1. Have you ever had a drug or alcohol problem?  yes  no  Describe:
   If yes, how old were you when it began?  _____
   If yes, were you ever hospitalized for this problem?  yes  no
*Has anyone ever complained about your drinking or drug use?  yes  no  Describe:
*Has your use of drugs or alcohol ever caused any problems for you or gotten you into any trouble?  yes  no  Describe:

   **Scoring for Substances, Disordered Eating, Sexual Impulsiveness**
   **Substances  _____**
   **Scores:**
   0 = none
   1 = mild (present, but not disruptive to life)
   2 = moderate (sometimes disruptive to life)
   3 = severe (frequently disruptive to life)

2. What is your present height?  _____  Weight?  _____
What is the most you have ever weighed?  _____
What is the least you have ever weighed as an adult?  _____
Do you have problems with overeating?  yes  no  Undereating?  yes  no
*Has anyone ever been worried that you were eating too much or not eating enough?  yes  no
Do you ever overuse diet pills, laxatives, or anything else to control your weight?  yes  no
Have you ever made yourself vomit?  yes  no  If so, do you do this often?  yes  no
For how long (did you have/ have you had) eating problems?  _____
What’s the longest time you’ve ever gone without food?  _____ (days)  Water?  _____ (days)

   **Eating  _____**
   (current:  )

3. Have you ever been afraid that there’s something wrong with the way you handle sex in your life?  yes  no
   If so, what worries you?  Has it been a big problem in your life?
   Would you say your sex drive is too high?  yes  no  DK  Too low?  yes  no  DK
   Do you ever like to be hurt when you’re having sex?  yes  no
   Do you ever find yourself involved with people who hurt you during sex?  yes  no

   **Sexual Impulsiveness  _____**
   (current:  )
4. Do you have any scars caused by you hurting yourself on purpose? yes no
   Describe all:

   How many times have you hurt yourself on purpose? ______
   If you have done this: How old were you when you first hurt yourself on purpose? ______
   How many times have you:
   Cut yourself? ______  Burned yourself? ______  Banged yourself? ______
   Picked open sores? ______  Choked yourself? ______  Overdosed? ______
   Done something to hurt or damage your sexual organs? ______  Jumped off something? ______
   Done other things? Specify:
   * Have you ever accidentally injured yourself? yes no
     If yes, describe:

   **Scoring for Self-harm:**
   0 = none  
   1 = mild (no serious injury)  
   2 = moderate (moderate or occasional injury)  
   3 = severe (severe or frequent injury)
   **Self Harm _____**
   (current: ______)

5. Have you ever seriously thought about killing yourself? yes no
   Did you ever make an attempt to kill yourself? yes no  How many times? ______
   How old were you at that time? ______ (years old)
   Describe:

   * Did you ever come close to killing yourself by accident? yes no
     If yes, describe:

   **Scoring for Suicidality:**
   0 = none (no ideation)  
   1 = mild (ideation, but no attempts)  
   2 = moderate (gestures or attempts with low lethality)  
   3 = severe (1 or more serious attempt)
   **Suicidality _____**
   (current: ______)

* Items not included in initial validation study.

**Lifetime Total SI-SD Score _____**
**Current Total SI-SD Score _____**