CHECKLIST OF CONCERNS

Name: _____Date: _____
Please mark all of the items below that apply and add a note or details in the space next to the concerns checked.

- — Alcohol abuse or history of abuse
- — Anger, hostility, arguing, irritability
- — Anxiety, nervousness
- — Attention, concentration, distractibility
- — Childhood issues (your own childhood) including trauma and abuse
- — Codependency or unhealthy relationships
- — Decision making, indecision, mixed feelings, putting off decisions
- — Depression, low mood, sadness, crying
- — Divorce, separation
- — Drug abuse-prescription medications, over-the-counter medications, street drugs, or history of substance abuse
- — Eating problems:_____
- — Fatigue, tiredness, low energy
- — Fears, phobias
- — Grieving, mourning, deaths, losses, divorce
- — Interpersonal conflicts
- — Impulsivity, loss of control, outbursts
- — Loneliness, isolating
- — Marital problems
- — Memory problems
- — Mood swings
- — Obsessions, compulsions
- — Oversensitivity to rejection & criticism
- — Panic or anxiety attacks
- — Relationship problems
- — Self-centeredness
- — Self-esteem issues
- — Self-neglect, poor self-care
- — Sexual issues, dysfunctions, conflicts, desire differences, other (see also “Abuse”)
- — Sleep problems:_____
- — Smoking and tobacco use
- — Spiritual or religious concerns
- — Stress:_____
- — Suspiciousness
- — Suicidal thoughts/attempts:_____
- — Weight and diet issues
- — Withdrawal, isolating
- — Work or career problems

What would you most like help with?_____

What do you hope to gain as a result to coming to counseling now? _____

_____