

J.P. Laurel Avenue, Diliman, Quezon City

NAME:

DATE OF BIRTH:

AGE:

College:

NAME OF PARENT/GUARDIAN/SPOUSE:

CONTACT NO.:

Have you ever had, or do you have any of the following? Please answer YES or NO and give the details.

[illegible]

Describe any other important health-related information about you.

List all prescriptions and over-the-counter medications you are currently taking.

Do you have any immediate health concerns that you think may affect your studies? Please specify.

MENTAL HEALTH SCREENING RESULT

GAD-7 SCORE:

PHQ-9 SCORE:

REMARKS:

Name and Signature of Physician