**Child's Name: _____**

**Birth Date: _____**

**Date of Screening: _____**

*Annual mental health screenings are crucial for your child's overall well-being and development. These screenings provide an opportunity to detect any potential mental health concerns early, enabling timely intervention and support. Mental health directly impacts a child's ability to learn, socialize, and function effectively in daily life. Identifying and addressing mental health issues early can significantly improve a child's academic performance, social interactions, emotional resilience, and long-term mental health outcomes.*

1. **Background Information:**
    - Is there any information about the family structure and dynamics that we should consider for the child's mental health assessment? **Yes or No**
    - Have there been any major life changes or events affecting the child recently? **Yes or No**
2. **Emotional Well-being:**
    - Does the child generally display a consistent mood and temperament? **Yes or No**
    - Have you noticed significant changes in the child's behavior or emotions? **Yes or No**
3. **Social Functioning:**
    - Is the child able to interact well with peers, adults, and family members? **Yes or No**
    - Does the child face challenges in making and maintaining friendships? **Yes or No**
4. **Academic Performance:**
    - Is the child actively engaged and motivated during learning activities? **Yes or No**
    - Are there concerns or challenges affecting the child's academic performance? **Yes or No**

5. **Behavioral Patterns:**
    - Are there any behavioral concerns or disruptive behaviors you've observed? **Yes or No**
    - Does the child struggle with attention and focus during tasks and activities? **Yes or No**
6. **Anxiety and Stress Levels:**
    - Have you observed signs of elevated anxiety levels or stress in the child? **Yes or No**
    - Are there identifiable stressors affecting the child? **Yes or No**
7. **Sleep Patterns:**
    - Is the child experiencing adequate and quality sleep? **Yes or No**
    - Are there any concerns related to the child's sleep patterns? **Yes or No**
8. **Follow-up:**
    - Do you recommend further assessments or therapies based on this screening? **Yes or No**
    - Are there specific strategies or interventions you suggest to support the child's mental health? **Yes or No**

**Professional's Name: _____**

**License number: _____**

**Signature: _____**

**Date:_____**

This form is to be completed by a licensed mental health professional during the annual mental health screening. The information gathered will be used to ensure the child's mental health needs are appropriately addressed and supported.