

What are you concerned about?

Please check all that apply.

(Completing this page is optional)

- | | |
|---|--|
| <input type="checkbox"/> Lack of appetite | <input type="checkbox"/> Attention problems |
| <input type="checkbox"/> Anger/temper | <input type="checkbox"/> Low self-esteem |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Relationship problems |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Divorce/separation issues |
| <input type="checkbox"/> Stress/anxiety | <input type="checkbox"/> Parenting concerns |
| <input type="checkbox"/> Loneliness | <input type="checkbox"/> Poor academics |
| <input type="checkbox"/> Sleep disturbance | <input type="checkbox"/> Social isolation |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Poor job performance |
| <input type="checkbox"/> Chronic pain | <input type="checkbox"/> Financial problems |
| <input type="checkbox"/> Low motivation | <input type="checkbox"/> Trouble with the law |
| <input type="checkbox"/> Constant worry | <input type="checkbox"/> Cigarette use |
| <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Alcohol use |
| <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> Cocaine use |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Marijuana use |
| <input type="checkbox"/> Grief | <input type="checkbox"/> Other drug use |
| <input type="checkbox"/> Suicidal thoughts | <input type="checkbox"/> Caffeine use |
| <input type="checkbox"/> Self-injurious behavior | <input type="checkbox"/> Other issues_____ |

Is this your first time talking to a counselor? Yes No