Mental Health Assessment Form Online

Personal Information

- **Full Name: _____**
- **Date of Birth (DD/MM/YYYY): _____**
- **Gender: _____**
- **Contact Email: _____**
- **Phone Number: _____**
- **Date of Assessment: _____**

Assessment Details

1. **Have you been feeling anxious or on edge in the past two weeks?**
    - ☐ **Yes**
    - ☐ **No**
2. **How often have you felt down, depressed, or hopeless in the last two weeks?**
    - ☐ **Never**
    - ☐ **Occasionally**
    - ☐ **Frequently**
    - ☐ **All the time**
3. **Have you experienced any sleep disturbances recently (insomnia, excessive sleeping)?**
    - ☐ **Yes**
    - ☐ **No**
4. **Are you having difficulty concentrating on tasks?**
    - ☐ **Yes**
    - ☐ **No**

Self-Rating for Mental Health (1-10)

- **Please rate your mental health: _____**

Additional Comments

- _____
- _____

Signature (Digital if online)

- **Signature: _____**
- **Date: _____**