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: .....

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ATHLETE FORM 1

Screening 1

The following questions relate to feeling anxious or stressed. Over the last 2 weeks, how often have you been bothered by the following problems? Please circle the answer that best represents how you have been.

	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Screening 2

The following questions relate to feeling depressed, sad or blue. Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle the answer that best represents how you have been.

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you're a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or, the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Screening 3

	No	Yes
Have you used cannabis/marijuana-containing products (e.g., vapes, concentrates, edibles, joints, blunts, pills, oils, capsules, sprays, creams, K1, spice) or related products (synthetic cannabis) in the last 6 months?	0	1

Screening 4

	No	Yes
Have you used any tobacco (e.g., cigarettes, cigars, pipes, snuff, snus, chew, hooka) or nicotine-containing products (e.g., electronic-cigarettes, vapes, pouches, gum, lozenges, inhaler, nasal spray) in the last 6 months?	0	1



Screening 5

The following questions relate to your sleep habits. Please circle the best answer which you think represents your typical sleep habits over the recent past.

	5-6 hours	6-7 hours	7-8 hours	8-9 hours	more than 9 hours
1. During the recent past, how many hours of actual sleep did you get at night? (This may be different than the number of hours you spent in bed.)	4	3	2	1	0

	very satisfied	somewhat satisfied	neither satisfied nor dissatisfied	somewhat dissatisfied	very dissatisfied
2. How satisfied/dissatisfied are you with the quality of your sleep?	0	1	2	3	4

	15 minutes or less	16-30 minutes	31-60 minutes	longer than 60 minutes
3. During the recent past, how long has it usually taken you to fall asleep each night?	0	1	2	3

	never	once or twice per week	three or four times per week	five to seven times per week
4. How often do you have trouble staying asleep?	0	1	2	3
5. During the recent past, how often have you taken medicine to help you sleep (prescribed or over-the-counter)?	0	1	2	3

Screening 6

On how many of the past 7 days...

	0 days	1-2 days	3-5 days	6-7 days
1. Have you been deliberately trying to limit the amount of food you eat to influence your weight or shape (whether or not you have succeeded)?	0	1	2	3
2. Have you gone for long periods of time (e.g., 8 or more waking hours) without eating anything at all in order to influence your weight or shape?	0	1	2	3
3. Has thinking about food, eating or calories made it very difficult to concentrate on things you are interested in (such as working, following a conversation or reading)?	0	1	2	3
4. Has thinking about your weight or shape made it very difficult to concentrate on things you are interested in (such as working, following a conversation or reading)?	0	1	2	3
5. Have you had a definite fear that you might gain weight?	0	1	2	3
6. Have you had a strong desire to lose weight?	0	1	2	3
7. Have you tried to control your weight or shape by making yourself sick (vomit) or taking laxatives?	0	1	2	3
8. Have you exercised in a driven or compulsive way as a means of controlling your weight, shape or body fat, or to burn off calories?	0	1	2	3
9. Have you had a sense of having lost control over your eating (at the time that you were eating)?	0	1	2	3
10. On how many of these days (i.e. days on which you had a sense of having lost control over your eating) did you eat what other people would regard as an unusually large amount of food in one go?	0	1	2	3

Over the past 7 days...

	Not at all	Slightly	Moderately	Markedly
11. Has your weight or shape influenced how you think about (judge) yourself as a person?	0	1	2	3
12. How dissatisfied have you been with your weight or shape?	0	1	2	3



Screening 7

The following questions are about alcohol use. Please respond to each question by circling the number from '0' to '4' that represents your alcohol use.

	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week
1. How often do you have a drink containing alcohol?	0 (skip to question 9)	1	2	3	4

	1-2	3-4	5-6	7-9	10 or more
2. How many standard drinks containing alcohol do you have on a typical day when you drink?	0	1	2	3	4

	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
3. How often do you have six or more drinks on one occasion?	0	1	2	3	4
4. How often during the last year have you found that you were not able to stop drinking once you had started?	0	1	2	3	4
5. How often during the last year have you failed to do what was normally expected from you because of drinking?	0	1	2	3	4
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	0	1	2	3	4
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	0	1	2	3	4
8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?	0	1	2	3	4

	No	Yes, but not in the last year	Yes, during the last year
9. Have you or someone else been injured as a result of your drinking?	0	2	4
10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down?	0	2	4