Chronic Illness Mental Health Assessment Form

Personal Information

Full Name

Date of Birth

Primary Chronic Illness

Duration of Illness (years)

Mental Health Assessment

In the past month, how often have you felt anxious or stressed?

- Never
- Sometimes
- Often
- Always

How would you rate your mood most days?

- Good
- Neutral
- Low

Do you have difficulty sleeping?

- Yes
- No

Have you experienced any of the following? (Select all that apply)

- Fatigue
- Loss of interest
- Appetite changes
- Irritability

Other symptoms or concerns

Coping & Support

How would you describe your current support system?

What coping strategies do you use?

Additional Comments