

Stress, Emotions and Affective State

Early Prediction and Prevention of Mood Disorders

Multinational Study Programme

Zurich Health Questionnaire (ZHQ)

St. Kuny and H. H. Stassen

STUDY	[_ _ _ _]	1-4
GROUP	[_ _]	5-6
PERSON	[_ _ _]	7-9
Sex (1= male, 2= female)	[_]	15
Date of Birth (year/month/day=01)	[_ _ _ _ : _ _ : 0 1]	16-21
Height (in inches)	[_ _ _]	22-24
Weight (in pounds)	[_ _ _]	25-27
Education (1= remedial, 2= junior high, 3= high, 4= college)	[_]	49
DATE (year/month/day)	[_ _ _ _ : _ _ : _ _]	50-57
INTERVIEWER	[_ _ _]	58-60
SITE	[_ _]	61-62



Please read the questions below carefully before answering them. If you have the feeling that none of the given answers describes your demeanor adequately, please choose the one that comes closest to your attitude or behavior. **All your personal information will be handled confidentially!**

Card number

1-12 dupl
[_ _] 13-14

SMOKING

do not fill out this part

How much do you usually smoke **per day**?

- 1) *Number of cigarettes*
- none (0)
 - 1-3 (1)
 - 4-10 (2)
 - 11-20 (3)
 - more than 20 (4)

[_] 15

- 2) *Number of cigars*
- none (0)
 - 1-3 (1)
 - 4-10 (2)
 - 11-20 (3)
 - more than 20 (4)

[_] 16

- 3) *Number of pipes*
- none (0)
 - 1-3 (1)
 - 4-10 (2)
 - 11-20 (3)
 - more than 20 (4)

[_] 17

ALCOHOL

How much do you usually drink **per week**?

- 1) *Number of glasses of beer*
- none (0)
 - 1-3 (1)
 - 4-10 (2)
 - 11-20 (3)
 - more than 20 (4)

[_] 18

- 2) *Number of glasses of wine*
- none (0)
 - 1-3 (1)
 - 4-10 (2)
 - 11-20 (3)
 - more than 20 (4)

[_] 19

- 3) *Number of glasses of spirits (whiskey etc)*
- none (0)
 - 1-3 (1)
 - 4-10 (2)
 - 11-20 (3)
 - more than 20 (4)

[_] 20

DRUGS: Please note that all information obtained is bound to professional secrecy and used only for the purpose of this study.

DRUGS

do not fill out this part

How often have you taken illegal drugs within the **last 3 months?**

- | | | | | |
|----|---|---------------------------------------|-----|----------|
| 1) | <i>Cannabis/Marihuana</i> | never <input type="checkbox"/> | (0) | |
| | | 1-3 <input type="checkbox"/> | (1) | |
| | | 4-10 <input type="checkbox"/> | (2) | |
| | | 11-20 <input type="checkbox"/> | (3) | |
| | | more than 20 <input type="checkbox"/> | (4) | |
| | within the last two weeks almost daily | <input type="checkbox"/> | (5) | [_] 26 |
| 2) | <i>LSD, STP, Mescaline, "Magic Mushrooms"</i> | never <input type="checkbox"/> | (0) | |
| | | 1-3 <input type="checkbox"/> | (1) | |
| | | 4-10 <input type="checkbox"/> | (2) | |
| | | 11-20 <input type="checkbox"/> | (3) | |
| | | more than 20 <input type="checkbox"/> | (4) | |
| | within the last two weeks almost daily | <input type="checkbox"/> | (5) | [_] 27 |
| 3) | <i>Opiates (Heroin, Morphine, Opium), Methadone</i> | never <input type="checkbox"/> | (0) | |
| | | 1-3 <input type="checkbox"/> | (1) | |
| | | 4-10 <input type="checkbox"/> | (2) | |
| | | 11-20 <input type="checkbox"/> | (3) | |
| | | more than 20 <input type="checkbox"/> | (4) | |
| | within the last two weeks almost daily | <input type="checkbox"/> | (5) | [_] 28 |
| 4) | <i>Cocaine, Crack, Free Base</i> | never <input type="checkbox"/> | (0) | |
| | | 1-3 <input type="checkbox"/> | (1) | |
| | | 4-10 <input type="checkbox"/> | (2) | |
| | | 11-20 <input type="checkbox"/> | (3) | |
| | | more than 20 <input type="checkbox"/> | (4) | |
| | within the last two weeks almost daily | <input type="checkbox"/> | (5) | [_] 29 |
| 5) | <i>Speed, MDMA ("Ecstasy"), MDE ("Eve")</i> | never <input type="checkbox"/> | (0) | |
| | | 1-3 <input type="checkbox"/> | (1) | |
| | | 4-10 <input type="checkbox"/> | (2) | |
| | | 11-20 <input type="checkbox"/> | (3) | |
| | | more than 20 <input type="checkbox"/> | (4) | |
| | within the last two weeks almost daily | <input type="checkbox"/> | (5) | [_] 30 |
| 6) | <i>Other drugs</i> | never <input type="checkbox"/> | (0) | |
| | | 1-3 <input type="checkbox"/> | (1) | |
| | | 4-10 <input type="checkbox"/> | (2) | |
| | | 11-20 <input type="checkbox"/> | (3) | |
| | | more than 20 <input type="checkbox"/> | (4) | |
| | within the last two weeks almost daily | <input type="checkbox"/> | (5) | [_] 31 |

