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**

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: _____**