

CLIENT CONCERNS

Please check the items you would like to address in therapy

CAREER/WORK

- | | | |
|---|--|--|
| <input type="checkbox"/> Career choice | <input type="checkbox"/> Difficulties at work | <input type="checkbox"/> Personality conflicts |
| <input type="checkbox"/> Financial concerns | <input type="checkbox"/> Problems making decisions | <input type="checkbox"/> Overwork/stress |
| <input type="checkbox"/> Other: _____ | | |

HEALTH CONCERNS

- | | | |
|--|---|---|
| <input type="checkbox"/> Weight change | <input type="checkbox"/> Bingeing | <input type="checkbox"/> Purging |
| <input type="checkbox"/> Eating pattern disorder | <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Lack of energy |
| <input type="checkbox"/> Tired all the time | <input type="checkbox"/> Headaches | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Concerns about drugs | <input type="checkbox"/> Concerns about alcohol | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Other: _____ | | |

PERSONAL CONCERNS

- | | | |
|---|--|---|
| <input type="checkbox"/> Suicidal thoughts | <input type="checkbox"/> Trouble concentrating | <input type="checkbox"/> Depressed |
| <input type="checkbox"/> Anxious | <input type="checkbox"/> Feeling panicky | <input type="checkbox"/> Feeling inferior |
| <input type="checkbox"/> Unhappy | <input type="checkbox"/> Sensitive | <input type="checkbox"/> Feelings easily hurt |
| <input type="checkbox"/> No self-confidence | <input type="checkbox"/> Worried | <input type="checkbox"/> Fearful |
| <input type="checkbox"/> Feeling anger | <input type="checkbox"/> Not feeling at all | <input type="checkbox"/> Dealing with death |
| <input type="checkbox"/> Dealing with loss | <input type="checkbox"/> Other: _____ | |

SOCIAL RELATIONSHIPS

- | | | |
|--|--|---|
| <input type="checkbox"/> Shy with people | <input type="checkbox"/> Problems maintaining a relationship | <input type="checkbox"/> Difficulty relating to people |
| <input type="checkbox"/> Difficulty making friends | <input type="checkbox"/> Feeling lonely | <input type="checkbox"/> Fighting in personal relationships |
| <input type="checkbox"/> Other: _____ | | |

FAMILY RELATIONS/SPOUSE

- | | | |
|--|---|---|
| <input type="checkbox"/> Sexual concerns | <input type="checkbox"/> Marital concerns | <input type="checkbox"/> Fighting |
| <input type="checkbox"/> Verbal abuse | <input type="checkbox"/> Physical abuse | <input type="checkbox"/> Financial stress |
| <input type="checkbox"/> Other: _____ | | |

FAMILY RELATIONS/CHILDREN

- | | | |
|--|--|--|
| <input type="checkbox"/> Behavior problems at
[] Home [] School | <input type="checkbox"/> Health Problems | <input type="checkbox"/> Victim of Abuse |
| <input type="checkbox"/> Academic problems | <input type="checkbox"/> Drug or alcohol abuse | |
| <input type="checkbox"/> Other: _____ | | |

FAMILY RELATIONS/PARENTS

- | | | |
|--|--|-----------------------------------|
| <input type="checkbox"/> Care-giver stress | <input type="checkbox"/> Financial concerns | <input type="checkbox"/> Fighting |
| <input type="checkbox"/> Conflict over child raising | <input type="checkbox"/> Impending loss of loved one | |
| <input type="checkbox"/> Other: _____ | | |

PERSONAL GOALS

- | | | |
|---|---|---|
| <input type="checkbox"/> Develop assertiveness skills | <input type="checkbox"/> Develop more realistic self-
expectations | <input type="checkbox"/> Accept personal limitations |
| <input type="checkbox"/> Develop clearer personal
identity | <input type="checkbox"/> Increase awareness of
emotional response | <input type="checkbox"/> Develop coping skills |
| <input type="checkbox"/> Other: _____ | | <input type="checkbox"/> Clarify personal goals and
values |

NAME _____

DATE _____