ADULT CHECKLIST OF CONCERNS

This is a strictly confidential patient medical record.

Name: ____ Date: _______________________

Please mark all of the issues below that apply to you, and feel free to add any others at the bottom form under “Any other concerns or issues.”

___ Abuse: physical, sexual, emotional, neglect (of children or elderly), cruelty to animals
___ Aggressive behaviors, violence
___ Alcohol use
___ Anger, hostility, arguing, irritability, loss of control, outbursts, threats
___ Anxiety, nervousness, panic, tension
___ Attention, difficulty concentrating distractibility
___ Career concerns, goals, and choices; employment/unemployment problems; workaholism
___ Childhood issues (your own)
___ Children, child management, child care, parenting
___ Codependence or dependence
___ Confusion, memory problems, thought disorganization
___ Compulsions and/or obsessions (thoughts or actions that repeat themselves)
___ Depression: low mood, sadness, crying, lack of interest in usual activities
___ Divorce: separation or custody issues
___ Drug use: prescription medications, over-the-counter medications, illegal drugs
___ Eating problems: overeating, low appetite, vomiting, over-exercising, diet issues
___ Sudden weight loss or gain
___ Feelings of emptiness
___ Feelings of failure, inferiority, or unworthiness
___ Fatigue, tiredness, low energy
___ Fears, phobias
___ Financial or money troubles, debt, impulsive spending
___ Friendship conflicts, difficulty making or keeping friends
___ Gambling
___ Gender identity issues
___ Grieving, loss
___ Guilt, worthlessness
___ Headaches, stomachaches, muscle pain
___ Illness issues, chronic issues
___ Irresponsibility, judgment problems, risk taking
___ Legal matters, charges, law suit
___ Lying
___ Marital conflict, distance/coldness, infidelity/affairs, remarriage, step-parenting issues
___ Memory problems, PMS, menopause
___ Military experience
___ Mood swings, pessimism
___ Perfectionism, self-esteem problems
___ Procrastination, laziness, work inhibitions

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___ Recurrent thoughts of death
___ Relationship problems
___ Self-neglect, poor self-care
___ Sexual dysfunction (desire, inhibitions, inappropriate sexual behaviors, etc.)
___ Shyness, sensitivity to criticism
___ Sleep disturbances
___ Smoking/tobacco use
___ Stealing
___ Suicidal thoughts/attempts
___ Suspiciousness
___ Withdrawal, isolation

Any other concerns or issues? ____

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Person to contact in case of an emergency:

Name: ____

Relationship: ____

Address: ____

Phone: ______________________________

What would you like to accomplish during therapy?

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Please look over those concerns you have checked and put a star next to the ones that you most want help with.