



Please mark all of the following that currently apply

**Feelings**

- Helpless
  - Depressed Mood
  - Shameful
  - Angry
  - Guilty
  - Hopeless
  - Lonely
  - Sad
  - Stressed
  - Unhappy
  - Other \_\_\_\_\_
- Anxious
  - Out of Control
  - Afraid
  - Numb
  - Relaxed
  - Happy
  - Excited
  - Hopeful
  - Inferiority Feeling
  - Mood Shifts

**Thoughts**

- Confused
  - Careless
  - Worthless
  - Unmotivated
  - Detached From Reality
  - Unlovable
  - Confident
  - Forgetful / Distracted
  - Lack of interest
  - Other \_\_\_\_\_
- Racing
  - Obsessive
  - Excessive Worry
  - Disorganized
  - Paranoid
  - Suicidal
  - Sensitive
  - Homicidal

**Symptoms/Behaviors**

- Eating Less
- Procrastinating
- Attempting Suicide
- Poor Concentration
- Crying
- Withdrawing Socially
- Skipping Classes
- Drop in academic performance
- Injuring self (cutting, etc.)
- Compulsivity
- Career / Major Choice
- Eating More
- Acting Aggressively
- Disorganization
- Impulsivity
- Recklessness
- Irritability
- Passivity
- Drug Use
- Alcohol Use
- Binge Drinking
- Sexual Issues / Problems
- Social Anxiety
- Marital Relationships
- Parent / Child Conflicts
- Lack of Ambition / Goals
- Poor Peer Relationships
- Nightmares
- Worries About Body Image
- Spiritual Problems
- Dating Concerns
- Finances
- Other \_\_\_\_\_

**Physical Symptoms**

- Insomnia
- Tired
- Weight Gain or Loss
- Pain
- Headaches
- Tightness In Chest
- Dizziness or Light-headedness
- Numbness or Tingling
- Vomiting
- Rapid Heart Beat
- Dry Mouth
- Excessive Sleep
- Loss of Memory
- Eating Problems
- Other \_\_\_\_\_

Are you presently under a physician's care? YES / NO

If yes, name of physician: \_\_\_\_\_

Please describe any medical conditions you have:

Anything else you would like us to know about you:

*Please also review the **Informed Consent for Counseling** form with your counselor.*