

**KATHY HIGGINS LPC LLC**  
**CHECKLIST OF CONCERNS**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Please mark all items you are concerned about. You may also add a note or details in the space next to the concerns checked. If an item gives you more than one choice, circle the choice(s) that apply to you.

- |   |   |
|---|---|
| <input type="checkbox"/> Abuse victim; physical, sexual, emotional, neglect   | <input type="checkbox"/> Judgment problems, risk taking   |
| <input type="checkbox"/> Abusive behavior; physical, sexual, emotional, neglect (of child or elderly), cruelty to animals | <input type="checkbox"/> Legal matters, charges, lawsuits, probation  |
| <input type="checkbox"/> Alcohol use  | <input type="checkbox"/> Loneliness, lack of support, lack of friends   |
| <input type="checkbox"/> Anger, hostility, arguing, irritability  | <input type="checkbox"/> Mania: pressured speech, expansive or euphoric mood, racing thoughts, spending sprees, excessive activity, involvement with risky activities |
| <input type="checkbox"/> Anxiety, nervousness   | <input type="checkbox"/> Marital problems, conflict, distance/coldness, infidelity/affairs, remarriage  |
| <input type="checkbox"/> Attention, concentration, distractibility  | <input type="checkbox"/> Memory problems  |
| <input type="checkbox"/> Caregiver issues   | <input type="checkbox"/> Menstrual problems, PMS, menopause   |
| <input type="checkbox"/> Career concerns, goals, and choices  | <input type="checkbox"/> Mood swings  |
| <input type="checkbox"/> Childhood issues (your own childhood) specify: _____   | <input type="checkbox"/> Motivation   |
| <input type="checkbox"/> Children, child management, child care, parenting  | <input type="checkbox"/> Obsessions/Compulsions (thoughts or actions that repeat themselves)  |
| <input type="checkbox"/> Custody of children  | <input type="checkbox"/> Oversensitivity to rejection   |
| <input type="checkbox"/> Decision-making, indecision, mixed feelings, putting off decisions                               | <input type="checkbox"/> Panic or anxiety attacks   |
| <input type="checkbox"/> Defiance, bed-wetting/soiling  | <input type="checkbox"/> Perfectionism  |
| <input type="checkbox"/> Delusions (false ideas)  | <input type="checkbox"/> Pessimism  |
| <input type="checkbox"/> Depression, low mood, sadness, crying  | <input type="checkbox"/> Procrastination  |
| <input type="checkbox"/> Disability, specify: _____   | <input type="checkbox"/> Racing thoughts  |
| <input type="checkbox"/> Divorce, separation, step-family issues  | <input type="checkbox"/> Relationship problems  |
| <input type="checkbox"/> Domestic violence  | <input type="checkbox"/> Running away from home   |
| <input type="checkbox"/> Drug use: prescription medications, over-the-counter medications, street drugs                   | <input type="checkbox"/> School problems: performance, behavior, truancy  |
| <input type="checkbox"/> Eating problems: overeating, under-eating, binge-eating, appetite, vomiting, weight              | <input type="checkbox"/> Self-destructive behavior: cutting, burning  |
| <input type="checkbox"/> Emptiness  | <input type="checkbox"/> Self-esteem, inferiority feelings  |
| <input type="checkbox"/> Fatigue, tiredness, low energy   | <input type="checkbox"/> Self-neglect, poor self-care   |
| <input type="checkbox"/> Fears, phobias   | <input type="checkbox"/> Sexual issues, dysfunctions, conflicts, desire differences   |
| <input type="checkbox"/> Financial or money troubles, debt, impulsive spending, low income                                | <input type="checkbox"/> Sexual orientation, GLBT issues  |
| <input type="checkbox"/> Fire setting   | <input type="checkbox"/> Shyness, oversensitivity to criticism  |
| <input type="checkbox"/> Gambling   | <input type="checkbox"/> Sleep problems; too much, too little, insomnia, nightmares   |
| <input type="checkbox"/> Grieving, mourning, losses   | <input type="checkbox"/> Smoking, tobacco use   |
| <input type="checkbox"/> Guilt  | <input type="checkbox"/> Stealing, shoplifting  |
| <input type="checkbox"/> Health, illness, medical concerns, physical problems; specify: _____                             | <input type="checkbox"/> Stress, relaxation, stress management, tension   |
| <input type="checkbox"/> Impulsiveness, loss of control   | <input type="checkbox"/> Suspiciousness, paranoia, defensiveness  |
| <input type="checkbox"/> Interpersonal conflicts: home, work, family  | <input type="checkbox"/> Suicidal thoughts  |
|   | <input type="checkbox"/> Temper problems, aggression, violence, threats   |
|   | <input type="checkbox"/> Thought disorganization and confusion  |
|   | <input type="checkbox"/> Withdrawal, isolating  |
|   | <input type="checkbox"/> Work problems, employment, can't keep a job, workaholism/over-working  |

Any other concerns or issues

\_\_\_\_\_

Please look over the concerns you have checked off and choose the **three** concerns you most want help with. Circle each of these concerns.