# MINI Patient Health Survey

Patient's Name: _____ Date: _____

## SECTION I

| NO | YES | |
|---|---|---|
| O | O | 1. Have you been consistently depressed or down, most of the day, nearly every day, for the past two weeks? |
| O | O | 2. In the past two weeks, have you been less interested in most things or less able to enjoy the things you used to enjoy most of the time? |

**If your answer to both questions above is "NO", please proceed to Section II without answering question 3.**

3. Over the past two weeks, when you felt depressed or uninterested:

| | | |
|---|---|---|
| O | O | a. Was your appetite decreased or increased nearly every day? Did your weight decrease or increase without trying intentionally (i.e. by +/- 5% of body weight or +/- 8 lbs or +/- 3.5 kg for a 160 lb/70kg person in a month)? (If yes to either, please check YES). |
| O | O | b. Did you have trouble sleeping nearly every night (difficulty falling asleep, waking up in the middle of the night, early morning wakening or sleeping excessively)? |
| O | O | c. Did you talk or move more slowly than normal or were you fidgety, restless or having trouble sitting still almost every day? |
| O | O | d. Did you feel tired or without energy almost every day? |
| O | O | e. Did you feel worthless or guilty almost every day? |
| O | O | f. Did you have difficulty concentrating or making decisions almost every day? |
| O | O | g. Did you repeatedly consider hurting yourself, feel suicidal, or wish that you were dead? |

## SECTION II

| NO | YES | |
|---|---|---|
| O | O | 1. In the past 12 months, have you had 3 or more alcoholic drinks within a 3 hour period on 3 or more occasions? |

**If your answer to this question was "NO", you have completed Section II. Please proceed to Section III without answering question 2.**

2. In the past 12 months:

| | | |
|---|---|---|
| O | O | a. Did you need to drink more in order to get the same effect that you got when you first started drinking? |
| O | O | b. When you cut down on drinking did your hands shake, did you sweat or feel agitated? Did you need to drink to avoid these symptoms? (If yes to either, please check "YES"). |
| O | O | c. During the times when you drank alcohol, did you end up drinking more than you planned when you started? |
| O | O | d. Have you tried to reduce or stop drinking alcohol, but failed? |
| O | O | e. On the days that you drank, did you spend substantial time obtaining alcohol, drinking, or recovering from the effects of alcohol? |

O O f. Did you spend less time working, enjoying hobbies, or being with others because of your drinking?
O O g. Have you continued to drink even though you knew that it caused you problems?

## SECTION III

**NO YES**

O O 1. Have you, on more than one occasion, had spells or attacks when you suddenly felt anxious, frightened, uncomfortable or uneasy, even in situations where most people would not feel that way? Did the spells peak within 10 minutes? (If yes to either, please check "YES").
O O 2. At any time in the past, did any of those spells or attacks come on unexpectedly or occur in an unprecedented or unprovoked manner?

**If your answer to both questions above was "NO", please proceed to Section IV without answering any other questions below in Section III.**

O O 3. Have you ever had one such attack followed by a month or more of persistent fear of having another attack, or worries about the consequences of the attack?
4. During the worst spell that you can remember:
O O a. Did you have skipping, racing or pounding of your heart?
O O b. Did you have sweating or clammy hands?
O O c. Were you trembling or shaking?
O O d. Did you have shortness of breath or difficulty breathing?
O O e. Did you have a choking sensation or a lump in your throat?
O O f. Did you have chest pain, pressure, or discomfort?
O O g. Did you have nausea, stomach problems or sudden diarrhea?
O O h. Did you feel dizzy, unsteady, lightheaded, or faint?
O O i. Did things around you feel strange, unreal, detached or unfamiliar, or did you feel outside of or detached from part, or all of your body?
O O j. Did you fear that you were losing control or going crazy?
O O k. Did you fear you were dying?
O O l. Did you have tingling or numbness in parts of your body?
O O m. Did you have hot flashes or chills?
O O 5. In the past month, did you have such attacks repeatedly (2 or more) followed by persistent fear of having another attack?

## SECTION IV

**NO YES**

O O 1. In the past month, were you fearful of or embarrassed by being watched or being the focus of attention, or fearful of being humiliated? This includes things like speaking in public, eating in public alone or with others, writing while someone watches, or being in social situations?
O O 2. Is this fear excessive or unreasonable?
O O 3. Do you fear these situations so much that you avoid them or suffer through them?
O O 4. Does this fear disrupt your normal work or social functioning or cause you significant distress?