

**Modified Mini Screen (MMS)**

Client Name: \_\_\_\_\_ OASAS ID \_\_\_\_\_

Weeks since admission \_\_\_\_\_ Interviewer \_\_\_\_\_

Today's Date \_\_\_\_\_ Supervisor Initials (Optional) \_\_\_\_\_

**SECTION A**

1. Have you been consistently depressed or down, most of the day, nearly every day, for the past 2 weeks?	YES	NO
2. In the past 2 weeks, have you been less interested in most things or less able to enjoy the things you used to enjoy most of the time?	YES	NO
3. Have you felt sad, low or depressed most of the time for the last two years?	YES	NO
4. In the past month, did you think that you would be better off dead or wish you were dead?	YES	NO
5. Have you ever had a period of time when you were feeling up, hyper or so full of energy or full of yourself that you got into trouble or that other people thought you were not your usual self? (Do not consider times when you were intoxicated on drugs or alcohol.)	YES	NO
6. Have you ever been so irritable, grouchy or annoyed for several days, that you had arguments, verbal or physical fights, or shouted at people outside your family? Have you or others noticed that you have been more irritable or overreacted, compared to other people, even when you thought you were right to act this way?	YES	NO
<b>PLEASE TOTAL THE NUMBER OF "YES" RESPONSES TO QUESTIONS 1-6</b>		

**SECTION B**

<p>7. Note this question is in 2 parts.</p> <p>a. Have you had one or more occasions when you felt intensely anxious, frightened, uncomfortable or uneasy even when most people would not feel that way?  YES NO</p> <p>b. If yes, did these intense feelings get to be their worst within 10 minutes?  YES NO</p> <p>Interviewer: If the answer to BOTH a and b is YES, code the question YES.  If the answer to either or both a and b is NO, code the question NO.</p>	<p align="center">YES</p>	<p align="center">NO</p>
<p>8. Do you feel anxious or uneasy in places or situations where you might have the panic-like symptoms we just spoke about? Or do you feel anxious or uneasy in situations where help might not be available or escape might be difficult?</p> <p>Examples include:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Being in a crowd</li> <li><input type="checkbox"/> Standing in a line</li> <li><input type="checkbox"/> Being alone away from home or alone at home</li> <li><input type="checkbox"/> Crossing a bridge</li> <li><input type="checkbox"/> Traveling in a bus, train or car</li> </ul>	<p align="center">YES</p>	<p align="center">NO</p>
<p>9. Have you worried excessively or been anxious about several things over the past 6 months?  Interviewer: If NO to question 9, answer NO to question 10 and proceed to question 11.</p>	<p align="center">YES</p>	<p align="center">NO</p>
<p>10. Are these worries present most days?</p>	<p align="center">YES</p>	<p align="center">NO</p>
<p>11. In the past month, were you afraid or embarrassed when others were watching you, or when you were the focus of attention? Were you afraid of being humiliated?</p> <p>Examples include:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Speaking in public</li> <li><input type="checkbox"/> Eating in public or with others</li> <li><input type="checkbox"/> Writing while someone watches</li> <li><input type="checkbox"/> Being in social situations</li> </ul>	<p align="center">YES</p>	<p align="center">NO</p>
<p>12. In the past month, have you been bothered by thoughts, impulses, or images that you couldn't get rid of that were unwanted, distasteful, inappropriate, intrusive or distressing?</p> <p>Examples include:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Were you afraid that you would act on some impulse that would be really shocking?</li> <li><input type="checkbox"/> Did you worry a lot about being dirty, contaminated or having germs?</li> <li><input type="checkbox"/> Did you worry a lot about contaminating others, or that you would harm someone even though you didn't want to?</li> <li><input type="checkbox"/> Did you have any fears or superstitions that you would be responsible for things going wrong?</li> <li><input type="checkbox"/> Were you obsessed with sexual thoughts, images or impulses?</li> <li><input type="checkbox"/> Did you hoard or collect lots of things?</li> <li><input type="checkbox"/> Did you have religious practice obsessions?</li> </ul>	<p align="center">YES</p>	<p align="center">NO</p>

