

Assessment of Service User's Mental Health - Depression

Service User: _____

Date of Birth: _____

A: SERVICE USER ASSESSMENT

#	Indicator	✓	X	Implications for Service User Care Plan
1	Feels tired and lacks energy / does less and less	<input type="checkbox"/>	<input type="checkbox"/>	
2	Feels irritable / impatient / prone to crying	<input type="checkbox"/>	<input type="checkbox"/>	
3	Feels sad / hopeless / empty for much of the time	<input type="checkbox"/>	<input type="checkbox"/>	
4	Gets no pleasure out of life / things they usually enjoy	<input type="checkbox"/>	<input type="checkbox"/>	
5	Finds it hard to concentrate and make decisions	<input type="checkbox"/>	<input type="checkbox"/>	
6	Preoccupied by negative thoughts	<input type="checkbox"/>	<input type="checkbox"/>	
7	Difficulty in sleeping / wakes up early / sleeps more	<input type="checkbox"/>	<input type="checkbox"/>	
8	Lacks confidence or self-esteem	<input type="checkbox"/>	<input type="checkbox"/>	
9	Consumes more alcohol than usual	<input type="checkbox"/>	<input type="checkbox"/>	
10	Uses more tobacco or recreational drugs than usual	<input type="checkbox"/>	<input type="checkbox"/>	
11	Distances themselves from others / doesn't ask for help	<input type="checkbox"/>	<input type="checkbox"/>	
12	Neglects their appearance or environment	<input type="checkbox"/>	<input type="checkbox"/>	
13	Doesn't eat properly / either losing or gaining weight	<input type="checkbox"/>	<input type="checkbox"/>	
14	EXTREME CASES: Attempts self-harm / suicide	<input type="checkbox"/>	<input type="checkbox"/>	

B: COMMENTS & SIGNATURES

Signature of Assessor: _____

Date of Assessment: _____