

Mental health checklist

Depression

Yes

- A. Low mood/sadness
- B. Loss of interest or pleasure
- C. Decreased energy and/or increased fatigue

If YES to any of the above, continue below

- 1. Sleep disturbance:
 Difficulty falling asleep
 Early morning wakening
- 2. Appetite disturbance:
 Appetite loss
 Appetite increase
- 3. Concentration difficulty
- 4. Psychomotor retardation or agitation
- 5. Decreased libido
- 6. Loss of self-confidence or self-esteem
- 7. Thoughts of death or suicide
- 8. Feelings of guilt

Summing up

- Positive to A, B or C and at least four positive from 1-8
 all occurring most of the time for two weeks or more.
- Indication of **depression**

Anxiety

Yes

- A. Feeling tense or anxious?
- B. Worrying a lot about things?

If YES to any of the above, continue below

- 1. Symptoms of arousal and anxiety?
- 2. Experienced intense or sudden fear unexpectedly or for no apparent reason?
 Fear of dying Feeling dizzy, lightheaded or faint
 Fear of losing control Pounding heart Numbness or tingling
 Sweating sensations
 Trembling or shaking Feelings of unreality
 Chest pains or difficulty breathing Nausea
- 3. Experiences fear/anxiety in specific situations
 leaving familiar places
 travelling alone, e.g. train, car, plane
 crowds confined places/public places
- 4. Experienced fear/anxiety in social situations
 speaking in front of others
 social events
 eating in front of others
 worry a lot about what others think or self-consciousness?

Summing up

- Positive to A, B and 1, recurring regularly negative to 2, 3 and 4:
 Indication of **generalized anxiety**
 Positive to 1 and 2: indication of **panic disorder**
 Positive to 1 and 3: indication of **agoraphobia**
 Positive to 1 and 4: indication of **social phobia**

Alcohol use problems

Yes

- A. No. of units of alcohol in a typical day when drinking?
- B. No. of days/week having alcoholic drinks?

If above limit, or if there is a regular / hazardous pattern, continue below

- 1. Have you been unable to stop, reduce or continue your drinking?
- 2. Have you ever felt such a strong desire or urge to drink that you could not resist it?
- 3. Did stopping or cutting down on your drinking ever cause you problems, such as:
 the shakes? heart beating fast?
 being unable to sleep? headaches?
 feeling nervous or restless? fits or seizures?
 sweating?
- 4. Have you ever continued to drink when you know that you had problems that can be made worse by drinking?
- 5. Has anyone expressed concern about your drinking; for example, your family, friends or your doctor?

Summing up

- If A x B is 21/week or more for men, or 14/week or more for women:
 possible **alcohol problem**
- If A x B is 21/week or more for men, or 14/week or more for women and positive to any of 1-5:
 likely **alcohol problem**
- Positive to A and any of 1-5: likely **alcohol problem**

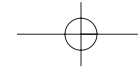
Functioning and disablement

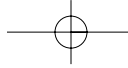
A. During the past month, have you been limited in one or more of the following activities most of the time?

- Self-care: bathing, dressing eating?
- Family relations: spouse, children, relatives?
- Going to work or school?
- Doing housework or household tasks?
- Social activities, seeing friends?
- Remembering things?

B. Because of these problems during the past month:

- how many days were you unable to fully carry out your usual daily activities?
- how many days did you spend in bed in order to rest?





Always check for Depression / Stressful situations / Anxiety

Sleep problems

Yes

- A. Have you had any problems with sleep?
- Difficulty falling asleep? Frequent or long periods of
 - Restless or unrefreshing sleep? being awake?
 - Early morning awakening?

If YES to any of the above, continue below

1. Do you have any medical problems or physical pains?
2. Are you taking any medication?
3. Do any of the following apply?
 - Drink alcohol, coffee, tea or eat before you sleep?
 - Take day time naps?
 - Experienced changes to your routine eg shift work?
 - Disruptive noises during the night?
4. Do you have problems at least three times a week?
5. Has anyone told you that your snoring is loud and disruptive?
6. Do you get sudden uncontrollable sleep attacks during the day?
7. Low mood or loss of interest or pleasure?
8. Worried, anxious or tense?
9. How much alcohol do you drink in a typical week (number of standard drinks/week)?

Summing up

- Positive to any of 1, 2 or 3: consider management of the underlying problem
- Positive to 4: indication of **sleep problem**
- Positive to 5: consider **sleep apnoea**
- If positive to 6: consider **narcolepsy**
- Positive to 7: consider **depression**
- Positive to 8: consider **anxiety**
- If weekly drinking is more than 21 standard drinks for men and more than 14 for women, consider **alcohol use problems**

Always check for Depression / Stressful situations / Anxiety

Chronic tiredness

Yes

- A. Do you get tired easily?
- Tired all the time?
 - Easily tired out while performing every day tasks?
 - Difficult to recover from the tiredness, despite rest?

If YES to any of the above, continue below

1. Do you have any medical problems or physical pains?
2. Are you taking any medication?
3. Low mood or loss of interest or pleasure?
4. Worried, anxious or tense?
5. How much alcohol do you drink in a typical week (number of standard drinks/week)?
6. Are you doing too much at home and/or work?
7. Do you fail to set time aside for leisure activities?
8. Have you been having problems with sleep?

Chronic Fatigue Syndrome is a much rarer condition, diagnosed when substantial physical and mental fatigue lasts longer than six months and there are no significant findings on physical examination or laboratory investigation.

Summing up

- Positive to A: indication of **fatigue problem**
- Positive to any of 1 and 2: consider management of the underlying problem
- Positive to 3: consider **depression**
- Positive to 4: consider **anxiety**
- If weekly drinking is more than 21 standard drinks for men and more than 14 for women: consider **alcohol use problems**
- Positive to 6 or 7: consider **lifestyle change**
- Positive to 8: consider **sleep problem**

Check for multiple doctors and negative test results / Dramatic presentation / Unusual symptoms

Unexplained somatic complaints

Yes

- A. Have you been bothered by continuing aches or pains or other physical complaints for which a cause has not been found (eg nausea / vomiting / diarrhoea / shortness of breath / chest pain / headaches / abdominal pain)?

If YES to any of the above, continue below

1. Have you seen more than one doctor for these problems?
2. Have you seen any specialists about these problems?
3. Have you experienced these pains or different physical problems for longer than six months?
4. Low mood or loss of interest or pleasure?
5. Worried, anxious or tense?
6. How much alcohol do you drink in a typical week (number of standard drinks/week)?

Summing up

- Positive to A and also to at least one positive from 1-3, and negative to 4, 5 and 6: consider **unexplained somatic complaints**

Functioning and disablement

A. During the past month, have you been limited in one or more of the following activities most of the time?

- Self-care: bathing, dressing, eating?
- Family relations: spouse, children, relatives?
- Going to work or school?
- Doing housework or household tasks?
- Social activities, seeing friends?
- Remembering things?

B. Because of these problems during the past month:

- how many days were you unable to fully carry out your usual daily activities?
- how many days did you spend in bed in order to rest?

