Mental Disorders Checklist

Depression

Yes

I. Low mood / sadness ❑
II. Loss of interest or pleasure ❑
III. 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. Thought of death or suicide ❑
8. Feelings of guilt ❑

Summing up

Positive to I,II or III and at least 5 positive from 1 to 8. ❑
all occurring most of the time for 2 weeks or more.
Indication of ***depression*** ❑

Anxiety

Yes

I. Feeling tense or anxious? ❑
II. 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 ❑
   Fear of losing control ❑
   Pounding heart ❑
   Sweating ❑
   Trembling or shaking ❑
   Chest pains or difficulty breathing ❑
   Feeling dizzy, lightheaded or faint ❑
   Numbness or tingling sensations ❑
   Feelings of unreality ❑
   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 I or II and negative to 2,3 and 4:
Indication of ***generalized anxiety*** ❑
Positive to I and 2: indication of ***panic disorder*** ❑
Positive to I and 3: indication of ***agoraphobia*** ❑
Positive to 1 and 4: indication of ***social phobia*** ❑

Alcohol Use Disorders

I. No. standart drinks in a typical day when drinking? ________
II. No. of days/wk. 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 ❑
   being unable to sleep ❑
   feeling nervous or restless ❑
   sweating ❑
   heart beating fast ❑
   headaches ❑
   fits or seizures ❑
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 I x II is 21/wk or more for men or 14/wk or more for women, then possible ***alcohol problem*** ❑
Positive to I and any of 1-5, then likely ***alcohol problem*** ❑

Functioning & Disablement

I. During the last 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? ❑

II. Because of these problems during the last month

For 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? ________