

Mental Health Checklist

Personal Information

Name: _____ Date: _____

Age: _____ Gender: _____

Contact Information: _____

Instructions

Please take a few moments to complete the checklist below. For each question, mark the column that best describes how often you felt or experienced each particular statement in the past four weeks. Your answers are for self-reflection and discussion with healthcare providers and should be honest.

In the past four weeks...

Question	None of the time	A little of the time	Some of the time	Most of the time	All of the time
How often did you feel tired out for no good reason?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often did you feel nervous?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often did you feel so nervous that nothing could calm you down?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often did you feel hopeless?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often did you feel restless or fidgety?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How often did you feel so restless you could not sit still?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often did you feel depressed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often did you feel that everything was an effort?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often did you feel so sad that nothing could cheer you up?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often did you feel worthless?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often did you have trouble sleeping?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often did you feel overwhelmed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often did you feel isolated or lonely?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often did you experience unexplained physical symptoms?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often did you feel mentally sharp and focused?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How often did you feel you had someone to talk to about your problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often did you feel that you couldn't cope with your problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often did you experience mood swings?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often did you feel optimistic about the future?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often did you feel irritated or angry for no apparent reason?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often did you engage in activities that you enjoy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How to Interpret Your Answers

Once you have filled out this checklist, review your answers. If you find multiple instances where you have marked "Most of the time" or "All of the time" for questions that indicate potential distress or emotional difficulty, consider consulting a healthcare provider for a comprehensive mental health assessment.

Similarly, notice that you frequently marked "None of the time" or "A little of the time" for positive aspects of mental well-being, like feeling optimistic or focused. This might also be a sign that speaking with a healthcare provider would be beneficial.

Remember, this checklist is designed to help you gain insight into your mental well-being and to facilitate discussions with healthcare providers. It is not a diagnostic tool and should not replace professional medical advice.