qEEG-Pro Questionnaires

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The Addictive Disorders Screen–7 (ADS-7)

The Addictive Disorders Screen–7 (ADS-7)[1] is a self-report instrument designed to indicate whether an individual may have 1 (or more) of 7 addictive disorders. In developing the ADS-7, the author used 2 sources (DSM-IV-TR[2] and Handbook of Addictive Disorders[3]) for examining each of its questions to help ensure that they were "meaningful, accurate, and practical."

The ADS-7 is an addictive disorder screening tool to predict potential risk for seven addictive disorders: chemical dependency (alcohol), compulsive buying, chemical dependency (drugs), eating disorders, compulsive gambling, sex addictions and workaholism. The ADS-7 has been designed to assess new clients' potential risk. This addictive disorder screening tool is for assessing risk in the assessment process; it is not a diagnostic tool.

The ADS-7 has 49 questions (7 questions per addictive disorder), which are to be answered with regard to behavior over the past six months, including today. Scoring is as follows for each question: *0=Never 1=Once 2=Fewer than three times 3=Fewer than six times 4=Seven times or more.* The client's scores indicate potential risk in certain addictive disorders. The client is instructed to read each question carefully and select the response that best fits the present situation and behaviors.

The results of the ADS-7 of your client will be depicted on the following pages. Each page will depict the results of one addictive disorder. For each disorder, the results of each of the 7 questions will be color-coded as follows:

Over the last six months:	Never	Once	Fewer than three times	Fewer than six times	Seven times or more
Example question: Have you tried to stop drinking?					

Scoring Key

The results are summed and the total score represents the potential risk level of the client.

0-2* Subclinical. May not be a concern – however, it is still important to explore this area in more detail with the client.
2-8* Medium Concern: Has the potential to be a serious concern. It is recommended to do a more in-depth assessment in this area.
9-28 Serious Concern: This score indicates that the client is at risk and there is a need for a more in-depth clinical assessment.

*In the current scoring key, as printed in the source material, scoring a '2' overlaps Subclinical and Medium Concern.

[1]Howatt W.A. Addiction screening tool vs. addiction clinical measure. *Counselor, The Magazine for Addiction Professionals, 7:* 48-53, 2006
[2]Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision (DSM-IV-TR), Washington DC: American Psychiatric Association, 2000.
[3]Coombs, R.H. (Ed.). Handbook of Addictive Disorders: A Practical Guide to Diagnosis and Treatment, New York, NY: John Wiley & Sons, 2004

The Adult ADHD Self-Report Scale (ASRS-v1.1)

The Adult ADHD Self-Report Scale (ASRS-V1.1) was developed by the 'Workgroup on Adult ADHD', in conjunction with the World Health Organization (WHO).

The ASRS-V1.1 has 18 questions, which are based on the DSM-IV criteria of ADHD. The questions need to be answered with regard to the frequency of experienced problems related to ADHD during the last 6 months. The questionnaire consists of two parts. The first part (Part A) consists of questions 1-6 and the second part (Part B) consists of questions 7-18. Research has shown that Part A can be used as an ADHD screening instrument, while Part B provides additional information about the patient's symptoms[1]. The scoring for Part A is zero for 'Never' and 'Rarely' and 1 for 'Sometimes', 'Often' and 'Very Often' for questions 1-3. For questions 4-6, the scoring is zero for 'Never', 'Rarely' and 'Sometimes' and one for 'Often' and 'Very Often'. The results of the questions in both Part A and Part B will be color-coded as follows:

Over the last six months:	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?			1	1	1

Clinical cutoff

The clinical cutoff for the total score of Part A is based on the proposed cutoff by Daigre et al. (2009[2]). The clinical cutoff for the total score for Part A is 4.

[1]Kessler, R.C., et al. (2005). The World Health Organization Adult ADHD Self-Report Scale (ASRS): a short screening scale for use in the general population. *Psychological Medicine, 35(2)*: 245-256.

[2]Daigre, C., et al. (2009). Adult ADHD Self-Report Scale (ASRS-v1.1) symptom checklist in patients with substance use disorders. *Actas Españolas de Psiquiatría, 37(6)*: 299-305.

