MAMI MATERNAL MENTAL HEALTH ASSESSMENT FORM

Basic Information

Primary caregiver name		**ID no.**	
Infant name		**Date of assessment**	_____ /_____ /_____

Over the last <u>two weeks,</u> how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things?	0	1	2	3
2. Feeling down, depressed, or hopeless?	0	1	2	3
3. Trouble falling or staying asleep? Or sleeping too much?	0	1	2	3
4. Feeling tired or having little energy?	0	1	2	3
5. Poor appetite? Or over-eating?	0	1	2	3
6. Feeling bad about yourself? Or that you are a failure? Or have let yourself or your family down?	0	1	2	3
7. Trouble concentrating on things, such as following a conversation with people?	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed a difference? Or being so fidgety or restless that you have been moving around a lot more than usual?	0	1	2	3
9. Thought that you would be better off dead or of hurting yourself in some way?	0	1	2	3
		Add column scores:	_____	_____	_____
		TOTAL ASSESSMENT SCORE:			

ACT

Classify	**LOW RISK:** 0 – 9 ***and*** 'no' to Question 9 (thoughts of self-harm)	**MODERATE RISK:** 10 – 14 ***and*** 'no' to Question 9 (thoughts of self-harm)	**HIGH RISK:** 15+ ***and/or*** 'yes' to Question 9 (thoughts of self-harm)

Other – specify:

Notes:

ACT	**RETURN TO MAMI ASSESSMENT FORM AND COMPLETE ASSESSMENT**