because of having experienced a traumatic event? |

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- | Yes | No | DURING THE PAST 2 WEEKS... |
|--------------------------|-------------------------------------|--|
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 37. ...did you often go on eating binges (eating a <i>very large</i> amount of food very quickly over a short period of time)? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 38. ...did you often feel you could not control how much you were eating during an eating binge? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 39. ...did you go on eating binges during which you ate so much that you felt uncomfortably full? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 40. ...did you go on eating binges during which you ate a large amount of food even when you didn't feel hungry? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 41. ...did you eat alone during an eating binge because you were embarrassed by how much you were eating? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 42. ...did you go on eating binges and then feel disgusted with yourself afterward? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 43. ...were you very upset with yourself because you were going on eating binges? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 44. ...to prevent gaining weight from an eating binge did you go on strict diets or exercise excessively? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 45. ...to prevent weight gain from an eating binge did you force yourself to vomit or use laxatives or water pills? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 46. ...was your weight, or the shape of your body, one of the most important things that affected your opinion of yourself? |

DURING THE PAST 2 WEEKS...

- | | | |
|--------------------------|-------------------------------------|--|
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 47. ...did you worry obsessively about dirt, germs, or chemicals? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 48. ...did you worry obsessively that something bad would happen because you forgot to do something important—like locking the door, turning off the stove, or pulling out the electrical cords of appliances? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 49. ...were there things you felt compelled to do over and over (for at least ½ hour per day) that you could not stop doing when you tried? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 50. ...were there things you felt compelled to do over and over even though they interfered with getting other things done? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 51. ...did you wash and clean yourself or things around you obsessively and excessively? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 52. ...did you obsessively and excessively check things or repeat actions over and over again? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 53. ...did you count things obsessively and excessively? |

DURING THE PAST 2 WEEKS...

- | | | |
|-------------------------------------|-------------------------------------|--|
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 54. ...did you get very scared because your heart was beating fast? |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 55. ...did you get very scared because you were short of breath? |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 56. ...did you get very scared because you were feeling shaky or faint? |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 57. ...did you get sudden attacks of intense anxiety or fear that came on from out of the blue, for no reason at all? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 58. ...did you get sudden attacks of very intense anxiety or fear during which you thought something terrible might happen, such as your dying, going crazy, or losing control? |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 59. ...did you have sudden, unexpected attacks of anxiety during which you had three or more of the following symptoms: heart racing or pounding, sweating, shakiness, shortness of breath, nausea, dizziness, or feeling faint? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 60. ...did you worry a lot about having unexpected anxiety attacks? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 61. ...did you have anxiety attacks that caused you to avoid certain situations or to change your behavior or normal routine? |

DURING THE PAST 2 WEEKS...

- | | | |
|--------------------------|-------------------------------------|---|
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 62. ...did things happen that you knew were true, but that other people told you were your imagination? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 63. ...were you convinced that other people were watching you, talking about you, or spying on you? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 64. ...did you think that you were in danger because someone was plotting to hurt you? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 65. ...did you think that you had special powers other people didn't have? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 66. ...did you think that some outside force or power was controlling your body or mind? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 67. ...did you hear voices that other people didn't hear, or see things that other people didn't see? |

NOTE: MOST OF THE FOLLOWING QUESTIONS REFER TO THE PAST 6 MONTHS.

- | Yes | No | DURING THE PAST 6 MONTHS... |
|--------------------------|-------------------------------------|---|
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 68. ...did you regularly avoid any situations because you were afraid they'd cause you to have an anxiety attack? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 69. ...did any of the following make you feel fearful, anxious, or nervous because you were afraid you'd have an anxiety attack in the situation? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | a. going outside far away from home |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | b. being in crowded places |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | c. standing in long lines |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | d. being on a bridge or in a tunnel |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | e. traveling in a bus, train, or plane |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | f. driving or riding in a car |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | g. being home alone |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | h. being in wide-open spaces (like a park) |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 70. ...did you almost always get very anxious as soon as you were in any of the above situations? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 71. ...did you avoid any of the above situations because they made you feel anxious or fearful? |

DURING THE PAST 6 MONTHS...

- | | | |
|--------------------------|-------------------------------------|--|
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 72. ...did you worry a lot about embarrassing yourself in front of others? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 73. ...did you worry a lot that you might do something to make people think that you were stupid or foolish? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 74. ...did you feel very nervous in situations where people might pay attention to you? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 75. ...were you extremely nervous in social situations? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 76. ...did you regularly avoid any situations because you were afraid you'd do or say something to embarrass yourself? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 77. ...did you worry a lot about doing or saying something to embarrass yourself in any of the following situations? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | a. public speaking |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | b. eating in front of other people |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | c. using public restrooms |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | d. writing in front of others |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | e. saying something stupid when you were with a group of people |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | f. asking a question when in a group of people |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | g. business meetings |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | h. parties or other social gatherings |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 78. ...did you almost always get very anxious as soon as you were in any of the above situations? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 79. ...did you avoid any of the above situations because they made you feel anxious or fearful? |

DURING THE PAST 6 MONTHS...