The 7-item Generalized Anxiety Disorder scale (GAD-7)

The Generalized Anxiety Disorder - 7 (GAD-7) was developed by Spitzer et al. (2006[1]). The GAD-7 measures depression severity using 7 questions which are based on the DSM-IV criteria for generalized anxiety disorder.

The GAD-7 has 7 questions, which are to be answered with regard to the frequency of experienced problems related to anxiety during the last 2 weeks. The scoring is as follows for each question: 0=*Not at all 1=Several days 2=More than half of the days 3=Nearly every day.* The results of each of the 7 questions will be color-coded as follows:

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge.	0	1	2	3

Scoring Key

The scoring is based on the proposed scoring key by Spitzer et al. (2006[1]), which is based on the sum of the scores of all the 7 items:

0-4 Minimal.
5-9 Mild.
10-14 Moderate.
>14 Severe.

[1]Spitzer, R.L, Kroenke, K., Williams, J.B.W., & Löwe, B. (2006). A Brief Measure for Assessing Generalized Anxiety Disorder. *Archives of Internal Medicine, 166(10):* 1092-1097.

The 20-item Autism Quotient Questionnaire (AQ-20)

The 20-item Autism Quotient Questionnaire (AQ-20), which was developed by Brugha et al. (2007[1]), is a shortened version of the 50-item Autism Quotient Questionnaire (AQ-50), which was developed by Baron-Cohen et al. (2001[2]). The AQ-20 measures the expression of Autism-Spectrum traits.

The AQ-20 has 20 questions, which are to be answered with regard to the self-assessed traits of an individual. The scoring is as follows for each question: *Definitely Agree, Slightly Agree, Slightly Disagree, Definitely Disagree.* The score is either 0 or 1 for each question, depending and can either be attributed to *Definitely Agree* and *Slightly Agree* or to *Slightly Disagree* and *Definitely Disagree*, depending on the question. The results of each of the 20 questions will be color-coded as follows:

The following statements are about the kind of person that you are, and the way you prefer to do things.	Definitely Agree	Slightly Agree	Slightly Disagree	Definitely Disagree
1. I prefer to do things the same way over and over again.	1	1	0	0

Or:

5. I find social situations easy.	0	0	1	1

Clinical cutoff

Since a clinical cutoff for the AQ-20 has not been established, the clinical cutoff of the AQ-50 is used (corrected for the number of questions). Ashwood et al. (2016[3]) showed that a clinical cutoff of 32 of the AQ-50 showed an optimal sensitivity and specificity, which translates to a cutoff of 32*(20/50) = 13 for the AQ-20. However, the authors note that using this relatively high cutoff score, there is a high chance of false negatives and while high scores on the AQ can also be caused by generalized anxiety disorder, leading to false positives. Therefore, the mean total score of the healthy population, as published by Ruzich et al. (2015[4]) is also depicted in the results.

[1]Brugha, T., et al. (2007). Autism Spectrum Disorders in adults living in households throughout England. The *NIHS Information Centre.*
[2]Baron-Cohen, S., Wheelwright, S., Skinner, R., Martin, J., & Clubley, E. (2001). The autism-spectrum quotient (AQ): evidence from Asperger syndrome/high-functioning autism, males and females, scientists and mathematicians. *Journal of Autism and Developmental Disorders. 31(1):* 5-17.
[3]Ashwood, K.L., et al. (2016). Predicting the diagnosis of autism in adults using the Autism-Spectrum Quotient (AQ) questionnaire. *Psychological Medicine, 46:* 2595-2604.
[4]Ruzich, E., et al. (2015). Measuring autistic traits in the general population: a systematic review of the Autism-Spectrum Quotient (AQ) in a nonclinical population sample of 6,900 typical adult males and females. *Molecular Autism, 6:* 2.

The 9-item Personal Health Questionnaire (PHQ-9)

The Patient Health Questionnaire - 9 (PHQ-9) was developed by Spitzer et al. (1994[1];1999[2]). The PHQ-9 measures depression severity using 9 questions which are based on the DSM-IV criteria for depression.

