Name: Date:

How am I doing?

Mood _____

Anxiety _____

Thoughts _____

Sleep _____

Appetite _____

Exercise _____

Relationships _____

Work, school or recreation _____

Tobacco, alcohol or drug use _____

Medicine side-effects _____

Physical health _____

Other problems in my life _____

How am I helping myself?

_____

_____

What are my goals?

For the next two weeks _____

For the next two months _____

For the next year _____

What do I want the doctor to do for me today?

_____

_____

Mental Health America