

Areas of Concern

Name: _____

Date: _____

For any item below that is a concern for you, indicate the severity by placing check marks on the line next to it: ✓ = low; ✓✓ = medium, ✓✓✓ = high. (blank = not a concern)

- | | |
|---|--|
| <input type="checkbox"/> Depression/Sadness | <input type="checkbox"/> Sexual concerns |
| <input type="checkbox"/> Low self-esteem | <input type="checkbox"/> Family |
| <input type="checkbox"/> Mood swings | <input type="checkbox"/> Children |
| <input type="checkbox"/> Suicidal thoughts | <input type="checkbox"/> Relationships |
| <input type="checkbox"/> Racing thoughts | <input type="checkbox"/> Dating |
| <input type="checkbox"/> Anxiety/Worrying/Fearfulness | <input type="checkbox"/> Grief/loss |
| <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Loneliness or isolation |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Shyness |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Trusting others |
| <input type="checkbox"/> Obsessive thinking | <input type="checkbox"/> Cultural identity |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Career |
| <input type="checkbox"/> Paranoia | <input type="checkbox"/> School |
| <input type="checkbox"/> Lack of energy | <input type="checkbox"/> Spiritual/religious |
| <input type="checkbox"/> Poor concentration | <input type="checkbox"/> Money/finances |
| <input type="checkbox"/> Poor memory | <input type="checkbox"/> Legal Issues |
| <input type="checkbox"/> Traumatic experiences | <input type="checkbox"/> Drug use |
| <input type="checkbox"/> Easily startled | <input type="checkbox"/> Alcohol use |
| <input type="checkbox"/> Nightmares | <input type="checkbox"/> Caffeine use |
| <input type="checkbox"/> Upsetting memories | <input type="checkbox"/> Cigarette/nicotine use |
| <input type="checkbox"/> Sleep difficulties | <input type="checkbox"/> Addictive behavior |
| <input type="checkbox"/> Physical pain or discomfort | <input type="checkbox"/> Impulsiveness |
| <input type="checkbox"/> Health issues | <input type="checkbox"/> Dishonesty |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Perfectionism |
| <input type="checkbox"/> Back aches | <input type="checkbox"/> Guilt |
| <input type="checkbox"/> Digestive problems | <input type="checkbox"/> Indecisiveness |
| <input type="checkbox"/> Weight | <input type="checkbox"/> Poor judgment |
| <input type="checkbox"/> Food, eating habits, nutrition | <input type="checkbox"/> Other |
| <input type="checkbox"/> Body image or appearance | <input type="checkbox"/> Other |