

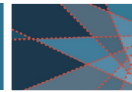


MENTAL HEALTH SCREENING FORM-III

Please circle “yes” or “no” for each question.

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| 1. Have you <i>ever</i> talked to a psychiatrist, psychologist, therapist, social worker, or counselor about an emotional problem? | Yes | No |
| 2. Have you <i>ever</i> felt you needed help with your emotional problems, or have you had people tell you that you should get help for your emotional problems? | Yes | No |
| 3. Have you <i>ever</i> been advised to take medication for anxiety, depression, hearing voices, or for any other emotional problem? | Yes | No |
| 4. Have you <i>ever</i> been seen in a psychiatric emergency room or been hospitalized for psychiatric reasons? | Yes | No |
| 5. Have you <i>ever</i> heard voices no one else could hear or seen objects or things which others could not see? | Yes | No |
| 6. (a) Have you <i>ever</i> been depressed for weeks at a time, lost interest or pleasure in most activities, had trouble concentrating and making decisions, or thought about killing yourself? | Yes | No |
| (b) Did you <i>ever</i> attempt to kill yourself? | Yes | No |
| 7. Have you <i>ever</i> had nightmares or flashbacks as a result of being involved in some traumatic/terrible event? For example, warfare, gang fights, fire, domestic violence, rape, incest, car accident, being shot or stabbed? | Yes | No |
| 8. Have you <i>ever</i> experienced any strong fears? For example, of heights, insects, animals, dirt, attending social events, being in a crowd, being alone, being in places where it may be hard to escape or get help? | Yes | No |
| 9. Have you <i>ever</i> given in to an aggressive urge or impulse, on more than one occasion, that resulted in serious harm to others or led to the destruction of property? | Yes | No |
| 10. Have you <i>ever</i> felt that people had something against you, without them necessarily saying so, or that someone or some group may be trying to influence your thoughts or behavior? | Yes | No |
| 11. Have you <i>ever</i> experienced any emotional problems associated with your sexual interests, your sexual activities, or your choice of sexual partner? | Yes | No |
| 12. Was there <i>ever</i> a period in your life when you spent a lot of time thinking and worrying about gaining weight, becoming fat, or controlling your eating? For example, by repeatedly dieting or fasting, engaging in much exercise to compensate binge eating, taking enemas, or forcing yourself to throw up? | Yes | No |
| 13. Have you <i>ever</i> had a period of time when you were so full of energy and your ideas came very rapidly, when you talked nearly nonstop, when you moved quickly from one activity to another, when you needed little sleep, and when you believed you could do almost anything? | Yes | No |
| 14. Have you <i>ever</i> had spells or attacks when you suddenly felt anxious, frightened, or uneasy to the extent that you began sweating, your heart began to beat rapidly, you were shaking or trembling, your stomach was upset, or you felt dizzy or unsteady, as if you would faint? | Yes | No |

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| 15. Have you <i>ever</i> had a persistent, lasting thought or impulse to do something over and over that caused you considerable distress and interfered with normal routines, work, or social relations? Examples would include repeatedly counting things, checking and rechecking on things you had done, washing and rewashing your hands, praying, or maintaining a very rigid schedule of daily activities from which you could not deviate. | Yes No |
| 16. Have you <i>ever</i> lost considerable sums of money through gambling or had problems at work, in school, or with your family and friends as a result of your gambling? | Yes No |
| 17. Have you <i>ever</i> been told by teachers, guidance counselors, or others that you have a special learning problem? | Yes No |

Instructions and scoring information are available online. (https://idph.iowa.gov/Portals/1/Files/SubstanceAbuse/jackson_mentalhealth_screeningtool.pdf).

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Substance Use/Misuse Screening and Assessment Tools

National Institute on Drug Abuse (NIDA)-Modified Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST) (www.drugabuse.gov/nmassist/): NIDA developed

an abbreviated version of the World Health Organization’s (WHO) ASSIST tool called the NIDA-Modified ASSIST that can be completed online.

PCSS – Clinical Tools: <https://pcssnow.org/resources/clinical-tools>

ALCOHOL USE DISORDERS IDENTIFICATION TEST

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential, so please be honest.

For each question in the chart below, place an X in one box that best describes your answer.

NOTE: In the U.S., a single drink serving contains about 14 grams of ethanol or “pure” alcohol. Although the drinks below are different sizes, each one contains the same amount of pure alcohol and counts as a single drink:



QUESTIONS	0	1	2	3	4
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week

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