Employee Mental Health Screening Form

Personal Information

Full Name

Email

Department

Date

Mental Health Screening

1. How often have you felt stressed at work recently?

- ○ Never
- ○ Rarely
- ○ Sometimes
- ○ Often
- ○ Always

2. In the past two weeks, have you experienced any of the following? (Select all that apply)

- ☐ Anxiety
- ☐ Low Mood
- ☐ Sleep Issues
- ☐ Fatigue
- ☐ None

3. Do you feel comfortable discussing mental health concerns at work?

- ○ Yes
- ○ No
- ○ Unsure

4. Is there anything else you would like to share about your mental well-being?