- | | | |
|--------------------------|-------------------------------------|--|
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 80. ...did you think that you were drinking too much? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 81. ...did anyone in your family think or say that you were drinking too much, or that you had an alcohol problem? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 82. ...did friends, a doctor, or anyone else think or say that you were drinking too much? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 83. ...did you think about cutting down or limiting your drinking? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 84. ...did you think that you had an alcohol problem? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 85. ...because of your drinking did you have problems in your marriage; at your job; with your friends or family; doing household chores; or in any other important area of your life? |

-
- | Yes | No | | DURING THE PAST 6 MONTHS... |
|-------------------------------------|-------------------------------------|-----|--|
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | 86. | ...did you think that you were using drugs too much? |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | 87. | ...did anyone in your family think or say that you were using drugs too much, or that you had a drug problem? |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | 88. | ...did friends, a doctor, or anyone else think or say that you were using drugs too much? |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | 89. | ...did you think about cutting down or limiting your drug use? |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | 90. | ...did you think you had a drug problem? |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | 91. | ...because of your drug use did you have problems in your marriage; at your job; with your friends or family; doing household chores; or in any other important area of your life? |
-

- DURING THE PAST 6 MONTHS...**
- | | | | |
|-------------------------------------|--------------------------|------|--|
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 92. | ...were you a nervous person on most days? |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 93. | ...did you worry a lot that bad things might happen to you or someone close to you? |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 94. | ...did you worry about things that other people said you shouldn't worry about? |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 95. | ...were you worried or anxious about a number of things in your daily life on most days? |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 96. | ...did you often feel restless or on edge because you were worrying? |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 97. | ...did you often have problems falling asleep because you were worrying about things? |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 98. | ...did you often feel tension in your muscles because of anxiety or stress? |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 99. | ...did you often have difficulty concentrating because your mind was on your worries? |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 100. | ...were you often snappy or irritable because you were worrying or feeling stressed out? |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 101. | ...was it hard for you to control or stop your worrying on most days? |
-

- DURING THE PAST 6 MONTHS...**
- | | | | |
|-------------------------------------|-------------------------------------|------|--|
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 102. | ...have you had a lot of stomach and intestinal problems such as nausea, vomiting, excessive gas, stomach bloating, or diarrhea? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 103. | ...have you been bothered by aches and pains in many different parts of your body? |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 104. | Do you get sick more than most people? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 105. | Has your physical health been poor <i>most of your life</i> ? |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 106. | Are your doctors <i>usually</i> unable to find a physical cause for your physical symptoms? |
-

- DURING THE PAST 6 MONTHS...**
- | | | | |
|-------------------------------------|-------------------------------------|------|--|
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 107. | ...did you often worry that you might have a serious physical illness? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 108. | ...was it hard to stop worrying that you have a serious physical illness? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 109. | ...did your doctor say you didn't have a serious illness but it was still hard to stop thinking about it? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 110. | ...did you worry so much about having a serious illness that it interfered with your activities or it caused you problems? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 111. | ...did you visit the doctor a lot because you were worried that you had a serious physical illness? |
-

SUMMARY SHEET

Psychiatric Diagnostic Screening Questionnaire (PDSQ)

Mark Zimmerman, M.D.



PDSQ Score Conversion

Total raw score _____

Raw	T
>102	>80
101-102	80
99-100	79
97-98	78
95-96	77
92-94	76
90-91	75
88-89	74
86-87	73
84-85	72
82-83	71
80-81	70
78-79	69
75-77	68
73-74	67
71-72	66
69-70	65
67-68	64
65-66	63
63-64	62
61-62	61
58-60	60
56-57	59
54-55	58
52-53	57
50-51	56
48-49	55
46-47	54
44-45	53
41-43	52
39-40	51
37-38	50
35-36	49
33-34	48
31-32	47
28-30	46
26-27	45
24-25	44
22-23	43
20-21	42
18-19	41
16-17	40
14-15	39
11-13	38
9-10	37
7-8	36
5-6	35
3-4	34
1-2	33

Name: _____

ID #: _____ Date: _____

Gender: Male Female Age: _____ Education (Years Completed): _____

Race/Ethnicity: Asian Black/African American Hispanic/Latino Native American Native Hawaiian/Pacific Islander White Other

PDSQ subscale	Subscale score	Cutoff score	Follow-up recommended ^a - (Check if subscale score ≥ cutoff score)	Critical items ^b (Circle ones answered yes)
Major Depressive Disorder Suicidality	_____	9 ^c	_____	16 17 8 9 20 21
Posttraumatic Stress Disorder	_____	5 ^d	_____	22 23
Bulimia/Binge-Eating Disorder	_____	7 ^e	_____	37 45 46
Obsessive-Compulsive Disorder	_____	1 ^f	_____	47 48 49 50 51 52 53
Panic Disorder	_____	4 ^g	_____	57 61
Psychosis	_____	1 ^h	_____	62 63 64 65 66 67
Agoraphobia	_____	4 ⁱ	_____	68
Social Phobia	_____	4 ^j	_____	76
Alcohol Abuse/Dependence	_____	1 ^k	_____	80 81 82 83 84 85
Drug Abuse/Dependence	_____	1 ^l	_____	86 87 88 89 90 91
Generalized Anxiety Disorder	_____	7 ^m	_____	92 101
Somatization Disorder	_____	2 ⁿ	_____	105 106
Hypochondriasis	_____	1 ^o	_____	107
PDSQ Total raw score	_____			

^aOf course, in actual clinical settings, referral for more comprehensive evaluation should never be based solely on the results of a single test, and should take into consideration all clinical information available for a given case. ^bThere should be a follow-up on all circled critical items. ^cNegative predictive value (percentage of cases not referred for further evaluation, based solely on this cutoff, that are true non-cases) = 86. ^dnpv = 99. ^enpv = 99. ^fnpv = 98. ^gnpv = 97. ^hnpv = 98. ⁱnpv = 98. ^jnpv = 95. ^knpv = 98. ^lnpv = 99. ^mnpv = 96. ⁿnpv = 99. ^onpv = 100.