



Katherine Anderson, LPC

LICENSED PROFESSIONAL COUNSELOR

CHECKLIST OF CONCERNS

Name: _____ Date: _____

Please mark all of the items below that apply and add a note or details in the space next to the concerns checked.

- Alcohol abuse or history of abuse
- Anger, hostility, arguing, irritability
- Anxiety, nervousness
- Attention, concentration, distractibility
- Childhood issues (your own childhood) (including trauma and abuse)
- Codependency or unhealthy relationships
- Decision making, indecision, mixed feelings, putting off decisions
- Depression, low mood, sadness, crying
- Divorce, separation
- Drug abuse—prescription medications, over-the-counter medications, street drugs or history of
- Eating problems: _____
- Fatigue, tiredness, low energy
- Fears, phobias
- Grieving, mourning, deaths, losses, divorce
- Interpersonal conflicts
- Impulsiveness, loss of control, outbursts
- Loneliness, isolating
- Marital problems
- Memory problems
- Mood swings
- Obsessive compulsive
- Oversensitivity to rejection & criticism
- Panic or anxiety attacks
- Relationship problems
- Self-centeredness
- Self-esteem issues
- Self-neglect, poor self-care
- Sexual issues, dysfunctions, conflicts, desire differences, other (see also "Abuse")
- Sleep problems: _____
- Smoking and tobacco use
- Spiritual or religious concerns
- Stress: _____
- Suspiciousness
- Suicidal thoughts/attempts: _____
- Weight and diet issues
- Withdrawal, isolating
- Work or career problems

What would you most like help with? _____

What do you hope to gain as a result to coming to counseling now? _____
