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MENTAL HEALTH ASSESSMENT

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 1074f, Medical Tracking System for Members Deployed Overseas; 10 U.S.C. 1074m, Mental Health Assessments for Members of the Armed Forces Deployed in Support of a Contingency Operation; 10 U.S.C. 1074n, Annual Mental Health Assessments for Members of the Armed Forces; DoDI 6490.03, Deployment Health; DoDI 6490.12, Mental Health Assessments for Service Members Deployed in Connection with a Contingency Operation; and E.O. 9397 (SSN), as amended.
PURPOSE: Information is being collected from you in order to identify any mental health concerns and, if necessary, refer you for additional assessment and/or care.
ROUTINE USES: Use and disclosure of your records outside of DoD may occur in accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a(b)). Collected information may also be shared with entities including the Departments of Health and Human Services, Veterans Affairs, and other Federal, State, local, or foreign government agencies, or authorized private business entities. Additionally, information may be shared with the contractor responsible for management of the system. For a full listing of the Routine Uses, please refer to the applicable SORN. Any protected health information (PHI) in your records may be used and disclosed generally as permitted by the HIPAA Privacy Rule (45 CFR Parts 160 and 164), as implemented within DoD. Permitted uses and discloses of PHI include, but are not limited to, treatment, payment, and healthcare operations. For a full listing of the applicable Routine Uses for the system, refer to the applicable SORN.
APPLICABLE SORN: A0040-5A DASG DoD, Defense Medical Surveillance System (DMSS) (August 19, 2009, 74 FR 41877) is the system of records notice (SORN) applicable to DD 2978. The SORN can be found at: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/569970/a0040-5a-dasg-dod.aspx
DISCLOSURE: Voluntary. Care will not be denied if you decline to provide the requested information, but you may not receive the required care and may experience administrative delays.

INSTRUCTIONS: You are encouraged to answer all questions. You must at least complete the first portion on who you are and when and where you deployed. If you do not understand a question, please discuss the question with a health care provider.

This assessment applies to all required mental health assessments including those required in-theater or at the time of separation.

SECTION I. DEMOGRAPHICS

1. NAME *(Last, First, MI)*	2. DoD ID NUMBER	3. TODAY'S DATE *(DD/MMM/YYYY)*	4. DATE OF BIRTH *(DD/MMM/YYYY)*	5. GENDER ◯ MALE ◯ FEMALE

6. PURPOSE

◯ Post Deployment
Home station/unit _____
◯ In-Theater
◯ Other List: _____

7. SERVICE BRANCH

◯ Air Force
◯ Army
◯ Navy
◯ Marine Corps
◯ Coast Guard
◯ Civilian Expeditionary Workforce (CEW)
◯ USPHS
◯ Other Defense Agency List: _____

8. COMPONENT

◯ Active Duty
◯ National Guard
◯ Reserves
◯ Civilian Government Employee

9. PAY GRADE

◯ E1 ◯ E2 ◯ E3 ◯ E4 ◯ E5 ◯ E6 ◯ E7 ◯ E8 ◯ E9
◯ O1 ◯ O2 ◯ O3 ◯ O4 ◯ O5 ◯ O6 ◯ O7 ◯ O8 ◯ O9 ◯ O10
◯ W1 ◯ W2 ◯ W3 ◯ W4 ◯ W5 ◯ Other List: _____

10. PLEASE ANSWER ALL QUESTIONS BASED ON YOUR DEPLOYMENT.

Total deployments in past 5 years: ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 or more

Primary country of deployment

DATE DEPARTED THEATER *(DD/MMM/YYYY)*

Current contact information:

Phone:
Cell:
DSN:
Email:
Address:

Point of contact who can always reach you:

Name:
Phone:
Email:
Address:

Controlled by: DHA
CUI Category: PRVCY, HLTH
Distribution/Dissemination Control: FEDCON
POC: dha.ncr.bus-ops.mbx.dha-formsmanagement@mail.mil

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1.a. Over the PAST MONTH, which major life stressors, if any, have you experienced that are a cause of significant concern or make it difficult for you to do your work, take care of things at home, or get along with other people? Mark all that apply. ◯ None (Skip to 2)

◯ Legal ◯ Financial ◯ Spiritual ◯ Substance abuse (including alcohol) ◯ Family/relationship
◯ Employment ◯ Sleep ◯ Behavioral health ◯ Other, explain: _____

b. Are you currently in treatment or getting professional help for this concern? ◯ Yes ◯ No

2. In the PAST YEAR, did you receive care for any mental health condition or concern such as, but not limited to, post-traumatic stress disorder (PTSD), depression, anxiety disorder, alcohol abuse, or substance abuse?

