Somatic mini Screen (SmS)

Name: …… date of birth: / / M / F
Do you use medication for mental health problems? O Yes O No
Do you use 7 or more medications in total of which 1 or more for mental health problems? O Yes O No
Do you use supplements and/ or medication without receipt from a doctor? Please, fill in below. (like vitamins, herbs, over the counter drugs or drugs bought on the internet)

.....

Do you have(had) one of the following conditions?				**Is this treated?**
Increased blood sugar	O No	O Yes in the present	O Yes In the past	O Yes O No
Increased cholesterol	O No	O Yes in the present	O Yes In the past	O Yes O No
High blood pressure	O No	O Yes in the present	O Yes In the past	O Yes O No
Hearth and vascular disease	O No	O Yes in the present	O Yes In the past	O Yes O No
Lung problems	O No	O Yes in the present	O Yes In the past	O Yes O No
Other.....	O No	O Yes in the present	O Yes In the past	O Yes O No

Does at least one of your (biological) father / mother / brothers / sisters / children have:

Diabetes	O Yes	O No	O I don't know
Increased cholesterol	O Yes	O No	O I don't know
Cardiovascular diseases (like thrombosis, congenital heart defects, acute cardiac death at a young age).	O Yes	O No	O I don't know
High blood pressure	O Yes	O No	O I don't know
Severe obesity	O Yes	O No	O I don't know
Other.....	O Yes	O No	O I don't know

How many <u>days a week</u> do you perform activities which make your heart rate and/ or breathing increase (such as brisk walking, bike riding, team sports or fitness)?
O none O 1-2 days a week O 3-5 days a week O > 5 days a week

How many <u>minutes a week</u> did you perform these activities during the past <u>month</u>?
…....minutes

How do you see your eating and drinking pattern?
O healthy O moderately healthy O unhealthy

Do you smoke?
O Yes, I smoke ….....number of cigarettes a day.
How many years did you smoke? ….....years.
O No, I never smoked.
O No, I stopped smoking.
How many years did you smoke? ….....years.
How much did you smoke? …... number of cigarettes a day.

How much alcohol did you drink per day during the <u>last two months</u>?
O I drank few or never alcohol
O I drank no more than a couple of glasses per week
O 1-2 glasses a day
O 3-5 glasses a day
O more than 5 glasses a day

Did you use weekly or more often (soft) drugs during <u>the past two months</u>? O Yes O No

To be completed by healthcare staff:	**To be completed by healthcare staff:**
Physical examination	**Laboratory research**
Lenght.....cm	Did you have your blood tested in the last 12 months during treatment in mental health care
Weight.....kg	
BMI.....	
Abdominal size.....cm	
Pulse/ per minute…….p/m	O Yes O No
Blood pressure……/……mmHg	

Somatic mini Screen (SmS)

Side effects

To what extent have you experienced the following syptoms in the past month?
Give a score between **0** and **4**:
0 = no discomfort, 4 = a great deal of discomfort.

						Do you think this symptom is a side effect of medication?		
	0	**1**	**2**	**3**	**4**	**Yes**	**No**	**Maybe**
Fatigue	O	O	O	O	O	O	O	O
Concentration difficulties	O	O	O	O	O	O	O	O
Memory disfunction	O	O	O	O	O	O	O	O
Feeling less emotions	O	O	O	O	O	O	O	O
Involuntary movements	O	O	O	O	O	O	O	O
Muscle stiffness	O	O	O	O	O	O	O	O
Slower in movement	O	O	O	O	O	O	O	O
Tremor	O	O	O	O	O	O	O	O
Restlessness / urge to move	O	O	O	O	O	O	O	O
Defecation problems	O	O	O	O	O	O	O	O
Urination problems	O	O	O	O	O	O	O	O
Increased sweating	O	O	O	O	O	O	O	O
Dizziness	O	O	O	O	O	O	O	O
Dry mouth/ thirst	O	O	O	O	O	O	O	O
Hypersalivation	O	O	O	O	O	O	O	O
Sexual dysfunction	O	O	O	O	O	O	O	O
Stomach problems	O	O	O	O	O	O	O	O
Change of weight	O	O	O	O	O	O	O	O
Other symptoms								
……	O	O	O	O	O	O	O	O
……	O	O	O	O	O	O	O	O

Of the mentioned symptoms, you are most troubled by: .....
How much discomfort does this cause you? Indicate on the scale below a point between 0 and 100.

(no discomfort) 0….....25.....50.....75.....100 (serious discomfort)