**Mental Health Assessment Form for Adults**

**horizontal line**

**Patient Information**

* **Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Date of Assessment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Current Mental Health Concerns**

1. **How often have you felt overwhelmed or unable to cope?**
   * **☐ Often**
   * **☐ Sometimes**
   * **☐ Rarely**
   * **☐ Never**
2. **Have you experienced panic attacks?**
   * **☐ Yes**
   * **☐ No**
3. **How often do you have trouble concentrating?**
   * **☐ Often**
   * **☐ Sometimes**
   * **☐ Rarely**
   * **☐ Never**
4. **Have you experienced persistent feelings of sadness or depression?**
   * **☐ Yes**
   * **☐ No**

**Daily Functioning and Social Behavior**

| **Symptoms/Behaviors** | **Often** | **Sometimes** | **Rarely** | **Never** |
| --- | --- | --- | --- | --- |
| **Difficulty completing tasks** | **☐** | **☐** | **☐** | **☐** |
| **Avoiding social interactions** | **☐** | **☐** | **☐** | **☐** |
| **Feeling fatigued or low energy** | **☐** | **☐** | **☐** | **☐** |
| **Sudden changes in appetite or weight** | **☐** | **☐** | **☐** | **☐** |

**Additional Comments**

**Signature of Patient**

* **Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**