◯ Yes ◯ No

If yes, please explain:

3. What prescription or over-the-counter medications (including herbals/supplements) for sleep, pain, combat stress, or a mental health problem are you CURRENTLY taking?

◯ Please list ◯ None

4. a. How often do you have a drink containing alcohol?

◯ Never ◯ Monthly or less ◯ 2-4 times a month ◯ 2-3 times per week ◯ 4 or more times a week

b. How many drinks containing alcohol do you have on a typical day when you are drinking?

◯ 1 or 2 ◯ 3 or 4 ◯ 5 or 6 ◯ 7 to 9 ◯ 10 or more

c. How often do you have six or more drinks on one occasion?

◯ Never ◯ Less than monthly ◯ Monthly ◯ Weekly ◯ Daily or almost daily

5. Have you ever had any experience that was so frightening, horrible, or upsetting that, in the PAST MONTH you:

a. Have had nightmares about it or thought about it when you did not want to? ◯ Yes ◯ No
b. Tried hard not to think about it or went out of your way to avoid situations that remind you of it? ◯ Yes ◯ No
c. Were constantly on guard, watchful or easily startled? ◯ Yes ◯ No
d. Felt numb or detached from others, activities, or your surroundings? ◯ Yes ◯ No
e. Felt guilt or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused? ◯ Yes ◯ No

NOTE: If three or more items on 5a. through 5e. are marked yes, continue to answer items 5f. through 5w.

Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please read each question carefully and check the box for how much you have been bothered by that problem in the PAST MONTH. Please answer all items.

	Not at all	A little bit	Moderately	Quite a bit	Extremely
f. Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?	◯	◯	◯	◯	◯
g. Repeated, disturbing dreams of a stressful experience from the past?	◯	◯	◯	◯	◯
h. Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?	◯	◯	◯	◯	◯
i. Feeling very upset when something reminded you of a stressful experience from the past?	◯	◯	◯	◯	◯
j. Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful experience from the past?	◯	◯	◯	◯	◯
k. Avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it?	◯	◯	◯	◯	◯
l. Avoid activities or situations because they remind you of a stressful experience from the past?	◯	◯	◯	◯	◯
m. Trouble remembering important parts of a stressful experience from the past?	◯	◯	◯	◯	◯
n. Loss of interest in things that you used to enjoy?	◯	◯	◯	◯	◯
o. Feeling distant or cut off from other people?	◯	◯	◯	◯	◯
p. Feeling emotionally numb or being unable to have loving feelings for those close to you?	◯	◯	◯	◯	◯
q. Feeling as if your future will somehow be cut short?	◯	◯	◯	◯	◯
r. Trouble falling or staying asleep?	◯	◯	◯	◯	◯
s. Feeling irritable or having angry outbursts?	◯	◯	◯	◯	◯
t. Having difficulty concentrating?	◯	◯	◯	◯	◯
u. Being “super alert” or watchful, on guard?	◯	◯	◯	◯	◯
v. Feeling jumpy or easily startled?	◯	◯	◯	◯	◯

	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
w. How difficult have these problems (5f. through 5v.) made it for you to do your work, take care of things at home, or get along with other people?	◯	◯	◯	◯

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6. Over the LAST 2 WEEKS, how often have you been bothered by the following problems?

	Not at all	Few or several days	More than half the days	Nearly every day
a. Little interest or pleasure in doing things	◯	◯	◯	◯
b. Feeling down, depressed, or hopeless	◯	◯	◯	◯

NOTE: If 6a. or 6b. are marked "More than half the days" or "Nearly every day," continue to answer items 6c. through 6i.

