Anxiety Disorders Screening Tool

MINI INTERNATIONAL NEUROPSYCHIATRIC INTERVIEW (MINI)

PLEASE FILL IN THE CIRCLES COMPLETELY Ⓨ (YES) OR Ⓝ (NO)

Section 1

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 mark YES.) .... Ⓨ Ⓝ

If your answer to question 1 above is no, please proceed to Section 2

2. At any time in the past, did any of these spells or attacks come on unexpectedly or occur in an unpredictable or unprovoked manner? .... Ⓨ Ⓝ
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 attacks that you can remember:*

   Did you have skipping, racing or pounding of your heart? .... Ⓨ Ⓝ
   Did you have sweating or clammy hands? .... Ⓨ Ⓝ
   Were you trembling or shaking? .... Ⓨ Ⓝ
   Did you have shortness of breath or difficulty breathing? .... Ⓨ Ⓝ
   Did you have a choking sensation or a lump in your throat? .... Ⓨ Ⓝ
   Did you have chest pain, pressure or discomfort? .... Ⓨ Ⓝ
   Did you have nausea, stomach problems or sudden diarrhea? .... Ⓨ Ⓝ
   Did you feel dizzy, unsteady, lightheaded or faint? .... Ⓨ Ⓝ
   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? .... Ⓨ Ⓝ
   Did you feel that you were losing control or going crazy? .... Ⓨ Ⓝ
   Did you fear that you were dying? .... Ⓨ Ⓝ
   Did you have tingling or numbness .... Ⓨ Ⓝ
   in parts of your body? .... Ⓨ Ⓝ
   Did you have hot flushes or chills? .... Ⓨ Ⓝ

5. In the past month, did you have such attacks repeatedly (2 or more) followed by persistent fear of having another attack? .... Ⓨ Ⓝ

Section 2

1. In the past month, were you fearful or embarrassed being watched, being the focus of attention, or fearful of being humiliated? This includes things like speaking in public, eating in public or with others, writing while someone watches, or being in social situations? .... Ⓨ Ⓝ

If your answer to question 1 above is no, please proceed to Section 3

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 3

1. Have you ever experienced or witnessed or had to deal with an extremely traumatic event that included actual or threatened death or serious injury to you or someone else? .... Ⓨ Ⓝ

If your answer to question 1 above is no, please proceed to Section 4

2. During the past month, have you re-experienced the event in a distressing way (such as dreams, intense recollections, flashbacks or physical reactions)? .... Ⓨ Ⓝ
3. *In the past month:*

   Have you avoided thinking about the event, or have you avoided things that remind you of the event? .... Ⓨ Ⓝ
   Have you had trouble recalling some important part of what happened? .... Ⓨ Ⓝ
   Have you become less interested in hobbies or social activities? .... Ⓨ Ⓝ
   Have you felt detached or estranged from others? .... Ⓨ Ⓝ
   Have you noticed that your feelings are numbed? .... Ⓨ Ⓝ
   Have you felt that your life would be shortened because of this trauma? .... Ⓨ Ⓝ

4. *In the past month:*

Have you had difficulty sleeping? .... Ⓨ Ⓝ
Were you especially irritable or did you have outbursts of anger? .... Ⓨ Ⓝ
Have you had difficulty concentrating? .... Ⓨ Ⓝ
Were you nervous or constantly on your guard? Were you easily startled? .... Ⓨ Ⓝ

5. During the past month, have these problems significantly interfered with your work or social activities, or caused significant distress? .... Ⓨ Ⓝ

Section 4

1. Have you worried excessively or been anxious about 2 or more things (e.g., finances, children's well-being, misfortune) over the past 6 months? More than most others would? Are these worries present most days? .... Ⓨ Ⓝ

If your answer to question 1 above is no, please proceed to Section 5

2. Do you find it difficult to control the worries or do they interfere with your ability to focus on what you are doing? .... Ⓨ Ⓝ

3. When you were anxious over the past 6 months, did you, most of the time:

Feel restless, keyed up or on edge? .... Ⓨ Ⓝ
Feel tense? .... Ⓨ Ⓝ
Feel tired, weak or exhausted easily? .... Ⓨ Ⓝ
Have difficulty concentrating or find your mind going blank? .... Ⓨ Ⓝ
Feel irritable? .... Ⓨ Ⓝ
Have difficulty sleeping (difficulty falling asleep, waking up in the middle of the night, early morning wakening or sleeping excessively)? .... Ⓨ Ⓝ