HEALTH: Please note that all information obtained is bound to professional secrecy and used only for the purpose of this study.

HEALTH

do not fill out this part

Have you ever suffered from one of the following disorders or diseases?

- | | | | |
|-----|---|---|----------|
| 1) | <i>Liver diseases (hepatitis)</i> | no <input type="checkbox"/> (0)
yes <input type="checkbox"/> (1) | [_] 32 |
| 2) | <i>Kidney diseases</i> | no <input type="checkbox"/> (0)
yes <input type="checkbox"/> (1) | [_] 33 |
| 3) | <i>Diabetes</i> | no <input type="checkbox"/> (0)
yes <input type="checkbox"/> (1) | [_] 34 |
| 4) | <i>Other metabolic disorders</i> | no <input type="checkbox"/> (0)
yes <input type="checkbox"/> (1) | [_] 35 |
| | <i>If yes, please specify:</i> | | |
| 5) | <i>Meningitis</i> | no <input type="checkbox"/> (0)
yes <input type="checkbox"/> (1) | [_] 36 |
| 6) | <i>Epileptic Seizures</i> | no <input type="checkbox"/> (0)
yes <input type="checkbox"/> (1) | [_] 37 |
| 7) | <i>Migraine, other headaches</i> | no <input type="checkbox"/> (0)
yes <input type="checkbox"/> (1) | [_] 38 |
| 8) | <i>Head injury, brain injury, concussion with loss of consciousness, intracranial bleeding without injury</i> | no <input type="checkbox"/> (0)
yes <input type="checkbox"/> (1) | [_] 39 |
| 9) | <i>Allergies: Asthma, hay fever, eczema</i> | no <input type="checkbox"/> (0)
yes <input type="checkbox"/> (1) | [_] 40 |
| 10) | <i>Was your own birth a difficult one? (premature or other complications)</i> | no <input type="checkbox"/> (0)
yes <input type="checkbox"/> (1)
I don't know <input type="checkbox"/> (9) | [_] 41 |
| 11) | <i>How often do you go for a walk/hike?</i> | rarely ever <input type="checkbox"/> (0)
occasionally <input type="checkbox"/> (1)
regularly <input type="checkbox"/> (2) | [_] 42 |
| 12) | <i>Do you ride a bicycle?</i> | no <input type="checkbox"/> (0)
occasionally <input type="checkbox"/> (1)
regularly <input type="checkbox"/> (2) | [_] 43 |
| 13) | <i>Are you doing sport?</i> | no <input type="checkbox"/> (0)
occasionally <input type="checkbox"/> (1)
regularly <input type="checkbox"/> (2) | [_] 44 |

HEALTH: Please note that all information obtained is bound to professional secrecy and used only for the purpose of this study.

Have you suffered from one of the following disorders within the **last 6 months?** do not fill out this part

