

MFIP Self-Screen



This information is available in other forms to people with disabilities by calling your county worker.
 For TTY/TDD users, contact your county worker through Minnesota Relay at 711 or (800) 627-3529.
 For Speech-to-Speech Relay, call (877) 627-3848.

Instructions: Sometimes people have problems that make it hard to do things they want to do. We would like to ask you some questions to see if you have these kinds of problems. Please think about only the last 30 days.

In the last 30 days, have you . . .	Please Circle	
1. Had a lot of trouble falling asleep or sleeping through the night?	Yes ₁	No
2. Been so tired or worn out that you couldn't get anything done?	Yes ₁	No
3. Failed to do what was normally expected from you because of drinking or drug use?	Yes ₃	No
4. Felt sad or depressed all or almost all of the time?	Yes ₁	No
5. Felt guilty or remorseful after drinking or using drugs?	Yes ₃	No
6. Been extremely restless or tense?	Yes ₁	No
7. Used alcohol or other drugs to cope with stress?	Yes ₃	No
8. Had a lot of trouble thinking, concentrating or making decisions?	Yes ₁	No
9. Had someone tell you about things you said or did while drinking or using drugs that you can't remember?	Yes ₃	No
10. Had thoughts that bother you that you can't get rid of?	Yes ₁	No
11. Heard voices in your head?	Yes ₃	No
12. Had nightmares or flashbacks about something that happened to you?	Yes ₂	No
13. Had angry outbursts that you could not control?	Yes ₂	No
14. Had periods of extreme fear when you were dizzy, sweating or shaking and felt like you were losing control?	Yes ₂	No
15. Thought about harming yourself or someone else?	Yes ₂	No
16. Tried to harm yourself or someone else?	Yes ₃	No

Counselor: Please fill in participant name and complete counselor information.

PARTICIPANT NAME	MAXIS CASE NUMBER
COUNSELOR NAME	COUNSELOR PHONE
AGENCY	DATE COMPLETED