Name_____ **Date_____**

Please circle and rate your top 5 concerns:

Nervousness	Family	Anxiety
Loneliness	Depression	Suicidal Thoughts
Shyness	Divorce	Unhappiness
Sleep Issues	Sexual Problems	Suicidal Behaviors
Grief	Substance Abuse	Relationships
Stress	Memory	Concentration
Legal Matters	Moodiness	Excess Energy
Focus	Nightmares	Worthlessness
Temper	Excessive Worry	Urge to Repeat Actions
PTSD	Career Choices	Body Image
Alcohol Use	Low self-esteem	Excessive Spending
Sadness	Aggressiveness	Health Concerns
Distractible	Lack of Friends	Hopelessness
Domestic abuse	Parenting	Family Members
Sexual Orientation	Employment	Panic Attacks
Drug use	Transitions	Gender Identity
Impulsivity	Intrusive Thoughts	Ruminative Thinking