Matthew A. Berger, MD, PC 340 Montage Mountain Road • Moosic, PA 18507 Phone (570) 346-3686 • Fax (570) 207-0615

# **MINI Patient Health Survey**

(Please Print)

Date

Name

Male		Female	Your Age	Phone		
SECTI	ON I					
YES	NO					
			you been consistently or the past two weeks?	depressed or down, most of the day, nearly every		
				you been less interested in most things or less able to enjoy most of the time?		
	answer t n 3 belo	o both questic		lease go to Section II without answering		
		<ol><li>Over t</li></ol>	the past two weeks, wh	nen you felt depressed or uninterested:		
			Was your appetite d weight decrease or i minus 5% body weig	lecreased or increased nearly every day? Did your increase without trying intentionally (i.e., by plus or ght or plus or minus 8 lbs or plus or minus 3.5 kg for on in a month)? (If yes to either, please check		
		b.	Did you have trouble	e sleeping nearly every night (difficulty falling in the middle of the night, early morning wakening or y)?		
		C.		e more slowly than normal or were you fidgety, rouble sitting still almost every day?		
		d.	Did you feel tired or	without energy almost every day?		
		e.	Did you feel worthles	ss or guilty almost every day?		
		f.		lty concentrating or making decisions almost every		
		g.	Did you repeatedly or you were dead?	consider hurting yourself, feel suicidal, or wish that		
SECTI	ON II					
YES	NO					
		<ol> <li>In the past 12 months, have you had 3 or more alcoholic drinks within a 3-hoperiod on 3 or more occasions?</li> </ol>				
		to this question. Please go t		completed II – please do not answer the		
		2. In the	past 12 months:			
		a.	Did you need to drin first started drinking			
		b.	When you cut down	on drinking did your hands shake, did you sweat or ou drink to avoid these symptoms? (If yes to either		

YES	NO		
		c.	During the times when you drank alcohol, did you end up drinking more
			than you planned when you started?
			Have you tried to reduce or stop drinking alcohol but failed?
		e.	On the days that you drank, did you spend substantial time in obtaining
			alcohol, drinking, or in recovering from the effects of alcohol?
		f.	Did you spend less time working, enjoyable hobbies, or being with
			others because of your drinking?
		g.	Have you continued to drink even though you knew that it caused you
			problems?

### **SECTION III**

YES	NO	
		<ol> <li>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".)</li> </ol>
		2. At any time in the past, did any of those spells or attacks come on unexpectedly or occur in an unpredictable or unprovoked manner?

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

otner ques	tions below in Section III.
	3. Have you even 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?
	During the worst spell that you can remember:
	a. Did you have skipping, racing, or pounding of your heart?
	h Did you have awarts as alammas handa?
	b. Did you have sweaty or clammy hands?
	c. Were you trembling or shaking?
	c. Were you trembing or snaking:
	d. Did you have shortness of breath or difficulty breathing?
	, , ,
	e. Did you have a choking sensation or lump in your throat?
	f. Did you have chest pain, pressure, or discomfort?
	D'I a la company de contra de la contra de con
	g. Did you have nausea, stomach problems, or sudden diarrhea?
	h. Did you feel dizzy, unsteady, lightheaded, or faint?
	3-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1
	did you feel outside of or detached from part or all of your body?
	i Did you foor that you were looing control or going crazy?
	j. Did you fear that you were losing control or going crazy?
	k. Did you fear that you were dying?
	it. Did you rour that you wore dying:
	I. Did you have tingling or numbness in parts of your body?
	m. Did you have hot flashes or chills?
	5. In the past month, did you have such attacks repeatedly (two or more) followed
	by persistent fear of having another attack?
L L	· · · · · · · · · · · · · · · · · · ·

### **SECTION IV**

YES	NO	
		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?
		2. Is this fear excessive or unreasonable?
		3. Do you fear these situations so much that you avoid them or suffer through them?
		4. Does this fear disrupt your normal work or social functioning or cause you significant distress?

## **SECTION V**

YES	NO	
		1. Have you had excessive anxiety and worry, occurring more days than not for at least six months, about a number of events or activities (such as work or school performance)?
		Did you find it difficult to control the worry?

If you answered "NO" to question 1 or 2 in this section, you are finished with this form. If you answered "YES" please answer these last two questions. Thank you!

3. During that six months, which of the following symptoms were present for more days than not?
a. Restlessness or feeling keyed up or on edge
b. Being easily fatigued
c. Difficulty concentrating or mind going blank
d. Irritability
e. Muscle tension
<ul> <li>f. Sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep)</li> </ul>
Do the anxiety, worry, or physical symptoms disrupt your normal work or functioning, or cause you significant distress?

PROVIDERS PLEASE COMPLETE THIS SECTION						
DX:	ок	D	AD	PD	SAD	GAD
	Other					
RX by Provider only?		YES		NO		
Provider Initials:						