**SECTION B (CONTINUED)**

<p>13. In the past month, did you do something repeatedly without being able to resist doing it?</p> <p>Examples include:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Washing or cleaning excessively</li> <li><input type="checkbox"/> Counting or checking things over and over</li> <li><input type="checkbox"/> Repeating, collecting, or arranging things</li> <li><input type="checkbox"/> Other superstitious rituals</li> </ul>	<p align="center">YES</p>	<p align="center">NO</p>
<p>14. 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?</p> <p>Examples Include:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Serious accidents</li> <li><input type="checkbox"/> Sexual or physical assault</li> <li><input type="checkbox"/> Terrorist attack</li> <li><input type="checkbox"/> Being held hostage</li> <li><input type="checkbox"/> Kidnapping</li> <li><input type="checkbox"/> Fire</li> <li><input type="checkbox"/> Discovering a body</li> <li><input type="checkbox"/> Sudden death of someone close to you</li> <li><input type="checkbox"/> War</li> <li><input type="checkbox"/> Natural disaster</li> </ul>	<p align="center">YES</p>	<p align="center">NO</p>
<p>15. Have you re-experienced the awful event in a distressing way in the past month?</p> <p>Examples include:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Dreams</li> <li><input type="checkbox"/> Intense recollections</li> <li><input type="checkbox"/> Flashbacks</li> <li><input type="checkbox"/> Physical reactions</li> </ul>	<p align="center">YES</p>	<p align="center">NO</p>
<p><b>PLEASE TOTAL THE NUMBER OF "YES" RESPONSES TO QUESTIONS 7-15</b></p>		

### SECTION C

16. Have you ever believed that people were spying on you, or that someone was plotting against you, or trying to hurt you?	YES	NO
17. Have you ever believed that someone was reading your mind or could hear your thoughts, or that you could actually read someone's mind or hear what another person was thinking?	YES	NO
18. Have you ever believed that someone or some force outside of yourself put thoughts in your mind that were not your own, or made you act in a way that was not your usual self? Or, have you ever felt that you were possessed?	YES	NO
19. Have you ever believed that you were being sent special messages through the TV, radio, or newspaper? Did you believe that someone you did not personally know was particularly interested in you?	YES	NO
20. Have your relatives or friends ever considered any of your beliefs strange or unusual?	YES	NO
21. Have you ever heard things other people couldn't hear, such as voices?	YES	NO
22. Have you ever had visions when you were awake or have you ever seen things other people couldn't see?	YES	NO
<b>PLEASE TOTAL THE NUMBER OF "YES" RESPONSES TO QUESTIONS 16-22</b>		

**SCORING THE SCREEN**

<b>NUMBER OF "YES" RESPONSES FROM SECTION A</b>	
<b>NUMBER OF "YES" RESPONSES FROM SECTION B</b>	
<b>NUMBER OF "YES" RESPONSES FROM SECTION C</b>	
<b>TOTAL NUMBER OF "YES" RESPONSES FROM SECTIONS A, B, AND C</b> <ul style="list-style-type: none"><li>• Score <math>\geq 10</math>, assessment needed</li><li>• Score <math>\geq 6</math> &amp; <math>\leq 9</math>, assessment need should be determined by treatment team</li><li>• Score <math>\leq 5</math>, no action necessary unless determined by treatment team</li></ul>	
<b>YES RESPONSE TO QUESTION #4</b> <ul style="list-style-type: none"><li>• If score = 1, assessment is needed</li></ul>	
<b>YES RESPONSES TO QUESTIONS #14 AND #15</b> <ul style="list-style-type: none"><li>• If score = 2, assessment is needed</li></ul>	

**SCORE INDICATED NEED FOR AN ASSESSMENT? (CIRCLE)                      YES    NO**

**IF NO, DID TREATMENT TEAM DETERMINE  
THAT AN ASSESSMENT WAS NEEDED? (CIRCLE)                      YES    NO**