

Adult Checklist of Concerns

Name: _____ Today's Date: _____

Please rate concerns you have on a scale from: 0=none 1=mild 2=moderate 3=severe

- | | | | | |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | I have no problems or concerns bringing me here today |
| 0 | 1 | 2 | 3 | Abuse – physical, sexual, emotional, neglect |
| 0 | 1 | 2 | 3 | Aggression, violence |
| 0 | 1 | 2 | 3 | Alcohol use |
| 0 | 1 | 2 | 3 | Anger, hostility, arguing, irritability |
| 0 | 1 | 2 | 3 | Anxiety, nervousness |
| 0 | 1 | 2 | 3 | Attention, concentration, distractibility |
| 0 | 1 | 2 | 3 | Career concerns, goals and choices |
| 0 | 1 | 2 | 3 | Childhood issues |
| 0 | 1 | 2 | 3 | Children, child management, child care, parenting |
| 0 | 1 | 2 | 3 | Codependence |
| 0 | 1 | 2 | 3 | Confusion |
| 0 | 1 | 2 | 3 | Compulsions |
| 0 | 1 | 2 | 3 | Custody of children |
| 0 | 1 | 2 | 3 | Decision making, indecision, mixed feelings, putting off decisions |
| 0 | 1 | 2 | 3 | Delusions (false ideas) |
| 0 | 1 | 2 | 3 | Dependence |
| 0 | 1 | 2 | 3 | Depression, low mood, sadness, crying |
| 0 | 1 | 2 | 3 | Divorce, separation |
| 0 | 1 | 2 | 3 | Drug use-prescription meds, over-the-counter meds, street drugs |
| 0 | 1 | 2 | 3 | Eating problem-over-eating, under-eating, appetite, vomiting |
| 0 | 1 | 2 | 3 | Emptiness |
| 0 | 1 | 2 | 3 | Failure |
| 0 | 1 | 2 | 3 | Fatigue, tiredness, low energy |
| 0 | 1 | 2 | 3 | Fears, phobias |
| 0 | 1 | 2 | 3 | Financial or money troubles, debt, impulsive spending, low income |
| 0 | 1 | 2 | 3 | Friendships |
| 0 | 1 | 2 | 3 | Gambling |
| 0 | 1 | 2 | 3 | Grieving, mourning, deaths, losses, divorce |
| 0 | 1 | 2 | 3 | Guilt |
| 0 | 1 | 2 | 3 | Headaches, other kinds of pains |
| 0 | 1 | 2 | 3 | Health, illness, medical concerns, physical problems |
| 0 | 1 | 2 | 3 | Hearing voices |
| 0 | 1 | 2 | 3 | Helplessness |
| 0 | 1 | 2 | 3 | Hopelessness |
| 0 | 1 | 2 | 3 | Inferiority feelings |
| 0 | 1 | 2 | 3 | Interpersonal conflicts |
| 0 | 1 | 2 | 3 | Impulsiveness, loss of control, outbursts |
| 0 | 1 | 2 | 3 | Irresponsibility |
| 0 | 1 | 2 | 3 | Judgment problems, risk-taking behaviors |
| 0 | 1 | 2 | 3 | Legal matters, charges, suits |
| 0 | 1 | 2 | 3 | Loneliness |
| 0 | 1 | 2 | 3 | Marital conflict, distance/coldness, infidelity/affairs, remarriage |
| 0 | 1 | 2 | 3 | Memory problems |
| 0 | 1 | 2 | 3 | Menstrual problems, PMS, menopause |

- 0 1 2 3 Mood swings
- 0 1 2 3 Motivation, laziness
- 0 1 2 3 Nervousness, tension
- 0 1 2 3 Obsessions, compulsions (thoughts or actions that repeat themselves)
- 0 1 2 3 Oversensitivity to rejection
- 0 1 2 3 Panic or anxiety attacks
- 0 1 2 3 Perfectionism
- 0 1 2 3 Pessimism
- 0 1 2 3 Procrastination, work inhibitions, laziness
- 0 1 2 3 Relationship problems
- 0 1 2 3 School problems (see also “career concerns...”)
- 0 1 2 3 Self-centeredness
- 0 1 2 3 Self-esteem
- 0 1 2 3 Self-neglect, poor self-care
- 0 1 2 3 Sexual issues, dysfunctions, conflicts, desire differences
- 0 1 2 3 Shyness, oversensitivity to criticism
- 0 1 2 3 Sleep problems-too much, too little, insomnia, nightmares
- 0 1 2 3 Smoking and tobacco use
- 0 1 2 3 Stress, relaxation, stress management, stress disorders, tension
- 0 1 2 3 Suspiciousness
- 0 1 2 3 Suicidal thoughts
- 0 1 2 3 Temper problems, self-control, low frustration tolerance
- 0 1 2 3 Thought disorganization and confusion
- 0 1 2 3 Threats, violence
- 0 1 2 3 Weight and diet issues
- 0 1 2 3 Withdrawal, isolating
- 0 1 2 3 Work problems, workaholism/over-working, can’t keep a job

List any stressors in these areas:

Primary Support Group: _____

Education: _____

Occupation: _____

Housing: _____

Economic: _____

Healthcare services: _____

Legal: _____

Death or losses: _____

Other: _____

Rate the severity of your stressors:

1	2	3	4	5
mild		moderate		severe