Over the LAST 2 WEEKS, how often have you been bothered by any of the following problems?	Not at all	Few or several days	More than half the days	Nearly every day
c. Trouble falling/staying asleep, sleeping too much.	◯	◯	◯	◯
d. Feeling tired or having little energy.	◯	◯	◯	◯
e. Poor appetite or overeating.	◯	◯	◯	◯
f. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	◯	◯	◯	◯
g. Trouble concentrating on things, such as reading the newspaper or watching television.	◯	◯	◯	◯
h. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you could have been moving around a lot more than usual.	◯	◯	◯	◯
	Not at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
i. How difficult have these problems (6a. through 6h.) made it for you to do your work, take care of things at home, or get along with other people?	◯	◯	◯	◯

7. Would you like to schedule an appointment with a health care provider to discuss any health concern(s)? ◯ Yes ◯ No

8. Are you interested in receiving information or assistance for a stress, emotional, or alcohol concern? ◯ Yes ◯ No

9. Are you interested in receiving assistance for a family or relationship concern? ◯ Yes ◯ No

10. Would you like to schedule a visit with a chaplain, mental health care provider, or a community support counselor? ◯ Yes ◯ No

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SECTION II. Health Care Provider Only – Provider Review, Interview, Assessment, and Recommendations:

I. MENTAL HEALTH ASSESSMENT (MHA) PROVIDER INFORMATION

1. Last Name:	2. First Name:	3. Middle Name:

4. Service Branch

- ◯ Air Force
- ◯ Army
- ◯ Navy
- ◯ Marine Corps
- ◯ Coast Guard
- ◯ U.S. Public Health Service
- ◯ Other (e.g., RHRP contractor)

5. Status

- ◯ Active Duty
- ◯ Traditional Guardsman
- ◯ Reservist
- ◯ Active Guard Reserve or Full-time Support
- ◯ Civilian Government Employee
- ◯ Civilian Contractor
- ◯ Other (List): _____

6. Select the appropriate title.

- ◯ Physician (MD, DO)
- ◯ Nurse Practitioner (NP)
- ◯ Physician Assistant (PA)
- ◯ Advance Practice Nurse (Clinical Nurse Specialist)
- ◯ Independent Duty Corpsman
- ◯ Independent Duty Medical Technician
- ◯ Independent Duty Health Services Technician
- ◯ Special Forces Medical Sergeant
- ◯ Clinical Psychologist
- ◯ Other Licensed Mental Health Professional

7. Email:	8. Facility:		9. Unit:
10. Address:	**11. State:**	**12. ZIP Code:**	**13. Phone (Commercial):**

Deployer reports most recent deployment was to _____ and has deployed _____ times before in the past five years.

1. Major life stressor as reported on Deployer question 1.

a. Did Deployer mark they have a concern or a difficulty with a major life stressor?

◯ Yes ◯ No (*go to block 2)* ◯ Not answered by Deployer

If yes, Deployer's concern:

b. If yes, ask additional questions to determine level of problem:

c. Consider need for referral. Referral indicated?

◯ Yes (complete blocks 9 and 10) ◯ No

- ◯ *Already under care*
- ◯ *Already has referral*
- ◯ *No significant impairment*
- ◯ *Other reason (explain)*

2. Address concerns as reported in Deployer questions 2 and 3.

Deployer Question	Not Answered	Yes Response	Deployer's Response	Provider Comments *(if indicated)*
History of mental health care	◯	◯		
Medications	◯	◯		

3. Alcohol use as reported in Deployer question 4.

a. Deployer's AUDIT-C screening score was _____. *(If score between 0-4 (men) or 0-3 (women) nothing required, go to block 4).*

◯ Not answered by Deployer

Number of drinks per week: _____ Maximum number of drinks per occasion: _____

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Based on the AUDIT-C score and assessment of alcohol use, follow the guidance below:

Alcohol Use Intervention Matrix

Assess Alcohol Use	AUDIT-C Score Men 5-7 and Women 4-7	AUDIT-C Score Men and Women ≥ 8
Alcohol use WITHIN recommended limits: Men: ≤ 14 drinks per week **OR** ≤ 4 drinks on any occasion Women: ≤ 7 drinks per week **OR** ≤ 3 drinks on any occasion	Advise patient to stay below recommended limits	Refer if indicated for further evaluation AND conduct BRIEF counseling*
Alcohol use EXCEEDS recommended limits: Men: > 14 drinks per week or > 4 drinks on any occasion Women: > 7 drinks per week or > 3 drinks on any occasion	Conduct BRIEF counseling* AND consider referral for further evaluation	

* **BRIEF** counseling: Bring attention to elevated level of drinking; Recommend limiting use or abstaining; Inform about the effects of alcohol on health; Explore and help/support in choosing a drinking goal; Follow-up referral for specialty treatment, if indicated.

b. Referral indicated for evaluation?