The PHQ-9 has 9 questions, which are to be answered with regard to the frequency of experienced problems related to depression during the last 2 weeks. The scoring is as follows for each question: 0=*Not at all* 1=*Several days* 2=*More than half of the days* 3=*Nearly every day.* The results of each of the 9 questions will be color-coded as follows:

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things.	0	1	2	3

Scoring Key

The scoring is based on the proposed scoring key by Kroenke et al. (2001[3]), which is based on the sum of the scores of all the 9 items:

0-4 Minimal.
5-9 Mild.
10-14 Moderate.
15-19 Moderately Severe.
>19 Severe.

[1]Spitzer, R.L., Williams, J.B.W., Kroenke, K., Linzer, M., DeGruy, F.V., Hahn. S.R., Brody, D., Johnson, J.G. (1994). Utility of a new procedure for diagnosing mental disorders in primary care: ThePRIME-MD 1000 study. *Journal of the American Medical Association, 272:* 1749-1756.
[2]Spitzer, R.L., Kroenke, K., Williams, J.B.W. (1999). Validation and utility of a self-report version of PRIME-MD: the PHQ Primary Care Study. *Journal of the American Medical Association, 282:* 1737-1744.
[3]Kroenke, K., Spitzer, R.L., Williams, J.B.W. (2001). The PHQ-9, validity of a brief depression severity measure. *Journal of General Internal Medicine, 16(9)*: 606-613.

The Adult Reading History Questionnaire (ARHQ)

The Adult Reading History Questionnaire (ARHQ) was originally developed by Finucci et al. (1982[1]) and later updated by Lefly & Pennington (2000[2]). The ARHQ measures attitudes and experiences related to reading behaviors.

The ADHQ has 23 questions, with different Likert scales for each question. Subjects are instructed to select the number (0-4) which most nearly describes his/her attitude or experience for each question. The results of each of the 23 questions will be color-coded as follows:

1. Which of the following most nearly describes *your* attitude toward school when you were a child?	0 (Loved School; favorite activity)	1	2	3	4 (Hated school; tried to get out of going)

Clinical cutoff

The clinical cutoff for the total score are based on the proposed cutoffs by Lefly & Pennington (2000[2]). The clinical cutoff for the total score is 37.

[1]Finucci, J.M., Isaacs, S.D., Whitehouse, C.C., & Childs, B. (1982). Derivation and validation of a quantitative definition of specific reading disability for adults. *Developmental Medicine and Child Neurology, 26:* 143-153.
[2]Lefly, D.L. & Pennington, B.F. (2000). Reliability and validity of the Adult Reading History Questionnaire. *Journal of Learning Disabilities, 33(3):* 286-296.

The Ottman Epilepsy Screening Instrument (OESI)

The Ottman Epilepsy Screening Instrument (OESI) is a questionnaire that has been developed by Ottman et al. (2010[1]). The OESI can be used a short screening tool for identifying people with epilepsy. It has been shown that the sensitivity of the OESI is very high, which makes it suitable for the first stage in a screening procedure for epilepsy.

The OESI has 9 questions, which measure the presence of absence of phenomena that are associated with epilepsy. Questions 3-9 are skipped when the subject answers 'yes' to question 2 (*Have you ever had, or has anyone ever told you that you had, a seizure disorder or epilepsy?*)*. The following answer categories are used: *No, Yes, Possible* and *Don't Know*. The results of each of the 9 questions will be color-coded as follows:

Scoring

A clinical cutoff score has not been published for the OESI. Instead, Ottmann et al. (2010[1]) showed that the OESI has the highest sensitivity when a positive answer (*'Yes',* or *'Possible'*) on one or more of the questions 2-9 is regarded as a 'positive screen'.

[1]Ottman, R., Barker-Cummings, C., Leibson, C.L., Vasoli, V.M., Hauser, A., and Buchhalter, J.R. (2010). Validation of a brief screening instrument for the ascertainment of epilepsy. *Epilepsia, 51(2):* 191-197.

*This is slightly different from the criterion that was used by Ottman et al. (2010[1]), where question 3-9 were skipped when the subject answered 'yes', 'possible' or 'don't know' to question 2.

