

Common Presenting Issues Brought to Therapy

Check all that

General Issues	General Symptoms
<ul style="list-style-type: none"> <input type="checkbox"/> Relationship discord <input type="checkbox"/> Perfectionism <input type="checkbox"/> Performance anxiety <input type="checkbox"/> Chronic pain <input type="checkbox"/> Unexplained pain <input type="checkbox"/> Stress reduction <input type="checkbox"/> Parenting problems <input type="checkbox"/> Phase of life adjustments <input type="checkbox"/> Spiritual / religious issues <input type="checkbox"/> Grief / loss <input type="checkbox"/> Self-esteem <input type="checkbox"/> Codependency <input type="checkbox"/> Childhood trauma <input type="checkbox"/> Sexual trauma <input type="checkbox"/> PTSD <input type="checkbox"/> Blended families <input type="checkbox"/> Procrastination <input type="checkbox"/> Marital / relationship / friendships <input type="checkbox"/> Divorce / separation <input type="checkbox"/> Sexual / intimacy issues <input type="checkbox"/> Problems with boundaries <input type="checkbox"/> OCD / phobias / fears <input type="checkbox"/> Postpartum depression <input type="checkbox"/> Medical trauma <input type="checkbox"/> Terminal / chronic illness <input type="checkbox"/> Loneliness / lack of connection <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____ <p>Distressing, Disturbing, or Traumatic Event / Memory</p> <ul style="list-style-type: none"> <input type="checkbox"/> A Recent distressing or disturbing event <ul style="list-style-type: none"> <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> A past distressing, disturbing or, traumatic event <ul style="list-style-type: none"> <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> An aspect of a memory <ul style="list-style-type: none"> <input type="checkbox"/> _____ <input type="checkbox"/> An aspect of an event <ul style="list-style-type: none"> <input type="checkbox"/> _____ 	<p>Uncontrollable or Distressing Emotions</p> <ul style="list-style-type: none"> <input type="checkbox"/> Anger <input type="checkbox"/> Sadness / depression <input type="checkbox"/> Fears / Worries (Anxiety) <input type="checkbox"/> Numbness / dissociation <p>Negative Beliefs</p> <ul style="list-style-type: none"> <input type="checkbox"/> About self <input type="checkbox"/> About others <input type="checkbox"/> About the world <p>Cognition</p> <ul style="list-style-type: none"> <input type="checkbox"/> Difficulties with concentration <input type="checkbox"/> Intrusive, distressing or unwanted thoughts <input type="checkbox"/> Uncontrollable worries / rumination <input type="checkbox"/> Inability to focus <input type="checkbox"/> Mind fog <p>Somatic</p> <ul style="list-style-type: none"> <input type="checkbox"/> Chronic / unexplained pain <input type="checkbox"/> Migraine <input type="checkbox"/> Sleep disruptions <input type="checkbox"/> Flashback / re-experiencing <input type="checkbox"/> Nightmares <input type="checkbox"/> Panic attacks <input type="checkbox"/> Body / muscle tension <input type="checkbox"/> Inability to relax <input type="checkbox"/> Hypervigilance / on guard <input type="checkbox"/> Numbness <input type="checkbox"/> Dissociation <p>Behavioral Responses</p> <ul style="list-style-type: none"> <input type="checkbox"/> Avoidance <ul style="list-style-type: none"> <input type="checkbox"/> Avoiding certain people <input type="checkbox"/> Avoiding certain places <input type="checkbox"/> Avoiding certain emotions <input type="checkbox"/> Avoiding certain situations <input type="checkbox"/> Avoiding Certain topics <input type="checkbox"/> Isolation from others <input type="checkbox"/> Shutdown / Freeze <input type="checkbox"/> Need to be busy all the time <input type="checkbox"/> Urges / Compulsions <ul style="list-style-type: none"> <input type="checkbox"/> Phobias / fears <input type="checkbox"/> Compulsions <input type="checkbox"/> Uncontrollable Anger: <ul style="list-style-type: none"> <input type="checkbox"/> Yelling <input type="checkbox"/> Screaming <input type="checkbox"/> Physical destruction <input type="checkbox"/> throwing objects

	<input type="checkbox"/> Controlling behaviors <input type="checkbox"/> Physical altercations <input type="checkbox"/> Making threats <input type="checkbox"/> Numbing /distraction responses <ul style="list-style-type: none"> <input type="checkbox"/> Excessive Drug/Alcohol use <input type="checkbox"/> Over/Under eating <input type="checkbox"/> Tobacco <input type="checkbox"/> Over/under working <input type="checkbox"/> Over exercising <input type="checkbox"/> Spacing Out / Zoning out <ul style="list-style-type: none"> <input type="checkbox"/> Excessive social media <input type="checkbox"/> Excessive gaming <input type="checkbox"/> Issues with Porn <input type="checkbox"/> Excessive Screen / TV <input type="checkbox"/> Self-Harm <ul style="list-style-type: none"> <input type="checkbox"/> Hair pulling <input type="checkbox"/> Skin picking <input type="checkbox"/> Cutting <input type="checkbox"/> Suicidal ideations <input type="checkbox"/> Suicidal threats <input type="checkbox"/> Uncontrollable Emotions <ul style="list-style-type: none"> <input type="checkbox"/> Uncontrollable sobbing <input type="checkbox"/> Uncontrollable Fears <ul style="list-style-type: none"> <input type="checkbox"/> Micro-managing <input type="checkbox"/> Need to control (situations, people) <input type="checkbox"/> Over planning (rigidity) <input type="checkbox"/> Procrastination <input type="checkbox"/> Reassurance Seeking <ul style="list-style-type: none"> <input type="checkbox"/> Partner <input type="checkbox"/> Friends <input type="checkbox"/> Medical <input type="checkbox"/> Other: _____ <input type="checkbox"/> People Pleasing <ul style="list-style-type: none"> <input type="checkbox"/> Partner <input type="checkbox"/> Friends <input type="checkbox"/> Other: _____
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How is/are the general issue(s) impacting my present day functioning?

- Interpersonal relationships
- Work / school
- Parenting
- Home
- Social situations
- Friendships
- My perceptions / thoughts about myself

How is/are the symptom (s) impacting my present day functioning?

- Interpersonal relationships
- Work / school
- Parenting
- Home
- Social situations
- Friendships
- My perceptions / thoughts about myself