IOC SMHAT2 | The International Olympic Committee Sport Mental Health Assessment Tool 2
Developed by the IOC Mental Health Working Group

International Olympic Committee

ATHLETE'S NAME: .....

ATHLETE'S ID NUMBER: .....

DATE: .....

2

ATHLETE FORM 2

Screening 8

Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example, a serious accident or fire, a physical or sexual assault or abuse, an earthquake or flood, a war, seeing someone be killed or seriously injured, or having a loved one die through homicide or suicide. Please respond to the following question by circling 'yes' or 'no'.

Have you ever experienced this kind of an event?		No	Yes
If yes, did the event occur inside or outside of sport?	Inside	Outside	Both

If you have not experienced one or more of these events, then stop here with Screening 8 and please go to Screening 9.
If you have experienced an event or events like this, please circle your answer to the following 5 questions.

	No	Yes
1. In the past month, have you had nightmares about the event(s) or thought about the event(s) when you did not want to?	0	1
2. In the past month, have you tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)?	0	1
3. In the past month, have you been constantly on guard, watchful, or easily startled?	0	1
4. In the past month, have you felt numb or detached from people, activities, or your surroundings?	0	1
5. In the past month, have you felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the events may have caused?	0	1

Screening 9

The following questions are about drug(s) use in the last 3 months. Please respond to each question by circling 'yes' or 'no'. When thinking about drug use consider legal ones like caffeine or nicotine, illicit/illegal drugs (including cannabis even if legal in your state/country) and prescription medications used in ways other than prescribed (i.e., higher dosages; different ways of taking them, i.e., crushing/sniffing, injecting). Do NOT include alcohol in these responses.

	No	Yes
1. In the last three months, have you felt you should cut down or stop using drugs?	0	1
2. In the last three months, has anyone annoyed you or gotten on your nerves by telling you to cut down or stop using drugs?	0	1
3. In the last three months, have you felt guilty or bad about how much you use drugs?	0	1
4. In the last three months, have you been waking up wanting to use drugs?	0	1

In the last 3 months, which drug(s) or substance(s) listed below caused concerns or problems in your life? Concerns may include drug-related stress, depression, insomnia, financial strain, relationship conflict, heavy use/overdose, cravings, withdrawal, blackouts, flashbacks, fights, arrests, missed work, and/or medical problems like hepatitis, seizures or weight loss. Please circle all that apply.

None	Caffeine	Tobacco/Nicotine	Cannabis/Marijuana
Synthetic Cannabis (e.g., K2, Spice)	Prescription Stimulants (e.g., ADD, ADHD Medications)	Prescription Opioids-Pain (e.g., oxycodone, hydrocodone)	Other – Specify