The Everyday Memory Questionnaire - Revised (EMQ-R)

The Everyday Memory Questionnaire - Revised (EMQ-R) is a shorter version of the EMQ and was developed by Royle and Lincoln (2008[1]). The EMQ-R measures memory failure in everyday life.

The EMQ-R has 13 questions, which are to be answered with regard to the frequency of a particular memory failure in everyday life. The frequency scoring is as follows for each question: 0=*Not at all 1=A Little 2=Moderately 3=A lot 4=Strongly agree*. The results of each of the 13 questions will be color-coded as follows:

In the past month, did you experience any of the following?	Once or less in the last month	More than once a month but less than once a week	About once a week	More than once a week or less than once a day	Once or more in a day
1. Having to check whether you have done something that you should have done.	0	1	2	3	4

Scoring

A clinical cutoff has not been published for the EMQ-R. However, Royle and Lincoln (2008[1]) showed that the average total score on the EMQ-R for a group of 98 healthy subjects (average age: 43) was 9.75. A group of 160 patients with Multiple Sclerosis (MS; average age: 43) showed an average total score of 14.4 and a group of 90 stroke patients (average age: 68) showed an average total score of 19.6.

[1]Royle, J. & Lincoln, N.B. (2008). The everyday memory questionnaire – revised: development of a 13-item scale. *Disability and Rehabilitation, 30(2):* 114-121.

The Obsessive-Compulsive Inventory – Revised (OCI-R)

The Obsessive-Compulsive Inventory – Revised (OCI-R), which was developed by Foa et al. (2002[1]) is a shorter version of the OCI, which was developed by Foa et al. (1998[2]). The OCI-R measures the severity of symptoms of Obsessive-Compulsive Disorder (OCD).

The OCI-R has 18 questions, which are to be answered with regard to the degree of distress a symptom has caused in the past month. The distress scoring is as follows for each question: 0=*Not at all 1=A little 2=Moderately 3=A lot 4=Strongly agree*. The results of each of the 18 questions will be color-coded as follows:

The following statements refer to experiences that many people have in their everyday lives. Tick the box that best describes HOW MUCH that experience has DISTRESSED or BOTHERED you during the PAST MONTH.	Not at all	A little	Moderately	A lot	Extremely
1. I have saved up so many things that they get in the way.	0	1	2	3	4

Clinical cutoff

The clinical cutoff for the total score are based on the proposed cutoffs by Foa et al. (2002[1]). The clinical cutoff for the total score is 21.

[1]Foa, E.B., et al. (2002). The Obsessive-Compulsive Inventory: Development and validation of a short version. *Psychological Assessment, 14:* 485-496.
[2]Foa, E.B., Kozak, M.J., Salkovskis, P.M., Coles, M.E., and Amir, N. (1998). The validation of a new obsessive-compulsive disorder scale: The Obsessive-Compulsive Inventory. *Psychological Assessment, 10(3)*: 206-214.

The Promodal Questionnaire - Brief (PQ-B)

It has been shown that 73% of patients with schizophrenia have suffered from a promodal phase that lasts 5 years on average and precedes the development of a full psychotic disorder. During this phase, symptoms that characterize a psychotic disorder are already present, but the severity is less than during an active psychotic disorder. With the Promodal Questionnaire – Brief (PQ-B), the clinical risk for developing psychosis can be assessed. However, as stated by Loewy et al. (2012[1]): "PQ-B users should be careful not to equate a high score with prodromal psychosis or unavoidable development of schizophrenia". The PQ-B should be used as a first step in a diagnostic procedure and a diagnosis can only be obtained after a thorough clinical interview.

