

# Mind-Skin Health Index

Hospital No:

Date:

Score:

**MSHI**

Name:

Diagnosis:

**/54**

This questionnaire assesses how **your condition has affected you OVER THE PAST MONTH**. Please select the option that **best describes your experience**. Each question is scored from 0 (**Not at all**) to 3 (**Severe/very often**). Add the scores from Questions 1–18 to calculate your total score (**maximum 54**). Ensure **all questions** are answered. *Important:* If you selected any option other than “0” on **Question 15**, please inform your clinician.

		Not at all	Mild/ occasional	Moderate /often	Severe/ very often
1	How often do you feel <b>distressed</b> about the <b>appearance of your condition</b> ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	How often do <b>concerns</b> about your condition <b>interfere</b> with your <b>sleep</b> ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	How often do <b>concerns</b> about your condition <b>interfere</b> with your ability to engage in <b>everyday physical activities</b> (e.g., walking, running, climbing stairs, exercising)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	How often have you <b>avoided</b> attending <b>social events or gatherings</b> because you were concerned about your appearance related to your condition?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	How often do you find it <b>difficult</b> to manage your <b>routine daily tasks</b> (e.g., dressing, bathing, shopping, cooking) because of your condition?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	How often do you feel the <b>need to consult a healthcare provider</b> (e.g., general/nurse practitioner, psychologist, psychiatrist, dermatologist, specialist) about your condition?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	How often do concerns about your condition interfere with your ability to <b>concentrate</b> or <b>function at work, school, or volunteer activities</b> ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	How often do you <b>feel judged by others</b> because of your condition?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	How often does your condition affect your <b>intimate relationships</b> ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	How often do you feel like your condition is <b>hopeless</b> and will <b>never improve</b> ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	How often do you feel <b>worried, anxious, or fearful</b> because of your condition or its symptoms?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12	How often do you experience <b>unwanted thoughts, images, or impulses</b> related to your condition that <b>repeatedly enter your mind</b> , despite trying to get rid of them?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13	How often do you feel <b>down, depressed, or hopeless</b> ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14	How often do you have <b>little interest or pleasure</b> in doing things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15	In the <b>past month</b> , how often do you experience any thoughts about <b>not wanting to live, harming yourself, or harming others</b> because of the impact of your condition?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16	How often do you <b>pick or scratch at your skin, bite your nails, or tear at the skin around your nails</b> in a way that causes discomfort, soreness, bleeding, scabbing, or visible damage?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17	How often do you <b>pull out your hair, eyebrows, or eyelashes</b> in a way that causes noticeable hair loss or discomfort?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18	How often do you experience the <b>sensation</b> that something (e.g., insects, parasites, fibers, or other sensations) is <b>under your skin</b> ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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