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)

____ Depression/Sadness
____ Low self-esteem
____ Mood swings
____ Suicidal thoughts
____ Racing thoughts
____ Anxiety/Worrying/Fearfulness
____ Panic attacks
____ Stress
____ Irritability
____ Obsessive thinking
____ Anger
____ Paranoia
____ Lack of energy
____ Poor concentration
____ Poor memory
____ Traumatic experiences
____ Easily startled
____ Nightmares
____ Upsetting memories
____ Sleep difficulties
____ Physical pain or discomfort
____ Health issues
____ Headaches
____ Back aches
____ Digestive problems
____ Weight
____ Food, eating habits, nutrition
____ Body image or appearance

____ Sexual concerns
____ Family
____ Children
____ Relationships
____ Dating
____ Grief/loss
____ Loneliness or isolation
____ Shyness
____ Trusting others
____ Cultural identity
____ Career
____ School
____ Spiritual/religious
____ Money/finances
____ Legal
____ Drug use
____ Alcohol use
____ Caffeine use
____ Cigarette/nicotine use
____ Addictive behavior
____ Impulsiveness
____ Dishonesty
____ Perfectionism
____ Guilt
____ Indecisiveness
____ Poor judgment
____ Other: _____
____ Other: _____