The PQ-B has 21 questions, which are to be answered with regard to the presence or absence of symptoms and whether the presence of a symptom generates distress. The distress scoring is as follows for each question: 1=*Strongly disagree 2=Disagree 3=Neutral 4=Agree 5=Strongly agree*. The results of each of the 21 questions will be color-coded as follows:

Please indicate whether you have had the following thoughts, feelings and experiences in the past month by checking "yes" or "no" for each item. Do not include experiences that occur only while under the influence of alcohol, drugs or medications that were not prescribed to you. If you answer "YES" to an item, also indicate how distressing that experience has been for you.			If "Yes": When this happens, I feel frightened, concerned, or it causes problems for me:				
	Yes	No	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
1. Do familiar surroundings sometimes seem strange, confusing, threatening or unreal to you?	1	0	1	2	3	4	5

Clinical cutoffs

The clinical cutoffs for the total score (based on the 'Yes/No' part of each question) and the distress score (based on the 5-point Likert scale regarding distress) are based on the proposed cutoffs by Xu et al. (2016[2]). The clinical cutoff for the total score is 4 and the clinical cutoff for the distress score is 24.

[1]Loewy, R.L., Pearson, R., Vinogradov, S. Bearden, C.E., & Cannon, T.D. (2011). Psychosis risk screening with the Promodal Questionnaire – Brief version (PQ-B). *Schizophrenia Research, 129(1):* 42-46.
[2]Xu, L., et al. (2016). Psychometric properties of Promodal Questionnaire – Brief version among Chinese help-seeking individuals. *PLOS One, 11(2).*

The Short Pittsburgh Sleep Quality Index (Short-PSQI)

The Short Pittsburgh Sleep Quality Index (Short-PSQI) is a Shortened version of the Pittsburgh Sleep Quality Index (PSQI). The original PSQI was developed by Buysse et al. (1989) and contains 19 questions. The Short-PSQI contains 13 questions and has been shown to have high validity compared with the original PSQI (Famodu et al. 2018). The Short-PSQI measures both sleep quantity and sleep quality.

Questions 1-4 address the sleep quantity directly (e.g. question 1: "During the past month, when have you usually gone to bed?"). Questions 5-13 address possible reasons for impaired sleep quality. Scoring for question 5-14 is as follows for each question: *0=Not during the past month 1=Less than once a week 2=Once or twice a week 3=Three or more times a week*. The results of each of the 25 questions will be color-coded as follows:

	Not during the past month	Less than once a week	Once or twice a week	Three or more times a week
8. During the past month, how often have you had trouble sleeping because you cough or snore loudly?	0	1	2	3

Scoring Key

The scoring is based on the proposed scoring key by Famodu et al. (2018[2]). Separate scores are calculated for four separate components (sleep latency, sleep duration, sleep efficiency, sleep disturbances). The scores can range between 0 and 3. For a detailed description of the formulas used to calculate these scores, the reader is referred to the publication by Famodu et al. (2018[2]; page 8). The scores of these four components are added to generate a global score. The clinical cutoff for the global score is 4, meaning that scoring 4 or higher is indicative for poor sleep quality.

[1]Buysse, D.J., Reynolds, C.F., Monk, T.H., Berman, S.R., & Kupfer, D.J. (1989). The Pittsburgh Sleep Quality Index: a new instrument for psychiatric practice and research. *Psychiatry Research, 28(2):* 193-213.
[2]Famodu, O.A., et al. (2018). Shortening of the Pittsburgh Sleep Quality Index Survey Using Factor Analysis. *Sleep Disorders, 2018.*

The Rivermead Post Concussion Symptoms Questionnaire (RPCSQ)

The Rivermead Post Concussion Symptoms Questionnaire (RPQ) was developed by King et al. (1995[1]) and measures the presence and severity of post concussive symptoms. Post concussive symptoms can be the results of traumatic brain injury, but may not necessarily be a direct cause of them. The RPQ was originally developed as a measure of the severity of symptoms following mild traumatic brain injury (MTBI). The RPQ is not a screening instrument. This means that it cannot be used to assess whether traumatic brain injury has occurred. Instead, it can be used to assess the symptoms *after* a traumatic brain injury (or injuries) has occurred. It can also be used to track changes in symptoms over time.

