



MAMI MATERNAL MENTAL HEALTH ASSESSMENT FORM

Basic Information			
Primary caregiver name	<i>Florence Okello</i>	ID no	<i>98765</i>
Infant name	<i>Rose Okello</i>	Date of assessment	<i>31-Jul - 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 checked="" type="checkbox"/> 2	<input 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:		2	6	3
	TOTAL ASSESSMENT SCORE:		11		
	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:

Florence is a first time mother and is 17 years old. Her baby was born low birthweight and she worries that she is small compared to the other babies. She is worried about her breastfeeding and feels she isn't doing a good job of caring for her baby.

ACT	RETURN TO MAMI ASSESSMENT FORM AND COMPLETE ASSESSMENT
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