








Session Issues/Concerns Checklist

Choose 4 - 5 items (or create your own list). Have the list handy during your session with Debi.

<input type="checkbox"/> Aching wrists, fingers, hands <input type="checkbox"/> Addiction: Adrenaline or Drama <input type="checkbox"/> Addiction: Alcohol or other drinks <input type="checkbox"/> Addiction: Cosmetic Surgery <input type="checkbox"/> Addiction: Drugs/Cigarettes <input type="checkbox"/> Addiction: Food <input type="checkbox"/> Addiction: Gambling <input type="checkbox"/> Addiction: Internet/Social Media <input type="checkbox"/> Addiction: Sex <input type="checkbox"/> Addiction: Shopping <input type="checkbox"/> Addiction: Sports <input type="checkbox"/> Addiction: TV/Video Games <input type="checkbox"/> Addiction: Work <input type="checkbox"/> Addiction: Other _____ <input type="checkbox"/> Anger/bitterness <input type="checkbox"/> Anxious <input type="checkbox"/> Bedwetting, nightmares, night terrors <input type="checkbox"/> Before or after medical/dental procedure <input type="checkbox"/> Blocks: clients (getting and/or keeping) <input type="checkbox"/> Blocks: creativity/writing <input type="checkbox"/> Blocks: health/wellness <input type="checkbox"/> Blocks: love/relationships <input type="checkbox"/> Blocks: money/finances <input type="checkbox"/> Body feels heavy or weighted down <input type="checkbox"/> Body image issues or eating disorder <input type="checkbox"/> Bowel Problems: Constipation <input type="checkbox"/> Bowel Problems: Diarrhea <input type="checkbox"/> Brain fog, unable to focus <input type="checkbox"/> Burning chest sensation <input type="checkbox"/> Chronic illness or physical dis-ease <input type="checkbox"/> Claustrophobia <input type="checkbox"/> Cold feet/hands <input type="checkbox"/> Congested nasal passages <input type="checkbox"/> Constant negativity <input type="checkbox"/> Depressed, sad, or mood swings <input type="checkbox"/> Difficult to take deep breaths	<input type="checkbox"/> Difficulty falling and staying asleep <input type="checkbox"/> Excessive sweating <input type="checkbox"/> Fear of _____ <input type="checkbox"/> Feeling insecure <input type="checkbox"/> Feeling of blocked breathing <input type="checkbox"/> Frustration <input type="checkbox"/> Grief <input type="checkbox"/> Guilt <input type="checkbox"/> Hatred of or toward someone <input type="checkbox"/> Headaches//Migraines <input type="checkbox"/> Heartache/Broken Heart <input type="checkbox"/> Helplessness/hopelessness <input type="checkbox"/> Highly Sensitive or Emotional <input type="checkbox"/> Hormonal issues <input type="checkbox"/> Hot Flashes/Night Sweats <input type="checkbox"/> Indecisiveness/wishy-washy <input type="checkbox"/> Indigestion/Gas/Bloating <input type="checkbox"/> Infertility <input type="checkbox"/> Jealously <input type="checkbox"/> Joint pain or lack of mobility <input type="checkbox"/> Lack of motivation or desire <input type="checkbox"/> Limiting beliefs about: career/Job <input type="checkbox"/> Limiting beliefs about: money <input type="checkbox"/> Limiting beliefs about: outlook on life <input type="checkbox"/> Limiting beliefs about: relationships <input type="checkbox"/> Limiting beliefs about: success <input type="checkbox"/> Limiting beliefs about: weight loss <input type="checkbox"/> Loneliness/Shy/Bashful <input type="checkbox"/> Menopause: Pre, Post, Peri <input type="checkbox"/> Morning sickness <input type="checkbox"/> Negative self-talk <input type="checkbox"/> Numbness/Tingling: Arms <input type="checkbox"/> Numbness/Tingling: Feet <input type="checkbox"/> Numbness/Tingling: Hands <input type="checkbox"/> Numbness/Tingling: Legs <input type="checkbox"/> Obsessive/Compulsive	<input type="checkbox"/> Old negative experiences/accidents <input type="checkbox"/> Old negative memories <input type="checkbox"/> Over-active/restless mind <input type="checkbox"/> Pain/Discomfort: Overall body <input type="checkbox"/> Pain/Discomfort: Head/Neck <input type="checkbox"/> Pain/Discomfort: Hips/Legs <input type="checkbox"/> Pain/Discomfort: Torso (front or back) <input type="checkbox"/> Pain/Discomfort: Shoulder/Arms <input type="checkbox"/> Pain/Discomfort: Other _____ <input type="checkbox"/> Panic attacks <input type="checkbox"/> Perfectionist <input type="checkbox"/> Physical/Mental/Emotional/Spiritual Abuse <input type="checkbox"/> Post-traumatic stress <input type="checkbox"/> Procrastination <input type="checkbox"/> Rage <input type="checkbox"/> Resentment <input type="checkbox"/> Resistance to: eating veggies <input type="checkbox"/> Resistance to: exercise <input type="checkbox"/> Resistance to: staying well-hydrated <input type="checkbox"/> Restless legs <input type="checkbox"/> Road rage or other rage <input type="checkbox"/> Scare/Startle Easily <input type="checkbox"/> Seasonal allergies <input type="checkbox"/> Self-esteem or social issues <input type="checkbox"/> Self-sabotaging thoughts/behaviors <input type="checkbox"/> Sharp electric-shock type pain <input type="checkbox"/> Sinus problems <input type="checkbox"/> Skin: rash, redness, itch, dryness, acne <input type="checkbox"/> Stiff hands and fingers <input type="checkbox"/> Stress/Worry/Unable to Relax <input type="checkbox"/> Struggling with school or work <input type="checkbox"/> Struggling with spiritual gifts/purpose <input type="checkbox"/> Teeth Grinding/Jaw Clenching <input type="checkbox"/> Traumatic Birth - Mom or Child <input type="checkbox"/> Unworthy/worthless <input type="checkbox"/> Urinary problems
<p style="text-align: center;"><i>Sexual Intimacy Issues/Concerns</i></p> <input type="checkbox"/> Lack of desire <input type="checkbox"/> Lack of arousal <input type="checkbox"/> Lack of orgasm <input type="checkbox"/> Physical pain	<p style="text-align: center;"><i>Request Info About Specialized Services</i></p> <input type="checkbox"/> Ancestral Lineage Clearing <input type="checkbox"/> Business Clearing <input type="checkbox"/> Name Clearing <input type="checkbox"/> Chakra Clearing & Balancing <input type="checkbox"/> Energy Clearing & Balancing <input type="checkbox"/> House & Land Healing	<p style="text-align: center;"><i>Heart-Wall</i></p>  <p style="text-align: center;">Checked at your first session!</p>
<p style="text-align: center;"><i>Severity Assessment Tool</i></p> <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;">  0 </div> <div style="text-align: center;">  1-2 MILD </div> <div style="text-align: center;">  3-4 MODERATE </div> <div style="text-align: center;">  5-6 </div> <div style="text-align: center;">  7-8 </div> <div style="text-align: center;">  9-10 SEVERE </div> </div>	<p style="text-align: center;"><i>Eliminate Food or Drink Cravings</i></p> <p>1 _____</p> <p>2 _____</p>	