- | | | | | |
|-----|---|--|-----|----------|
| 1) | <i>Headaches</i> | never <input type="checkbox"/> | (0) | |
| | | occasionally <input type="checkbox"/> | (1) | |
| | | frequently <input type="checkbox"/> | (2) | |
| | | currently under treatment <input type="checkbox"/> | (3) | [_] 45 |
| 2) | <i>Sleeping disorder</i> | never <input type="checkbox"/> | (0) | |
| | | occasionally <input type="checkbox"/> | (1) | |
| | | frequently <input type="checkbox"/> | (2) | |
| | | currently under treatment <input type="checkbox"/> | (3) | [_] 46 |
| 3) | <i>Concentration or memory problems</i> | never <input type="checkbox"/> | (0) | |
| | | occasionally <input type="checkbox"/> | (1) | |
| | | frequently <input type="checkbox"/> | (2) | |
| | | currently under treatment <input type="checkbox"/> | (3) | [_] 47 |
| 4) | <i>Rapidly decreasing vision</i> | never <input type="checkbox"/> | (0) | |
| | | occasionally <input type="checkbox"/> | (1) | |
| | | frequently <input type="checkbox"/> | (2) | |
| | | currently under treatment <input type="checkbox"/> | (3) | [_] 48 |
| 5) | <i>Disturbed vision (flickering, double vision, etc.)</i> | never <input type="checkbox"/> | (0) | |
| | | occasionally <input type="checkbox"/> | (1) | |
| | | frequently <input type="checkbox"/> | (2) | |
| | | currently under treatment <input type="checkbox"/> | (3) | [_] 49 |
| 6) | <i>Dizziness</i> | never <input type="checkbox"/> | (0) | |
| | | occasionally <input type="checkbox"/> | (1) | |
| | | frequently <input type="checkbox"/> | (2) | |
| | | currently under treatment <input type="checkbox"/> | (3) | [_] 50 |
| 7) | <i>Faints</i> | never <input type="checkbox"/> | (0) | |
| | | occasionally <input type="checkbox"/> | (1) | |
| | | frequently <input type="checkbox"/> | (2) | |
| | | currently under treatment <input type="checkbox"/> | (3) | [_] 51 |
| 8) | <i>Unilateral bodily weakness</i> | never <input type="checkbox"/> | (0) | |
| | | occasionally <input type="checkbox"/> | (1) | |
| | | frequently <input type="checkbox"/> | (2) | |
| | | currently under treatment <input type="checkbox"/> | (3) | [_] 52 |
| 9) | <i>Shaking, disturbance of gait (other signs of withdrawal)</i> | never <input type="checkbox"/> | (0) | |
| | | occasionally <input type="checkbox"/> | (1) | |
| | | frequently <input type="checkbox"/> | (2) | |
| | | currently under treatment <input type="checkbox"/> | (3) | [_] 53 |
| 10) | <i>Numb or prickly sensation in parts of the body</i> | never <input type="checkbox"/> | (0) | |
| | | occasionally <input type="checkbox"/> | (1) | |
| | | frequently <input type="checkbox"/> | (2) | |
| | | currently under treatment <input type="checkbox"/> | (3) | [_] 54 |

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Have you suffered from one of the following disorders within the **last 6 months**? do not fill out this part

- | | | | | |
|-----|--|--|-----|----------|
| 11) | <i>Loss of appetite, swallowing problems</i> | never <input type="checkbox"/> | (0) | |
| | | occasionally <input type="checkbox"/> | (1) | |
| | | frequently <input type="checkbox"/> | (2) | |
| | | currently under treatment <input type="checkbox"/> | (3) | [_] 55 |
| | | | | |
| 12) | <i>Heartburn, stomach ache</i> | never <input type="checkbox"/> | (0) | |
| | | occasionally <input type="checkbox"/> | (1) | |
| | | frequently <input type="checkbox"/> | (2) | |
| | | currently under treatment <input type="checkbox"/> | (3) | [_] 56 |
| | | | | |
| 13) | <i>Ulcer (stomach or duodenum)</i> | never <input type="checkbox"/> | (0) | |
| | | occasionally <input type="checkbox"/> | (1) | |
| | | frequently <input type="checkbox"/> | (2) | |
| | | currently under treatment <input type="checkbox"/> | (3) | [_] 57 |
| | | | | |
| 14) | <i>Constipation, diarrhea, abdominal pain</i> | never <input type="checkbox"/> | (0) | |
| | | occasionally <input type="checkbox"/> | (1) | |
| | | frequently <input type="checkbox"/> | (2) | |
| | | currently under treatment <input type="checkbox"/> | (3) | [_] 58 |
| | | | | |
| 15) | <i>Conspicuous weight change (loss or gain)</i> | never <input type="checkbox"/> | (0) | |
| | | occasionally <input type="checkbox"/> | (1) | |
| | | frequently <input type="checkbox"/> | (2) | |
| | | currently under treatment <input type="checkbox"/> | (3) | [_] 59 |
| | | | | |
| 16) | <i>Skin allergies, hay fever</i> | never <input type="checkbox"/> | (0) | |
| | | occasionally <input type="checkbox"/> | (1) | |
| | | frequently <input type="checkbox"/> | (2) | |
| | | currently under treatment <input type="checkbox"/> | (3) | [_] 60 |
| | | | | |
| 17) | <i>Asthma</i> | never <input type="checkbox"/> | (0) | |
| | | occasionally <input type="checkbox"/> | (1) | |
| | | frequently <input type="checkbox"/> | (2) | |
| | | currently under treatment <input type="checkbox"/> | (3) | [_] 61 |
| | | | | |
| 18) | <i>Back problems</i> | never <input type="checkbox"/> | (0) | |
| | | occasionally <input type="checkbox"/> | (1) | |
| | | frequently <input type="checkbox"/> | (2) | |
| | | currently under treatment <input type="checkbox"/> | (3) | [_] 62 |
| | | | | |
| 19) | <i>Cardiac problems</i> | never <input type="checkbox"/> | (0) | |
| | | occasionally <input type="checkbox"/> | (1) | |
| | | frequently <input type="checkbox"/> | (2) | |
| | | currently under treatment <input type="checkbox"/> | (3) | [_] 63 |
| | | | | |
| 20) | <i>For women only:
Menstrual pain and/or irritability,</i> | never <input type="checkbox"/> | (0) | |
| | | occasionally <input type="checkbox"/> | (1) | |
| | | frequently <input type="checkbox"/> | (2) | |
| | | currently under treatment <input type="checkbox"/> | (3) | [_] 64 |

