

Name: _____ Date of Birth: _____

Address: _____ City, State, Zip: _____

Who are you presently living with? _____

School: _____ Grade: _____

Hobbies: _____

Job: _____

Do you believe in God? Yes No What is your present religious preference? _____

What concerns have brought you to counseling today? _____

PROBLEMS CHECKLIST

Please Rate Each Issue With a Number: 1 = Major Problem 2 = Sometimes a Problem 3 = Never a Problem

- _____ Feeling accepted by my peers
- _____ Learning how to trust others
- _____ Feeling bad about the way I look/my body
- _____ Getting along with my parents or other family members
- _____ Getting a clear sense of what I value
- _____ Worrying about whether I'm normal
- _____ Dealing with sexual feelings and/or problems
- _____ Excessive worry or anxiety
- _____ Trying to decide on a career
- _____ Never eating/eating too much and vomiting to control weight
- _____ Dealing with my alcohol or drug abuse
- _____ Dealing with problems at school
- _____ Dealing with how I feel about myself

Are there any other problems or concerns you would like to address? _____
