



# MAMI MATERNAL MENTAL HEALTH ASSESSMENT FORM

Basic Information			
Primary caregiver name	<i>Khatera Mohammed</i>	ID no	<i>23457</i>
Infant name	<i>Mohammed Arafat</i>	Date of assessment	<i>_31_/_07_/_2021</i>

Over the last two weeks, 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	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input checked="" type="checkbox"/> 2	<input type="checkbox"/> 3
2.	Feeling down, depressed, or hopeless?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input checked="" type="checkbox"/> 2	<input type="checkbox"/> 3
3.	Trouble falling or staying asleep? Or sleeping too much?	<input checked="" type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
4.	Feeling tired or having little energy?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input checked="" type="checkbox"/> 3
5.	Poor appetite? Or over-eating?	<input type="checkbox"/> 0	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
6.	Feeling bad about yourself? Or that you are a failure? Or have let yourself or your family down?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input checked="" type="checkbox"/> 3
7.	Trouble concentrating on things, such as following a conversation with people?	<input type="checkbox"/> 0	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 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?	<input checked="" type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
9.	Thought that you would be better off dead or of hurting yourself in some way?	<input checked="" type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
ACT	Add column scores:		<i>2</i>	<i>4</i>	<i>6</i>
	TOTAL ASSESSMENT SCORE:		<i>12</i>		
	Classify	LOW RISK: 0 – 9 <i>and</i> 'no' to Question 9 (thoughts of self-harm)	MODERATE RISK: 10 – 14 <i>and</i> 'no' to Question 9 (thoughts of self-harm)	HIGH RISK: 15+ <i>and/or</i> 'yes' to Question 9 (thoughts of self-harm)	
	Other – specify:				

## Notes:

*Mother feels she has let her baby down as he is always unwell, is thin and feels she never has enough time to care for him.*

*She feels that if she asks anyone for help, like her mother or her sister, then this looks like she can't cope.*

*She hadn't planned for this pregnancy – her other children (a girl and a boy) are aged 16 months and 3 years, and need a lot of attention. She is no longer breastfeeding her 16 month old. She has had one outpatient admission for treatment for malnutrition when she was 13 months old, about a month after Robel was born (she stopped breastfeeding her daughter about a month before he was born).*

ACT	RETURN TO MAMI ASSESSMENT FORM AND COMPLETE ASSESSMENT
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