PSYCHIATRY: Please note that all information obtained is bound to professional secrecy and used only for the purpose of this study.

PSYCHIATRY

do not fill out this part

Have you ever suffered from one of the following symptoms?

- | | | | | |
|----|--|--|-----|----------|
| 1) | <i>Unwarranted anxiety about certain situations (large crowds, animals, etc.)</i> | never <input type="checkbox"/> | (0) | |
| | | occasionally <input type="checkbox"/> | (1) | |
| | | frequently <input type="checkbox"/> | (2) | |
| | | currently under treatment <input type="checkbox"/> | (3) | [_] 65 |
| 2) | <i>Panic attacks without any clear reason</i> | never <input type="checkbox"/> | (0) | |
| | | occasionally <input type="checkbox"/> | (1) | |
| | | frequently <input type="checkbox"/> | (2) | |
| | | currently under treatment <input type="checkbox"/> | (3) | [_] 66 |
| 3) | <i>Nervous disorders</i> | never <input type="checkbox"/> | (0) | |
| | | occasionally <input type="checkbox"/> | (1) | |
| | | frequently <input type="checkbox"/> | (2) | |
| | | currently under treatment <input type="checkbox"/> | (3) | [_] 67 |
| 4) | <i>Severely depressed mood</i> | never <input type="checkbox"/> | (0) | |
| | | occasionally <input type="checkbox"/> | (1) | |
| | | frequently <input type="checkbox"/> | (2) | |
| | | currently under treatment <input type="checkbox"/> | (3) | [_] 68 |
| 5) | <i>Thoughts about committing suicide</i> | never <input type="checkbox"/> | (0) | |
| | | occasionally <input type="checkbox"/> | (1) | |
| | | frequently <input type="checkbox"/> | (2) | |
| | | currently under treatment <input type="checkbox"/> | (3) | [_] 69 |
| 6) | <i>Compulsive actions (to feel a strong necessity to carry out certain actions over and over again; e.g. to wash, to check on something)</i> | never <input type="checkbox"/> | (0) | |
| | | occasionally <input type="checkbox"/> | (1) | |
| | | frequently <input type="checkbox"/> | (2) | |
| | | currently under treatment <input type="checkbox"/> | (3) | [_] 70 |
| 7) | <i>Have you ever undergone psychiatric or psychological treatment?</i> | no <input type="checkbox"/> | (0) | |
| | | yes <input type="checkbox"/> | (1) | [_] 71 |
| 8) | <i>Has a member of your family ever undergone psychiatric or psychological treatment?</i> | no <input type="checkbox"/> | (0) | |
| | <i>If yes,</i> | yes <input type="checkbox"/> | (1) | |
| | | father <input type="checkbox"/> | (2) | |
| | | mother <input type="checkbox"/> | (3) | |
| | | brothers or sisters <input type="checkbox"/> | (4) | [_] 72 |
| 9) | <i>Has a member of your family committed suicide?</i> | no <input type="checkbox"/> | (0) | |
| | <i>If yes,</i> | yes <input type="checkbox"/> | (1) | |
| | | father <input type="checkbox"/> | (2) | |
| | | mother <input type="checkbox"/> | (3) | |
| | | brothers or sisters <input type="checkbox"/> | (4) | [_] 73 |