

NAME/ID:

RATER NAME:

DATE:

Read the initial statement (*italics*) to the participant or patient and then ask the following questions in order to gather information to complete the related VAGUS-CR Insight Scale.

*“I am interested in your own understanding of your unusual or unique experiences **at the present moment**. I am **NOT** interested in what others may wish you to believe about your experiences.”*

1) Describe your unusual or unique experiences. For example,

	Yes	No
A) Have you ever heard voices or sounds that others can't hear?	<input type="checkbox"/>	<input type="checkbox"/>
B) Have you ever had visions or seen things that others can't see?	<input type="checkbox"/>	<input type="checkbox"/>
C) Have you ever feared that someone, some force or entity was after you or out to get you or hurt you?	<input type="checkbox"/>	<input type="checkbox"/>
D) Have you ever received special messages just for you from the TV, radio, newspaper or any other device?	<input type="checkbox"/>	<input type="checkbox"/>
E) Have you ever received special messages just for you from strangers on the street?	<input type="checkbox"/>	<input type="checkbox"/>
F) Have you ever had any special gifts or abilities?	<input type="checkbox"/>	<input type="checkbox"/>
G) Could you ever read minds?	<input type="checkbox"/>	<input type="checkbox"/>
H) Have you ever felt that others could read your thoughts or that your thoughts were broadcast for others to hear?	<input type="checkbox"/>	<input type="checkbox"/>
I) Have you ever had a special relationship with God beyond the average person?	<input type="checkbox"/>	<input type="checkbox"/>
J) Have you ever communicated with spiritual beings, such as angels or demons or aliens?	<input type="checkbox"/>	<input type="checkbox"/>
K) Have you ever felt excessively guilty or that you had done something very bad?	<input type="checkbox"/>	<input type="checkbox"/>
L) Have you ever felt that some outside force controlled your thoughts or actions?	<input type="checkbox"/>	<input type="checkbox"/>
M) Have you ever felt that you were possessed?	<input type="checkbox"/>	<input type="checkbox"/>
N) Have you ever felt that your body or some part of your body was diseased, rotting, or dying?	<input type="checkbox"/>	<input type="checkbox"/>
O) Other: _____	<input type="checkbox"/>	<input type="checkbox"/>

2) How do you explain your unusual or unique experiences? *At the present moment*, what do you believe the cause is for these experiences?

3) Do you **currently** believe you have a mental illness or a psychiatric disorder, such as Schizophrenia, Bipolar Disorder or Depression with psychosis, etc.? Please elaborate.

4) Do you think your unusual or unique experiences require treatment? Do you NEED antipsychotic medication? Please elaborate.

5) Have you experienced any negative consequences as a result of your unusual or unique experiences? Or as a result of your emotional or psychiatric problems? (e.g. hospitalization, occupational or social dysfunction).