

## Adult 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 in the space provided below.

- |  |  |
|--|--|
| <input type="checkbox"/> I have no problem or concern bringing me here   | <input type="checkbox"/> Drug use-prescription medications, over-the-counter medications, street drugs                   |
| <input type="checkbox"/> Abuse-physical, sexual, emotional, neglect (of children or elderly), cruelty to animals | <input type="checkbox"/> Eating problems-overeating, undereating, appetite, vomiting (see also "Weight and diet issues") |
| <input type="checkbox"/> Aggression, violence  | <input type="checkbox"/> Emptiness   |
| <input type="checkbox"/> Alcohol use   | <input type="checkbox"/> Failure   |
| <input type="checkbox"/> Anger, hostility, arguing, irritability   | <input type="checkbox"/> Fatigue, tiredness, low energy  |
| <input type="checkbox"/> Anxiety, nervousness  | <input type="checkbox"/> Fears, phobias  |
| <input type="checkbox"/> Attention, concentration, distractibility   | <input type="checkbox"/> Financial or money troubles, debt, impulsive spending, low income                               |
| <input type="checkbox"/> Career concerns, goals, and choices   | <input type="checkbox"/> Friendships   |
| <input type="checkbox"/> Childhood issues (your own childhood)   | <input type="checkbox"/> Gambling  |
| <input type="checkbox"/> Children, child management, child care, parenting                                       | <input type="checkbox"/> Grieving, mourning, deaths, losses, divorce   |
| <input type="checkbox"/> Codependence  | <input type="checkbox"/> Guilt   |
| <input type="checkbox"/> Confusion   | <input type="checkbox"/> Headaches, other kinds of pains   |
| <input type="checkbox"/> Compulsions   | <input type="checkbox"/> Health, illness, medical concerns, physical problems  |
| <input type="checkbox"/> Custody of children   | <input type="checkbox"/> Inferiority feelings  |
| <input type="checkbox"/> Decision making, indecision, mixed feelings, putting off decisions                      | <input type="checkbox"/> Interpersonal conflicts   |
| <input type="checkbox"/> Delusions (false ideas)   | <input type="checkbox"/> Impulsiveness, loss of control, outbursts   |
| <input type="checkbox"/> Dependence  | <input type="checkbox"/> Irresponsibility  |
| <input type="checkbox"/> Depression, low mood, sadness, crying   | <input type="checkbox"/> Judgment problems, risk taking  |
| <input type="checkbox"/> Divorce, separation   | <input type="checkbox"/> Self-neglect, poor self-care  |
| <input type="checkbox"/> Legal matters, charges, suits   | <input type="checkbox"/> Sexual issues, dysfunctions, conflicts, desire differences, other                               |
| <input type="checkbox"/> Loneliness  | <input type="checkbox"/> Shyness, oversensitivity to criticism   |
| <input type="checkbox"/> Marital conflict, distance/coldness, infidelity/affairs, remarriage                     | <input type="checkbox"/> Sleep problems-too much, too little, insomnia, nightmares                                       |
| <input type="checkbox"/> Memory problems   | <input type="checkbox"/> Smoking and tobacco use   |
| <input type="checkbox"/> Menstrual problems, PMS, menopause  | <input type="checkbox"/> Stress, relaxation, stress management, stress disorders, tension                                |
| <input type="checkbox"/> Mood swings   | <input type="checkbox"/> Suspiciousness  |
| <input type="checkbox"/> Motivation, laziness  | <input type="checkbox"/> Suicidal thoughts   |
| <input type="checkbox"/> Nervousness, tension  | <input type="checkbox"/> Temper problems, self-control, low frustration tolerance  |
| <input type="checkbox"/> Obsessions, compulsions (thoughts or actions that repeat themselves)                    | <input type="checkbox"/> Thought disorganization and confusion   |
| <input type="checkbox"/> Oversensitivity to rejection  | <input type="checkbox"/> Threats, violence   |
| <input type="checkbox"/> Panic or anxiety attacks  | <input type="checkbox"/> Weight and diet issues  |
| <input type="checkbox"/> Perfectionism   | <input type="checkbox"/> Withdrawal, isolating   |
| <input type="checkbox"/> Pessimism   | <input type="checkbox"/> Work problems, employment, workaholism/overworking, can't keep a job                            |
| <input type="checkbox"/> Procrastination, work inhibitions, laziness   |  |
| <input type="checkbox"/> Relationship problems   |  |
| <input type="checkbox"/> School problems (see also "Career concerns. . .")                                       |  |
| <input type="checkbox"/> Self-centeredness   |  |
| <input type="checkbox"/> Self-esteem   |  |

Any other concerns or issues:

*This is a strictly confidential patient medical record. Re-disclosure or transfer is expressly prohibited by law.*