◯ Yes (complete blocks 9 and 10) ◯ No, Provide education/awareness as needed. State reason if AUDIT-C score was 8+:

◯ *Already under care* ◯ *Other reason (explain):*

◯ *Already has referral*

◯ *No significant impairment*

4. PTSD screening as reported in Deployer question 5.

a. Did Deployer mark yes on three or more of questions 5a through 5e? ◯ **Yes** ◯ No (go to block 5) ◯ Not answered by Deployer

b. If yes, Deployer's responses to questions 5f. through 5v. resulted in a PCL-C score of _____ and the Deployer's response to level of impairment with life events (5w.) is indicated in the table below.

◯ 5e. through 5w. were not answered or are incomplete.

Based on the PCL-C score, the Deployer's level of functioning, and your exploration of responses, follow the guidance below:

Post-Traumatic Stress Disorder Intervention Matrix

Self-Reported Level of Functioning	**PCL-C Score <30** (Sub-threshold or no Symptoms)	**PCL-C Score 30-39** (Mild Symptoms)	**PCL-C Score 40-49** (Moderate Symptoms)	**PCL-C Score ≥ 50** (Severe Symptoms)
◯ Not Difficult at All or Somewhat Difficult	No intervention	Provide PTSD education*		Consider referral for further evaluation AND provide PTSD education*
◯ Very Difficult to Extremely Difficult	Assess need for further evaluation AND provide PTSD education*	Consider referral for further evaluation AND provide PTSD education*		Refer for further evaluation AND provide PTSD education*

* PTSD Education = Reassurance/supportive counseling, provide literature on PTSD, encourage self-management activities, and counsel Deployer to seek help for worsening symptoms.

c. Referral indicated? ◯ Yes (complete blocks 9 and 10) ◯ No

◯ *Already under care* ◯ *Other reason (explain):*

◯ *Already has referral*

◯ *No significant impairment*

5. Depression screening as reported in Deployer question 6.

a. Did Deployer mark "More than half the days" or "Nearly every day" on question 6a. or 6b.?

◯ Yes

◯ No *(go to block 6)*

◯ Not answered by Deployer

b. If yes, Deployer's responses to questions 6a. - 6h. resulted in a total PHQ-8 score of _____ and the Deployer's response to level of impairment with life events (6i.) is indicated in the table below.

◯ 6c. through 6i. were not answered or incomplete

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Based on the PHQ-8 score, Deployer's level of functioning, and exploration of responses, follow the guidance below:

Depression Intervention Matrix

Self-Reported Level of Functioning	**PHQ-8 Score 1-4** (No Symptoms)	**PHQ-8 Score 5-9** (Sub-Threshold Symptoms)	**PHQ-8 Score 10-14** (Mild Symptoms)	**PHQ-8 Score 15-18** (Moderate Symptoms)	**PHQ-8 Score 19-24** (Severe Symptoms)
◯ Not Difficult at All or Somewhat Difficult	No intervention	Depression education*		Consider referral for further evaluation AND provide depression education*	Consider referral for further evaluation AND provide depression education*
◯ Very Difficult to Extremely Difficult	Assess need for further evaluation AND provide depression education*		Consider referral for further evaluation AND provide depression education*	Consider referral for further evaluation AND provide depression education*	Refer for further evaluation AND provide depression education*

* Depression Education = Reassurance/supportive counseling, provide literature on depression, encourage self-management activities, and counsel Deployer to seek help for worsening symptoms.

c. Referral indicated? ◯ Yes (complete blocks 9 and 10) ◯ No

◯ *Already under care* ◯ *Other reason (explain):*

◯ *Already has referral*

◯ *No significant impairment*

6. Suicide risk evaluation

a. **Ask** "Over the PAST MONTH, have you wished you were dead or wished you could go to sleep and not wake up?" ◯ Yes ◯ No

b. **Ask** "Have you actually had any thoughts of killing yourself?" ◯ Yes ◯ No (go to question 6.f.1)

c. **Ask** "Over the PAST MONTH, have you been thinking about how you might do this?" ◯ Yes ◯ No

d. **Ask** "Over the PAST MONTH, have you had these thoughts and had some intention of acting on them?" ◯ Yes ◯ No

e.1. **Ask** "Over the PAST MONTH, have you started to work out or worked out the details of how to kill yourself?" ◯ Yes ◯ No (skip to 6.f.1)

e.2. **Ask** "At any time in the PAST MONTH, did you intend to carry out this plan?" ◯ Yes ◯ No

f.1. **Ask** "In your lifetime, have you ever done anything, started to do anything, or prepared to do anything to end your life?" ◯ Yes ◯ No (skip to 6.g.)

