

ADULT ISSUES CHECKLIST

Name _____ Date _____

To help me better understand your concerns, please review the following list of stressors or issues and check those which apply to you and/or your current situation. This information is confidential.

- | | |
|---|--|
| <input type="checkbox"/> Employment problems | <input type="checkbox"/> Anxious/ worried/nervous |
| <input type="checkbox"/> School problems | <input type="checkbox"/> Shy, uneasy with others |
| <input type="checkbox"/> Legal problems | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Financial problems | <input type="checkbox"/> Trouble sleeping |
| <input type="checkbox"/> Living arrangements | <input type="checkbox"/> Passive behavior |
| <input type="checkbox"/> Increase/decrease in appetite/weight | <input type="checkbox"/> Aggressive behavior |
| <input type="checkbox"/> Confusion | <input type="checkbox"/> Unwanted compulsive behavior |
| <input type="checkbox"/> Unexplainable and/or uncontrollable crying | <input type="checkbox"/> Withdrawn |
| <input type="checkbox"/> Extravagance with money | <input type="checkbox"/> Worry about alcohol/drug use |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Worry about eating habits |
| <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Physically abused |
| <input type="checkbox"/> Frequent lying | <input type="checkbox"/> Sexually abused |
| <input type="checkbox"/> Risk taking behavior | <input type="checkbox"/> Emotionally abused |
| <input type="checkbox"/> Generalized dissatisfaction | <input type="checkbox"/> Abuse issues toward others |
| <input type="checkbox"/> Guilt feelings | <input type="checkbox"/> Excessive fighting |
| <input type="checkbox"/> Difficulty being alone | <input type="checkbox"/> Sexual problems |
| <input type="checkbox"/> Anxiety that limits activities | <input type="checkbox"/> Sexual identity concerns |
| <input type="checkbox"/> Mood swings | <input type="checkbox"/> Physical problems |
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Poor concentration |
| <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Relationship problems |
| <input type="checkbox"/> Sadness/depression | <input type="checkbox"/> _____ with child(ren) |
| <input type="checkbox"/> Chronic illness | <input type="checkbox"/> _____ with spouse |
| | <input type="checkbox"/> _____ with significant other |
| | <input type="checkbox"/> _____ with other family member(s) |
| | <input type="checkbox"/> _____ with peers |

Place a check next to any of the following that have happened to you or any immediate family members or others in your household ***in the last two years***:

- | | |
|--|---|
| <input type="checkbox"/> Death of a spouse/partner | <input type="checkbox"/> Reconciliation with spouse/partner |
| <input type="checkbox"/> Death of a close friend | <input type="checkbox"/> Separation/divorce |
| <input type="checkbox"/> Death of a family member | <input type="checkbox"/> Death of a pet |
| <input type="checkbox"/> Major change in health | <input type="checkbox"/> Incarceration |
| <input type="checkbox"/> Marriage | <input type="checkbox"/> Pregnancy/new child |
| <input type="checkbox"/> School failure | <input type="checkbox"/> Unemployment |
| <input type="checkbox"/> Victim of a crime | <input type="checkbox"/> Change of employment |
| | <input type="checkbox"/> Change of residence |

Comments: