Mental Health Assessment Form for Adults

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**

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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: ____**

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