f.2. **Ask** "Was this within the past three months?" ◯ Yes ◯ No

g. **Conduct further risk assessment** (e.g., interpersonal conflicts, social isolation, alcohol/substance abuse, hopelessness, severe agitation/anxiety, diagnosis of depression or other psychiatric disorder, recent loss, financial stress, legal disciplinary problems, or serious physical illness).

Comments:

h. Does Deployer pose a current risk of harm to self? ◯ Yes (complete blocks 9 and 10) ◯ No

7. Violence/harm risk evaluation.

a. **Ask,** "Over the past month have you had thoughts or concerns that you might hurt or lose control with someone?"

◯ Yes ◯ No *(go to block 8)*

If yes, **ask** additional questions to determine extent of problem (target, plan, intent, past history). Comments:

b. Does Deployer pose a current risk to others?

◯ Yes (complete blocks 9 and 10) ◯ No(briefly state reason):

8. Deployer issues with this assessment *(mark as appropriate)*:

◯ Deployer declined to complete form

◯ Deployer declined to complete interview/assessment

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Assessment and Referral: After review of Deployer's responses and interview with the Deployer, the assessment and need for further evaluation is indicated in blocks 9 through 12.

9. Summary of provider's identified concerns needing referral (Mark all that apply)	Yes	No
a. None Identified ◯		
b. Physical health	◯ Yes	◯ No
c. Dental health	◯ Yes	◯ No
d. Mental health symptoms	◯ Yes	◯ No
e. Alcohol use	◯ Yes	◯ No
f. PTSD symptoms	◯ Yes	◯ No
g. Depression symptoms	◯ Yes	◯ No
h. Environment/work exposure	◯ Yes	◯ No
i. Risk of self-harm	◯ Yes	◯ No
j. Risk of violence	◯ Yes	◯ No
k. Other, list:	◯ Yes	◯ No

10. Recommended referral(s) (Mark all that apply even if Deployer does not desire)	Within 24 hours	Within 7 days	Within 30 days
a. Primary Care, Family Practice, Internal Medicine	◯	◯	◯
b. Behavioral Health in Primary Care	◯	◯	◯
c. Mental Health Specialty Care	◯	◯	◯
d. Dental	◯	◯	◯
e. Other specialty care:	◯	◯	◯
Audiology	◯	◯	◯
Dermatology	◯	◯	◯
OB/GYN	◯	◯	◯
Physical Therapy	◯	◯	◯
TBI/Rehab Med	◯	◯	◯
Podiatry	◯	◯	◯
Other, list	◯	◯	◯
f. Case Manager / Care Manager	◯	◯	◯
g. Substance Abuse Program	◯	◯	◯
h. Other, list:	◯	◯	◯

11. Comments *(if indicated)*

12. Address requests as reported on Deployer questions 7 through 10.

Deployer question	Not answered	Yes response	Comments (if indicated)
Request medical appointment	◯	◯	
Request info on stress/emotional/alcohol	◯	◯	
Family/relationship concern assistance	◯	◯	
Chaplain/mental health care provider/ counselor visit request	◯	◯	

13. Supplemental services recommended / information provided

◯ Appointment Assistance:	◯ Family Support
◯ Contract Support:	◯ Military One Source
◯ Community Service:	◯ TRICARE Provider
◯ Chaplain	◯ VA Medical Center or Community Clinic
◯ Health Education and Information	◯ Veteran's Center
◯ Health Care Benefits and Resources Information	◯ Other, list: _____
◯ In Transition	◯ No Supplemental Services Required

◯ I hereby certify that the Mental Health Assessment process has been completed.

Mental Health Assessment (MHA) Provider Digital Signature	Date Completed (dd/mmm/yyyy):