

Mental Health Assessment Form for Child

Child's Information

- Full Name: _____
- Date of Birth: _____
- Age: _____
- School Name: _____
- Parent/Guardian Name: _____
- Contact Number: _____

Behavioral and Emotional Concerns

1. Has your child shown signs of mood swings?
 - Yes
 - No
2. Has your child had difficulty focusing on schoolwork?
 - Yes
 - No
3. How often does your child seem anxious or worried?
 - Often
 - Sometimes
 - Rarely
 - Never
4. Does your child have trouble sleeping or frequent nightmares?
 - Yes
 - No

Social and Developmental Factors

Areas of Concern	Often	Sometimes	Rarely	Never
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Difficulty making friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Outbursts of anger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble following rules	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shy or withdrawn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Parent/Guardian Comments

- _____
- _____

Signature of Parent/Guardian

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