Section 5

1. In the past month, have you been bothered by recurrent thoughts, impulses, or images that were unwanted, distasteful, inappropriate, intrusive or distressing? (For example, the idea that you were dirty, contaminated or had germs, fear of contaminating others, or fear of harming someone even though you didn't want to, or fearing that you would act on some impulse, or fear or superstitions that you would be responsible for things going wrong, or obsessions with sexual thoughts, images or impulses, or hoarding, collecting or religious obsessions). Ⓨ Ⓝ

If answer is no, skip to #4

2. Did they keep coming back into your mind even when you tried to ignore or get rid of them? .... Ⓨ Ⓝ

3. Do you think these obsessions are the product of your own mind and that they are not imposed from the outside? .... Ⓨ Ⓝ

4. In the past month, did you do something repeatedly without being able to resist doing it, like washing or cleaning excessively, counting or checking things over and over, or repeating, collecting, arranging things, or other superstitious rituals? .... Ⓨ Ⓝ

5. Did you recognize that either these obsessive thoughts or these compulsive behaviours were excessive or unreasonable? .... Ⓨ Ⓝ

6. Did these obsessive thoughts and/or compulsive behaviours significantly interfere with your normal routine, occupational functioning, usual social activities, or relationships, or did they take more than one hour? .... Ⓨ Ⓝ

Section 6

1. *Have you EVER...*

Discussed an emotional problem with your medical doctor? .... Ⓨ Ⓝ
Received care from a psychiatrist? .... Ⓨ Ⓝ
Received care from a psychologist, psychotherapist, social worker, family therapist, or other mental health professional? .... Ⓨ Ⓝ
Been to Alcoholics Anonymous? .... Ⓨ Ⓝ
Talked to a drug counselor? .... Ⓨ Ⓝ

Section 7

Please fill ONE circle for each of the following 3 scales.
To what extent have emotional symptoms disrupted...

1. ... your work in the last month:

not at all — *mildly* — *moderately* — *mostly* — *extremely*
⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

2. ... your social life in the last month:

not at all — *mildly* — *moderately* — *mostly* — *extremely*
⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

3. ... your family life/home responsibilities in the last month:

not at all — *mildly* — *moderately* — *mostly* — *extremely*
⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

Anxiety Disorders Screening Tool

MINI INTERNATIONAL NEUROPSYCHIATRIC INTERVIEW (MINI)

The screening questionnaire used in the National Anxiety Disorders Screening Day is the Mini-International Neuropsychiatric Interview (M.I.N.I.). It is a short, structured, diagnostic interview that was developed by a group of psychiatrists and clinicians in the United States and Europe. the MINI was designed for DSM-IV and ICD-10 psychiatric disorders. The version in the screening program is designed to explore five Axis I psychiatric disorders (panic disorder, social phobia, post-traumatic stress disorder, generalized anxiety disorder, and obsessive-compulsive disorder) according to DSM-IV diagnostic criteria. Validated against both the SCID and ICD-10 diagnostic criteria, the MINI is a sensitive, valid and reliable instrument (Sheehan et al., 1997).

Interpreting the Questionnaire Results

Question 1 must be answered positively to meet criteria

Section 1 – Panic Disorder

Rule out Panic Disorder if	NO to Question 1
Panic Disorder lifetime if	Y to Questions 1, 2 & 3 + (4 or more Y responses in Q4)
Panic Disorder current if	Y to Questions 1, 2 & 3 + (4 or more Y responses in Q4) + Q5

Section 2 – Social Anxiety Disorder

Rule out Social Phobia if	NO to Question 1
Social Anxiety Disorder if	Y to Questions 1, 2, 3 & 4

Section 3 – Post-traumatic Stress Disorder

Rule out PTSD if	NO to Question 1
Rule out PTSD if	YES to Question 1 + NO to Question 2
PTSD if	Y to Questions 1 & 2 + (3 or more Y responses in Q3) + (2 or more Y responses in Q4) + Q5

Section 4 – Generalized Anxiety Disorder

Rule out GAD if	NO to Question 1
GAD if	Y to Questions 1 & 2 + (3 or more Y responses in Q3)

Section 5 – Obsessive-Compulsive Disorder

Rule out OCD (obsessions) if	NO to Question 1
OCD obsessions if	Y to Questions 1, 2, 3, & 6
Rule out OCD (compulsions) if	NO to Question 1
OCD compulsions if	Y to Questions 4, 5, & 6

▲CAUTION – If there are several YES answers in any section even though the screening participant does not meet criteria, check the impairment scale (section 7). If substantial impairment is evident, it is recommended that the screening participant be referred for a complete clinical evaluation.