

Check List

Counseling and Psychological Services

Name: _____

Date: _____

Please read the following checklist and check **once** the items of concern to you.
Check **twice** those items which are of most concern to you.

Academic:

- _____ not spending enough time studying
- _____ worried about grades
- _____ fearing failure in college
- _____ absent from classes too often
- _____ test taking anxiety
- _____ problems with a professor
- _____ procrastination
- _____ lack of academic motivation
- _____ not knowing how to study effectively
- _____ frequently late for class
- _____ difficulty mastering academic demands of my major
- _____ questions about my major
- _____ difficulty following academic "rules" and policies
- _____ alcohol or drug use has affected my grades
- _____ spending too much time on the computer
- _____ concerns related to post-graduation

Learning Difficulties:

- _____ difficulty with vocabulary/language skills
- _____ difficulty with note taking
- _____ trouble concentrating
- _____ time management (meeting deadlines)
- _____ difficulties getting organized
- _____ poor reading comprehension
- _____ difficulty communicating through writing
- _____ difficulty performing math calculations
- _____ day dreaming
- _____ poor memory
- _____ difficulty sitting through a lecture
- _____ shifting from one uncompleted activity to another
- _____ loses things necessary for tasks or activities at school, work or at home
- _____ difficulty copying from the blackboard
- _____ poor spelling skills

Family:

- _____ homesickness
- _____ financial worries
- _____ family illness
- _____ problems with parents/relatives
- _____ choosing a major based on family pressures
- _____ lack of family support
- _____ feeling a great deal of pressure from family to succeed in college
- _____ excessive credit card debt

Personal/Interpersonal:

- _____ roommate difficulties
- _____ sexual concerns
- _____ long-distance relationship
- _____ anxious about meeting new people
- _____ lack of friends
- _____ too much social life
- _____ over reliance on others
- _____ not feeling good about appearance
- _____ uncomfortable at social affairs
- _____ wondering if I will find a suitable partner
- _____ significant other relationship problems
- _____ feeling lonely and isolated
- _____ being made fun of
- _____ feelings are easily hurt by others
- _____ not trusting others
- _____ getting into arguments
- _____ fear of being rejected
- _____ too easily led by other people
- _____ feeling that nobody understands
- _____ feeling discriminated against
- _____ lack of assertiveness
- _____ not being comfortable with the current culture
- _____ trouble socializing with others
- _____ difficulty getting over a relationship
- _____ abusive relationship
- _____ victim of physical/sexual/verbal/emotional Abuse
- _____ criminal/legal problems

THIS IS A DOUBLE-SIDED FORM – PLEASE COMPLETE BOTH SIDES.

Emotional Issues:

- _____ feeling nervous/anxious
- _____ unhappy much of the time
- _____ feeling tired
- _____ emotional ups and downs
- _____ being impulsive
- _____ feeling as though life is not worth living
- _____ periods of crying
- _____ thoughts of harming others
- _____ thoughts of suicide
- _____ cutting oneself or thoughts of doing so
- _____ flashbacks of past trauma
- _____ recurrent and persistent ideas, thoughts, impulses or images that are intrusive or unwanted
- _____ getting into arguments with others
- _____ worrying about unimportant things
- _____ feeling uncomfortable when alone
- _____ feeling that others are talking about me
- _____ hearing voices or sounds, seeing things others don't see
- _____ difficulty controlling anger
- _____ feeling easily hurt by others
- _____ feeling that no one understands you
- _____ feeling inferior to others
- _____ unusual sensory experiences
- _____ feeling agitated/irritable

Spiritual/Existential:

- _____ values conflict
- _____ concerns with my religious beliefs
- _____ lacking a philosophy in life
- _____ death of a significant other

Health/Physical:

- _____ experiencing negative consequences of drugs and/or alcohol
- _____ use of alcohol or drugs as a way to cope
- _____ difficulty controlling drinking/drugging
- _____ difficulty cutting down on alcohol/drug
- _____ feeling guilty about drug/alcohol use
- _____ eating problems
- _____ worrying about weight/body image
- _____ physical pain
- _____ difficulties falling asleep
- _____ too much sleep
- _____ too little sleep
- _____ others say that I have an alcohol/drug problem
- _____ not feeling refreshed when waking
- _____ lack of appetite
- _____ weight loss
- _____ weight gain
- _____ history of blackouts
- _____ excessive energy
- _____ insufficient knowledge about sexual matters
- _____ concerns about pregnancy
- _____ concerns about sexually transmitted diseases
- _____ history of head injury, loss of consciousness, neurological illness
- _____ concerns regarding my health

Briefly describe any other concerns that were not covered above:

Rate the level of distress you are currently experiencing by circling the appropriate number:

No Distress 0 1 2 3 4 5 6 7 8 9 10 Extreme Distress

THIS IS A DOUBLE-SIDED FORM – PLEASE COMPLETE BOTH SIDES.