Family ID _____

Modified IPSS Screening tool

The following questions are asked to identify possible serious mental illness in the family. Please enquire and probe gently to the key informant. For positive responses to items , enter Id No. (Sr.no) & name of Individual

[You have given information about people living in your household. Can you now tell me if any one of them ….]

1. * has become very quiet and does not talk to people?

2. * is upset, talk's nonsense and acts in a strange manner?

3. * claims to hear voices or see things others cannot hear or see?

4. * is very suspicious and claims that some people are trying to harm him?

5. gets possessed by evil spirits or ghost?

6. has become unusually cheerful, makes jokes and brags that he is a big man, when he is not really so?

7. has become sad lately, and cries without reason?

8. has tried to commit suicide?

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9. * has been unkempt, needs supervision for bathing , eating etc ?

10. * is not earning & refusing to work regularly or discontinued or lost a job due to mental problems?

11. * is slow in all activities, does not leave the house, avoids social functions (marriage, temple festivals etc)

12. has suffered or has problems in marriage due to mental illness ?

13. Who has always from birth been dull and shown delay in speech &growth , failure in school etc?

14. drinks too much or gambles too much or has other bad habits?

15. suffers from fits or loss of consciousness?

16. has lost his memory, or is losing his memory?

17. is suspected of being mentally unwell?

18. Have relatives or neighbors in the village commented that he is crazy or mad?

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19. * has taken treatment or admitted in the hospital for any of the above mentioned conditions?

If any of the symptoms are present in any individual then continue interview with informant and collect remaining details in the Family Performa

*** Items are indicative of Psychoses. If any * symptoms have been identified then complete following section**

1. Age of patient (yrs):
2. Sex of the patient (male=1, female=2)
3. Age of onset
4. Age at first treatment
5. Current mental state – Has the patient been in a psychotic episode in the last 30days?
   0=no,
   1=yes, still in episode of inclusion,
   2=yes, but not continuous with episode of inclusion, 8=impossible to assess(specify reason),
   9=no information/not known.

6. Remissions- Has the patient had a remission of psychotic symptoms for a period of at least 30 days since the initial evaluation ?
   0=no,
   1=yes
   8=impossible to assess.

7. Relapse episodes- How many discrete psychotic episodes (not including the inclusion) has the patient had since the initial evaluation? (Each psychotic episode must be separated by at least 30 days spent in remission)
   No. of episodes :
   00 =Patient presently in remission from episode of inclusion
   88= patient still in episode of inclusion
   99=not known/impossible to assess.

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8. Current treatment status –Pt's treatment status at the time of this examination?(only allopathic treatment)
   0= Never treated
   1=Discontinued treatment (specify reason)
   2=Compliant on prescribed medication
   3=taking drugs on and off.

9. Date of last treatment

10. Type of treatment taken in the past :
    1 = psychiatric medication
    2= Alternative medication
    3= magico-religious
    4 = No treatment

11. Pattern of course- Which of the following patterns of course best describe the patient's condition since the initial evaluation?
    0= complete or near complete recovery without relapses or exacerbations
    1=no relapses or exacerbations of psychotic symptoms but with residual personality change
    2= one or more relapses or acute exacerbations of psychotic symptoms with full or nearly full remissions
    3 = one or more relapses or exacerbations of psychotic symptoms against a background of marked personality change
    4=continuous psychotic illness
    9=impossible to assess

12. Medical History: Patient's physical health since the index episode.
    0= no serious medical problems
    1= has had atleast one serious medical problem (HTN, DM, Stroke, MI)
    9=no information/not known

13. Suicide attempts: Rate the number of suicide attempts by the patient since index episode evaluation.
    0=none
    9=no information/not known.

14. Alcohol Consumption: Rate the patient's drinking habits since the index episode evaluation.
    0=does not drink at all,
    1=occasional social drinking,
    2=moderate alcohol use,
    3=serious alcohol problem suspected
    4=clear evidence of serious alcohol problem,
    9=no information /not known.

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15. Rate use of illicit drug taking or abuse of licit drugs. 0=none at all,
    1=sporadic drug taking (less than once a month), 2=Occasional abuses (more than once a month)
    3=regular or frequent pattern of drug –taking
    4= periodic binges
    7=drug taking a definite possibility but impossible to assess the frequency or extent of use
    9=no information/not known.

16. Life events involving pt, family and house hold members (marriage, birth, death, health problems, loss of job, housing, police or legal issues)
    0=no
    1=yes
    8=inapplicable
    9=no information/not known.