

Your initials: _____

To assist you with achieving your goals, it is helpful for me to know more about your concerns. Please circle the number that reflects how you are feeling today and hand back to me.

Life Stressors:

(very few) 1-----2-----3-----4-----5-----6-----7-----8-----9-----10 (a lot)

Sleep/energy:

(I get enough/am rested) 1---2---3---4---5---6---7---8---9---10 (very tired/have to nap)

Appetite:

(too little) 1---2---3---4---5---6---7---8---9---10 (too much/feels out of control)

Periods:

(not concerned) 1-----2-----3-----4-----5-----6-----7-----8-----9-----10 (VERY concerned bc irregular/ heavy/or painful)

Pimples:

(no concerns) 1-----2-----3-----4-----5-----6-----7-----8-----9-----10 (pretty bad)

Weight concern:

(no concerns) 1---2---3---4---5---6---7---8---9---10 (very concerned)

Excess hair on face, belly, back:

(no concerns) 1---2---3---4---5---6---7---8---9---10 (very concerned)

Mood concern:

(I'm happy or fine) 1-----2-----3-----4-----5-----6-----7-----8-----9-----10 (really anxious &/or depressed)