



COHESION INTERVENTION SERVICES

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ISSUES • SYMPTOMS

Please check issues that you have been experiencing in the past 6 months:

- | | |
|---|--|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Job related problems |
| <input type="checkbox"/> Grief/Loss | <input type="checkbox"/> Sleep problems |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Health related problems |
| <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Educational problems |
| <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> Relationship problems |
| <input type="checkbox"/> Substance Dependence | |
| <input type="checkbox"/> Other addiction | |

Please clarify briefly for any of the checked items:

Please indicate any other information, which you would like to be known prior to initial appointment.
