

Checklist of Concerns

Name: _____

Date: _____

Please mark all of the items below that apply and feel free to add any others at the bottom under "any other concerns or issues." You may add a note or details. Please look back over the concerns you have checked off and choose the one that you most want to address:

- | | |
|---|--|
| <input type="checkbox"/> I have no problem or concern bringing me here | <input type="checkbox"/> Abuse: physical, sexual, emotional, neglect, cruelty to animals |
| <input type="checkbox"/> Aggression, violence | <input type="checkbox"/> Alcohol use |
| <input type="checkbox"/> Anger, hostility, arguing, irritability | <input type="checkbox"/> Anxiety, nervousness |
| <input type="checkbox"/> Attention, concentration, distractibility | <input type="checkbox"/> Career concerns, goals, choices |
| <input type="checkbox"/> Childhood issues (your childhood) | <input type="checkbox"/> Children, child management, child care, parenting |
| <input type="checkbox"/> Codependence | <input type="checkbox"/> Confusion |
| <input type="checkbox"/> Compulsions | <input type="checkbox"/> Custody of children |
| <input type="checkbox"/> Decision making, indecision, procrastination | <input type="checkbox"/> Delusions (false ideas) |
| <input type="checkbox"/> Depression, low mood, sadness, crying | <input type="checkbox"/> Divorce, separation |
| <input type="checkbox"/> Drug use: prescription, over the counter, street diets | <input type="checkbox"/> Eating issues: overeating, underrating, vomiting, chronic |
| <input type="checkbox"/> Emptiness | <input type="checkbox"/> Feelings of failure |
| <input type="checkbox"/> Fatigue: tiredness, low energy | <input type="checkbox"/> Fears, phobias |
| <input type="checkbox"/> Financial troubles, debt, compulsive spending | <input type="checkbox"/> Friendships |
| <input type="checkbox"/> Gambling | <input type="checkbox"/> Grieving, mourning, deaths, losses, divorce |
| <input type="checkbox"/> Guilt | <input type="checkbox"/> Headaches, other chronic pain |
| <input type="checkbox"/> Health, illness, medical concerns | <input type="checkbox"/> Inferiority feelings |
| <input type="checkbox"/> Interpersonal conflicts | <input type="checkbox"/> Impulsiveness, loss of control, outbursts |
| <input type="checkbox"/> Irresponsibility | <input type="checkbox"/> Judgment problems, risk taking |
| <input type="checkbox"/> Legal matter, charges, suits | <input type="checkbox"/> Loneliness |
| <input type="checkbox"/> Marital / Relationship conflict, distance, infidelity | <input type="checkbox"/> Memory problems |
| <input type="checkbox"/> Menstrual issues, PMS, menopause | <input type="checkbox"/> Mood swings |
| <input type="checkbox"/> Motivation issues | <input type="checkbox"/> Nervousness, tension |
| <input type="checkbox"/> Obsessions, compulsions: thoughts or actions | <input type="checkbox"/> Oversensitivity to rejection |
| <input type="checkbox"/> Panic / Anxiety attacks | <input type="checkbox"/> Perfectionism |
| <input type="checkbox"/> Pessimism | <input type="checkbox"/> Procrastination, work inhibitions |
| <input type="checkbox"/> Relationship issues / concerns | <input type="checkbox"/> School issues |
| <input type="checkbox"/> Self-centeredness | <input type="checkbox"/> Self-esteem |
| <input type="checkbox"/> Self-neglect, poor care | <input type="checkbox"/> Sexual issues, dysfunctions, conflicts |
| <input type="checkbox"/> Shyness, oversensitivity to criticism | <input type="checkbox"/> Sleep problems: too much, too little, nightmares, |
| <input type="checkbox"/> insomnia | |
| <input type="checkbox"/> Smoking / tobacco use | <input type="checkbox"/> Stress, relaxation, stress management, tension |
| <input type="checkbox"/> Suspiciousness | <input type="checkbox"/> Self harm / Suicidal: thoughts, plans, attempts |
| <input type="checkbox"/> Temper problems, self-control, low frustration | <input type="checkbox"/> Thought disorganization and confusion |
| <input type="checkbox"/> Treats of violence: to others, to self | <input type="checkbox"/> Weight / body image issues |
| <input type="checkbox"/> Withdrawal, isolation | <input type="checkbox"/> Work problems, employments, work overload, instability |

This information is maintained in confidence in your record.

Disclosure of information only occurs with express written permission via a Release of Information form.

Other: Please note on reverse