Patient Name: _____
Patient DOB: _____

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Please *CIRCLE the #* of any of the following concerns that apply to you.

* Clinician will add relevant information on line next to concern during initial assessment

1. Depressed:_____
2. Anxiety:_____
3. Fears/Worries:_____
4. Crying lot:_____
5. Temper:_____
6. Tantrum:_____
7. Tired:_____
8. Guilt:_____
9. Concentration:_____
10. School:_____
11. Stress:____ _____
12. Isolation:_____
13. Thoughts of Suicide:_____
14. Food/Appetite:_____
15. Finances:_____
16. Relationships:_____
17. Friendships:_____
18. Education:_____
19. Career:_____
20. Direction in Life:_____
21. Health:_____
22. Grief/Bereavement:_____
23. Self Esteem/Image:_____
24. Identify:_____
25. Addiction:_____
26. Victim of Abuse:_____
27. Death & Dying:_____
28. Infidelity:_____
29. Sexual/Intimacy: _____