Checklist of Concerns

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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 in the space next to the concerns checked. (For a child, mark any of these and then complete the "Child Checklist of Characteristics.")

	I have no problem or concern bringing me here.
	Abuse – victim of physical, sexual, and / or emotional abuse or neglect
	Aggression, violence
	Alcohol use
	Anger, hostility, arguing, irritability
	Anxiety, nervousness
	Attention, concentration, distractibility
	Career concerns, goals, and choices
	Childhood issues (your own childhood)
	Children, child management, child care, parenting
	Codependence
	Confusion
	Compulsions
	Custody of children
	Decision making, indecision, mixed feelings, putting off decisions
	Delusions (false ideas)
	Dependence
	Depression, low mood, sadness,
	Divorce, separation
	Drug use – prescription medications, over-the-counter medications, street drugs
	Eating disorders – overeating, undereating, appetite, vomiting
	Emptiness
	Failure
	Fatigue, tiredness, low energy
	Fears, phobias
	Financial or money troubles, debt, impulsive spending, low income
	Friendships
	Gambling

	Grieving, mourning, deaths, losses, divorce
	Guilt
	Headaches, other kinds of pains
	Health, illness, medical concerns, physical problems
	Inferiority feelings
	Interpersonal conflicts
	Impulsiveness, loss of control, outbursts
	Irresponsibility
	Judgment problems, risk taking
	Legal matters, charges, suits
	Loneliness
	Marital conflict, distance / coldness, infidelity / affairs, remarriage
	Memory problems
	Menstrual problems, PMS, menopause
	Mood swings
	Motivation, laziness
	Nervousness, tension
	Obsessions, compulsions (thoughts or actions that repeat themselves)
	Oversensibility to rejection
	Panic or anxiety attacks
	Perfectionism
	Please disclose this item only with the knowledge of my duty to report such abuse. Perpetrator of physical, sexual, or emotional abuse or neglect (of children or elderly), or cruelty to animals
	Procrastination, work inhibitions, laziness
	Relationship problems
	School problems
	Self-centeredness
	Self-esteem
	Self-neglect, poor self-care
	Sexual issues, dysfunctions, conflicts, desire differences, other (see also "Abuse")
	Shyness, oversensitivity to criticism
	Sleep problems – too much, too little, insomnia, nightmares
	Smoking and tobacco use
	Stress, relaxation, stress management, stress disorders, tension
	Suspiciousness
	Suicidal thoughts

	Temper problems, self-control, low frustration tolerance
	Thought disorganization and confusion
	Threats, violence
	Weight and diet issues
	Withdrawal, isolating
	Work problems, employment, workaholism / overworking, can't keep a job

Any other concerns or issues:

[ ] _____

[ ] _____

[ ] _____

Please look back over the concerns you have checked off and choose the one that you most want help with. It is: _____

Client's Signature: _____ Date ___/___/___

_____ Date ___/___/___

Counselor's Signature: _____ Date ___/___/___

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.