Mental Health and Wellness Screening Form

Please complete this section to help us better understand your overall health, including your mental well-being, which plays a significant role in your oral health. All responses are confidential and will only be used to provide the best care for you.

1. Over the past two weeks, how often have you been bothered by any of the following? (Check one response for each item)

	Not at All	Several Days	More than Half the Days	Nearly Every Day
Feeling nervous, anxious, or on edge				
Feeling down, depressed, or hopeless				
Trouble sleeping or staying asleep				
Feeling tired or having little energy				
Having thoughts of suicide or self-harm				

2. Do you currently take any medications for mental health conditions (e.g., anxiety, depression, mood stabilization)?

[ ] Yes

Please list: _____

[ ] No

3. In the past year, have you experienced any of the following? (Check all that apply)

[ ] Excessive stress or overwhelming feelings

[ ] Difficulty concentrating or making decisions

[ ] Changes in appetite or weight

[ ] Loss of interest in activities you usually enjoy

4. Do you feel your mental health has impacted your ability to care for your oral health (e.g., brushing, flossing, regular dental visits)?

[ ] Yes

[ ] No

[ ] Not Sure

5. Would you like resources or support related to mental health?

[ ] Yes, please provide resources

[ ] No, I'm not interested at this time

Patient Consent and Acknowledgment

I acknowledge that the information provided above is accurate to the best of my knowledge and that I understand the relationship between mental health and oral health.

Signature: _____ Date: _____