

CLIENT CONCERNS CHECKLIST

Client Name: _____ DOB: _____ Date completed: _____

Completed by: _____ Relationship to client: _____

*If you check an item, please provide explanation in the Notes section to the right of the item.

<p>Domain: BEHAVIORAL</p> <p><u>Concern</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Anger/Aggression <input type="checkbox"/> Hyperactivity/Impulsivity <input type="checkbox"/> Gambling <input type="checkbox"/> Sexual acting out <input type="checkbox"/> Suicidal thoughts/behaviors <input type="checkbox"/> Homicidal thoughts/behaviors <input type="checkbox"/> Gender identity issues <input type="checkbox"/> Anxiety/worry <input type="checkbox"/> Emotional Trauma <input type="checkbox"/> Sadness/depression <input type="checkbox"/> Mood instability <input type="checkbox"/> Grief/loss/bereavement <input type="checkbox"/> Phobia/unusual fears <input type="checkbox"/> Eating disorder <input type="checkbox"/> Sleep disturbance <input type="checkbox"/> Psychosis (delusions/hallucinations) <input type="checkbox"/> Additive or obsessive behavior/thoughts <input type="checkbox"/> Chemical dependency/abuse <input type="checkbox"/> _____ 	<p><u>Notes</u></p>
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<p>Domain: SOCIAL</p> <p><u>Concern</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Isolation <input type="checkbox"/> Dishonesty <input type="checkbox"/> Relational difficulties <input type="checkbox"/> Limited social support <input type="checkbox"/> Social anxiety/phobia <input type="checkbox"/> _____ 	<p><u>Notes</u></p>
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<p>Domain: FAMILY/HOME</p> <p><u>Concern</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Parenting challenges <input type="checkbox"/> Separation/divorce <input type="checkbox"/> Household member violence/abuse <input type="checkbox"/> Difficulty accessing resources <input type="checkbox"/> Conflictual relationships <input type="checkbox"/> Blended family <input type="checkbox"/> Organizational skills <input type="checkbox"/> Experiencing homelessness <input type="checkbox"/> _____ 	<p><u>Notes</u></p>
<p>Domain: OCCUPATIONAL/SCHOOL</p> <p><u>Concern</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Grades/achievement/performance <input type="checkbox"/> Absenteeism/lateness <input type="checkbox"/> Inattention/disengagement <input type="checkbox"/> Suspension/expulsion/termination <input type="checkbox"/> Bullying (victim or perpetrator) <input type="checkbox"/> Career change <input type="checkbox"/> _____ 	<p><u>Notes</u></p>
<p>Domain: FINANCIAL</p> <p><u>Concern</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Financial management/organization <input type="checkbox"/> Unemployment/underemployment/job loss <input type="checkbox"/> Public assistance (food stamps, Medicaid, etc.) <input type="checkbox"/> Debt <input type="checkbox"/> Overspending <input type="checkbox"/> _____ 	<p><u>Notes</u></p>
<p>Domain: LEGAL</p> <p><u>Concern</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Victim of criminal act <input type="checkbox"/> DUI/drug arrest <input type="checkbox"/> Domestic violence/order of protection <input type="checkbox"/> Involved in civil suit <input type="checkbox"/> On parole/probation <input type="checkbox"/> Child custody dispute <input type="checkbox"/> Gang involvement <input type="checkbox"/> _____ 	<p><u>Notes</u></p>

<p>Domain: HEALTH</p> <p><u>Concern</u></p> <p><input type="checkbox"/> Nicotine use</p> <p><input type="checkbox"/> Alcohol/drug use</p> <p><input type="checkbox"/> Self-care/hygiene</p> <p><input type="checkbox"/> Body weight or appearance satisfaction</p> <p><input type="checkbox"/> Chronic medical condition</p> <p><input type="checkbox"/> Somatic complaint</p> <p><input type="checkbox"/> Pregnancy</p> <p><input type="checkbox"/> Brain injury or other serious injury</p> <p><input type="checkbox"/> Prescription drug use (list): _____</p> <p><input type="checkbox"/> Other: _____</p>	<p><u>Notes</u></p>
<p>Domain: ABUSE/NEGLECT/EXPLOITATION</p> <p><u>Concern</u></p> <p><input type="checkbox"/> Victim of physical/emotional/sexual abuse</p> <p><input type="checkbox"/> Perpetrator of physical/emotional/sexual abuse</p> <p><input type="checkbox"/> Victim of exploitation (financial or otherwise)</p> <p><input type="checkbox"/> Perpetrator of exploitation (financial or otherwise)</p> <p><input type="checkbox"/> _____</p>	<p><u>Notes</u></p>
<p>Domain: OTHER/MISCELLANEOUS</p> <p><u>Concern</u></p> <p><input type="checkbox"/> _____</p> <p><input type="checkbox"/> _____</p>	<p><u>Notes</u></p>

Comments/notes: _____
