SDQ-20

This questionnaire asks about different physical symptoms or body experiences, which you may have had either briefly or for a longer time.
Please indicate to what extent these experiences apply to you **in the past year**.

For each statement, please circle the number in the first column that best applies to YOU.
The possibilities are:

1 = this applies to me NOT AT ALL
2 = this applies to me A LITTLE
3 = this applies to me MODERATELY
4 = this applies to me QUITE A BIT
5 = this applies to me EXTREMELY

If a symptom or experience applies to you, please indicate whether a **physician** has connected it with a **physical disease**.
Indicate this by circling the word YES or NO in the column "Is the physical cause known?"
If you wrote YES, please write the physical cause (if you know it) on the line.

Example:

	Extent to which the symptom or experience applies to you	Is the physical cause cause known?
Sometimes:		
my teeth chatter	1 2 3 4 5	NO YES, namely .....
I have cramps in my calves	1 2 3 4 5	NO YES, namely .....

If you have circled a 1 in the first column (i.e., This applies to me NOT AT ALL), you do NOT have to respond to the question about whether the physical cause is known.

On the other hand, if you circle 2, 3, 4, or 5, you MUST circle No or YES in the "Is the physical cause known?" column.

Please do not skip any of the 20 questions.
Thank you for your cooperation

Name							Date	
	Sometimes:	Extent to which the symptom or experience applies to you					Is the physical cause known?	
		Not at all	A little	Moderately	Quite a bit	Extremely		
		1	2	3	4	5	NO	YES, namely
1	I have trouble urinating.							
2	I dislike tastes that I usually like (women: at times OTHER THAN pregnancy or monthly periods).							
3	I hear sounds from nearby as if they were coming from far away.							
4	I have pain while urinating.							
5	My body, or a part of it, feels numb.							
6	People and things look bigger than usual.							
7	I have an attack that resembles an epileptic seizure.							
8	My body, or a part of it, is insensitive to pain							
9	I dislike smells that I usually like.							
10	I feel pain in my genitals (at times OTHER THAN sexual intercourse).							
11	I cannot hear for a while (as if I am deaf).							
12	I cannot see for a while (as if I am blind).							
13	I see things around me differently than usual (for example, as if Looking through a tunnel, or seeing merely a part of an object).							
14	I am able to smell much BETTER or WORSE than I usually do (even though I do ***not*** have a cold).							
15	It is as if my body, or a part of it, has disappeared.							
16	I cannot swallow, or can swallow only with great effort.							
17	I cannot sleep for nights on end, but remain very active during daytime.							
18	I cannot speak (or only with great effort) or I can only whisper.							
19	I am paralyzed for a while.							
20	I grow stiff for a while.							