

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.