Resilient Hearts Therapy

PRESENTING CONCERNS

Please provide the following information for our records to help understand your current needs and goals. Complete dates and frequency of symptoms to the best of your knowledge. Information you provide here is held to the same standards of confidentiality as our therapy.

First name: _____Middle initial: ____Last name: _____

Date of birth: _____ Age: _____ Phone: _____ Email: _____

Symptom/Behavior	YES	Start date	Last date	Times per week
Depressed Mood				
Anxious Thoughts/Feelings				
Panic Attacks				
Mood Swings				
Phobias				
Obsessive Thoughts				
Repetitive Behaviors				
Intrusive or Disturbing Thoughts/Memories				
Flashbacks				
Eating Disorder				
Body Image Problems				
Alcohol and/or Substance Abuse				
Relationship Difficulties				
Neurological Problems				
Learning Disabilities				
Suicidal Thoughts				
Suicide Attempt				

Resilient Hearts Therapy

(**PRESENTING Cont.**)

Please check any of the following that you have experienced recently or in the past:

- ❑ Abuse (physical, sexual, emotional, neglect)
- ❑ Anger, arguing, temper
- ❑ Attention, Focus, Concentration
- ❑ Boundary issues (personal/boundaries of others)
- ❑ Compulsions/impulsivity
- ❑ Communication problems
- ❑ Delusions/hallucinations
- ❑ Developmental issues/delays
- ❑ Difficulty decision-making
- ❑ Divorce/separation
- ❑ Emptiness
- ❑ Fatigue, low energy
- ❑ Financial problems (Shopping, Gambling, Budget)
- ❑ Grief & loss
- ❑ Guilt
- ❑ Health issues/illness
- ❑ Homicidal thoughts/urge or impulse to hurt others
- ❑ Incarceration (self/family member)
- ❑ Isolation/withdrawal
- ❑ Legal issues/matters
- ❑ Life Transition (new home, school, job, partner, etc.)
- ❑ Loss of interest
- ❑ Menstrual problems (PMS, Menopause)
- ❑ Motivation challenges
- ❑ Obsessive behaviors/thoughts
- ❑ Parenting problems
- ❑ Perfectionism
- ❑ Poor self-care
- ❑ Relationship conflict (marital, family, interpersonal)
- ❑ School problems
- ❑ Self-esteem/self-worth issues
- ❑ Sexual issues
- ❑ Sleep problems
- ❑ Smoking/tobacco use
- ❑ Spiritual/religious issues
- ❑ Stress
- ❑ Weight gain/loss
- ❑ Violence/aggression

_____ _____

Client (parent) signature Date