The RPQ has 16 questions, which are to be answered with regard to experienced symptoms that were not present before the accident. Scoring is as follows for each question: *0=Not Experienced 1=No More of a Problem 2=Mild Problem 3=Moderate Problem 4=Severe Problem.* The results of each of the 16 questions will be color-coded as follows:

Compared with before the accident, do you now (i.e., over the last 24 hours) suffer from:	Not Experienced	No More of a Problem	Mild Problem	Moderate Problem	Severe Problem
1. Headaches	0	1	2	3	4

Scoring Key

The scoring is based on the proposed scoring key by Potter et al. (2006[2]), which is based on the sum of the scores of all the 16 items:

0-12 Minimal.
13-24 Mild.
25-32 Moderate.
>33 Severe.

However, a study by Eyres et al. (2005[3]) showed that the first three items of the RPQ reflect a different construct than items 4-16. More specifically, the first three items (RPQ-3) tap into predominantly physical symptoms, while items 4-16 (RPQ-13) tap into psychological symptoms and better reflect the impact on lifestyle. For this reason, the sum of the RPQ-3 and the RPQ-13 are depicted separately.

RPQ-3: Predominantly Physical Symptoms
RPQ-13: Predominantly Psychological Symptoms

[1]King, N.S., Crawford, S., Wenden, F.J., Moss, N.E., & Wade, D.T. (1995). The Rivermead Post Concussion Symptoms Questionnaire: A measure of symptoms commonly experienced after head injury and its reliability. *Journal of Neurology. 242 (9)*: 587–92.
[2]Potter, S., Leigh, E., Wade, D., & Fleminger S. (2006). The Rivermead Post Concussion Symptoms Questionnaire, A Confirmatory Factor Analysis. *Journal of Neurology, 253:* 1603-1614.
[3]Eyres, S., Carey, A., Gilworth, G., Neumann, V., & Tennant, A. (2005). Construct validity and reliability of the Rivermead Post Concussion Symptoms Questionnaire. *Clinical Rehabilitation, 19*: 878-887.

The Tinnitus Handicap Questionnaire (THI)

The Tinnitus Handicap Inventory (THI) was developed by Newman et al. (1996[1]) and measures the severity of tinnitus and the impact of tinnitus on daily life.

The THI has 25 questions, which address the presence or absence of difficulties resulting from tinnitus. Scoring is as follows for each question: *4=Yes 2=Sometimes 0=No.*
The results of the THI of your client will be depicted on the following pages. The results of each of the 25 questions will be color-coded as follows:

The purpose of this questionnaire is to identify difficulties that you may be experiencing because of your tinnitus. Please answer every question. Please do not skip any questions.	Yes	Sometimes	No
1. Because of your tinnitus, is it difficult for you to concentrate?	4	2	0

In addition to the original THI, the current THI questionnaire has the following question at the end of the questionnaire: "On which side is your tinnitus most dominant?". Which can be answered with "Left", "Right", or "Equal". The additional question does not contribute to the total score.

Scoring Key
The scoring is based on the proposed scoring key by McCombe et al. (2001[2]), which is based on the sum of the scores of all the 25 items:

0-16 Slight (Grade 1): Only heard in quiet environment, very easily masked. No interference with sleep or daily activities.
18-36 Mild (Grade 2): Easily masked by environmental sounds and easily forgotten with activities. May occasionally interfere with sleep but not daily activities.
38-56 Moderate (Grade 3): May be noticed, even in the presence of background or environmental noise, although daily activities may still be performed.
58-76 Severe (Grade 4): Almost always heard, rarely, if ever, masked. Leads to disturbed sleep pattern and can interfere with ability to carry out normal daily activities. Quiet activities affected adversely.
78-100 Catastrophic (Grade 5): Always heard, disturbed sleep patterns, difficulty with any activity.

[1]Newman, C. W., Jacobson, G. P., & Spitzer, J. B. (1996). Development of the Tinnitus Handicap Inventory. *Archives of Otolaryngology - Head and Neck Surgery, 122(2):* 143–148.
[2]McCombe, A., Baguley, D., Coles, R., McKenna, L., McKinney, C., & Windle-Taylor, P. (2001). Guidelines for the grading of tinnitus severity: the results of a working group commissioned by the British Association of Otolaryngologists, Head and Neck Surgeons, 1999. *Clinical Otolaryngology & Allied Sciences, 26(5)*: 388-393.