BLOOMING BRAINS™

NAME: ___________________________________

Date: ____________________________________

Session #: _____________

CHECKLIST OF CONCERNS

Below is a list of problems that clients frequently describe to us. Please check off any that match your current concerns and comment to clarify. Use the past month as a guide. Please note the Duration, Intensity and Frequency of each occurrence. Scale: 1(not at all) to 10(extreme). Put a star beside your top 5 concerns.

Concern	Duration	Intensity	Frequency		Concern	Duration	Intensity	Frequency
Sleep								
Difficulty falling asleep					Waking not feeling rested			
Wakeful or restless during night					Nightmares or night terrors			
Waking up early					Snoring			
Difficulty waking up					Other:			
Skin/Hair/Nails								
Problems with skin, hair or nails					Other:			
Immune System								
Allergies					Frequent colds, infections			
Asthma					Fatigue			
Eyes								
Double or blurred vision					Floaters or spots in your vision			
Blind spots					Other			
Ear/Nose/Throat								
Hearing loss					Grinding your teeth			
Ringing in ears					Sense of taste changed or lost			
Sense of smell changed or lost					Hoarseness or sore throat			
Nose or sinuses blocked					Other			
Heart/Lungs								
Problems breathing					Palpitations			
Heart problems (including pacemaker)					Dizziness			
Hypertension					Other:			
Bladder/Intestines								
Nausea or vomiting					Diarrhea			
Gastric pain					Constipation			
Gas or bloating					Difficulty controlling bladder/bowels			
Irritable bowel					Other			
Hormonal/Blood								
Appetite problems (too much/ too little)					Thyroid problems			
Diabetes					PMS symptoms			
Strong food cravings					Other menopausal symptoms			

Sensitivity to heat or cold					Libido concerns (high or low)			
Bones/Joints/Muscles								
Pain or stiffness in joints or muscles					Fibromyalgia			
Sore trigger points					Other:			
Brain and Central Nervous System								
Headaches or migraines					Difficulty speaking			
Fainting or weakness					Tremor (shaking)			
Seizures					Hyper or hypo activity			
Sweating					Problems with balance			
Blocking on words					Motor or vocal tics			
Clenching feeling in abdomen					Coordination			
Concussion Symptoms					Other			
Habits								
Alcohol or marijuana use / abuse					Repetitive or self-soothing actions			
Other drug use / abuse					Eating or diet concerns			
Other:					Other			
Attention & Organization								
Difficulty with focusing/easily distracted					Not completing tasks			
Forgetful					Lose train of thought			
Disorganized or messy					Other			
Learning/Academic								
Difficulty completing schoolwork					Spatial problems			
Getting into trouble at school					Difficulty with particular subjects			
Inverting letters/numbers					Other:			
Behavior/Emotions								
Mood swings					Feeling others are against you			
Feeling down, depressed or flat					Behaviours that cause trouble			
Feeling sad					Intense or frequent anger			
Feeling anxious					Impulsiveness			
Panic attacks					Feeling overwhelmed			
Worrying					Easily discouraged			
'Stuck' or repetitive thoughts					Difficulty controlling emotions			
Concern about what others think of you					Disengaged in relationships			
Phobias/ intense fears					Other			
Other								
Medications					Other:			
Mental Health Concerns (list)					Other:			
Other Health Concerns (list)					Other:			