Please check any problems that you feel apply to you and/or a significant other (please note to whom the problem refers).

Mood
- ☐ depression
- ☐ suicidal thoughts
- ☐ suicidal actions

Anxiety
- ☐ stress/tension
- ☐ general anxiety
- ☐ panic attacks
- ☐ phobias

Identity
- ☐ self-esteem
- ☐ general identity
- ☐ sexual/gender
- ☐ ethnic identity

Trauma
- ☐ rape/sexual assault
- ☐ physical assault
- ☐ physical abuse
- ☐ sexual abuse
- ☐ battered/domestic violence

Medical/Health
- ☐ sleep disturbances
- ☐ pregnancy
- ☐ abortion
- ☐ other health problem

Academic/Career
- ☐ academic performance
- ☐ academic/career choice
- ☐ test anxiety
- ☐ speech performance anxiety
- ☐ concentration problems
- ☐ motivation problems

Relationship Problems
- ☐ with peers
- ☐ dating/marital
- ☐ family
- ☐ bereavement/grief
- ☐ abusive relationship

Eating Disturbance
- ☐ anorexia
- ☐ bullimia
- ☐ overeating/obesity
- ☐ other eating issue

Miscellaneous
- ☐ financial concerns
- ☐ legal difficulties
- ☐ compulsive gambling

Family History (not client)
- ☐ divorced/separated parents
- ☐ psychiatric history

Substance Use
- ☐ alcohol or other drug
- ☐ cigarette smoking

Prior Therapy or Counseling (name of therapist and dates seen):

Please provide any additional information that you feel is important:

I authorize Dr. Davis to contact the referral source for professional purposes, if applicable.

Yes: ○ No: ○

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