DIRECTED WELLNESS CENTER
Checklist of Concerns

Name: _____ **Date:** _____

Below is a list of problems that clients frequently describe to us. Please circle any that match your current concerns. If you are not sure whether to endorse an item, use the past week as a guide.
Please rate each item you circled from 1 to 10 with 1 being a mild concern and 10 being extremely problematic. Feel free to add any comments as necessary.

BODY

Immune System
___Allergies
___Asthma
___Frequent colds, infections
___Yeast infections
___Fatigue
___Chronic Fatigue Syndrome

Sleep
___Difficulty falling asleep
___Wakeful or restless during night
___Waking up early
___Difficulty waking up
___Nightmares or night terrors
___Snoring
___Sleep walking
___Sleep apnea
___Frequent night waking
___Sleeps greater than 9 hours
___Fall asleep in low stimulation
___Bedwetting advanced age

Skin/Hair/Nails
___Problems with skin
___Hair
___Nails

Eyes
___Double or blurred vision
___Blind spots
___Spots in your vision
___

Heart/Lungs
___Problems breathing
___Heart problems
___Hypertension
___Palpitations
___Dizziness

Ear/Nose/Throat
___Hearing loss
___Ringing in ears
___Earaches
___Sense of smell less or lost
___Nose or sinuses blocked
___Grinding your teeth
___Sense of taste changed
___Hoarseness or sore throat

Intestines
___Nausea or vomiting
___Gastric pain
___Gas or bloating
___Irritable bowel
___Diarrhea
___Constipation

Hormonal/Blood
___Appetite problems (e.g. wanting to eat when not hungry, etc)
___Diabetes
___Desire for sweets or carbohydrates
___Sensitivity to heat or cold
___Thyroid problems
___PMS symptoms
___Hot flashes
___Other menopausal symptoms
___Low interest in sex
___Excessive interest in sex

Bones/Joints/Muscles
___Pain or stiffness in joints or muscles
___Sore trigger points
___Fibromyalgia
___Bodily fatigue

Nervous System
___Headaches or migraines
___Fainting
___Seizures
___Memory loss
___Blocking on words
___Reading problems
___Difficult speaking
___Tremor (shaking)
___Weakness
___Hyperactivity
___Problems with balance
___Hand/ arm flapping
___Motor or vocal tics

Attention & Organization
___Inattentive
___Frequent daydreaming
___Spaciness
___Forgetful
___Confused Thinking
___Difficult focusing
___Easily distracted
___Make mistakes
___Difficult organizing activities
___Not completing tasks
___Lose train of thought

School/Learning
___Difficulty completing schoolwork
___Getting into trouble at school
___Inverting letters/numbers
___Spatial problems (e.g. difficult building things, understanding how things should be put together)
___Difficulty with particular subjects

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Name: _____ **Date:** _____

BODY (continued)		
Bowel/Bladder	**Habits**	**Habits (continued)**
___Difficulty urinating	___Dislikes caffeine	___Smoke cigarettes
___Difficulty holding urine	___Dislikes alcohol affects	___Concerns about your diet
___Difficult bowel control	___Likes alcohol affects	___Desire caffeine
___Freq bladder infections	___Abuses substances	___Use marijuana
	___Sometimes drink too much	___Other addictions

Behavior/Emotions		
__Depression/sad	__Need to repeat actions or words over and over	__Low emotional awareness
__Depression/angry	__Bingeing	__Multiple relationship issues
__Low self-esteem	__Restricting your food intake	__Low motivation
__Introversion	__Making yourself vomit	__Busy mind
__Excessive shy	__Phobias - avoiding things	__Fidgety
__Mood swings	__Feeling others are against you	__Easily boredImpatient
__Feeling down, depressed or flat	__Behaviors that get you into trouble, or are not good for you	__Agitated
__Feeling sad	__Feeling angry a lot	__Aggressive
__Feeling anxious	__Impulsive	__Autism
__Panic attacks	__Feeling overwhelmed	__Early Developmental Trauma
__Worry	__Lethargy	__Reactive Attachment Disorder
__Thoughts that won't leave your mind	__Multiple social conflicts	__Bonding Issues
		__Bipolar diagnosis

Reminder: While many NeurOptimal® users have reported observing significant improvements in a variety of problem areas, this office does not diagnose or treat any medical or psychological conditions. The purpose of this list is purely to allow for the tracking of any changes over time. Thank you.

Symptom Severity Index: _____ (to be completed by staff)