

A questionnaire about you and how you are feeling

We hope that this questionnaire will help us to have a better understanding of your feelings. Please answer the four questions on this page and then return this form to your therapist. All your answers will be confidential. We will ask you to fill in just one more form like this near the end of your course of therapy.

Question 1

a Choose the problem that troubles you most. (Please write it in the box below.)

b How much has it affected you over the last week? (Please tick one box below.)

Not at all affected 0 1 2 3 4 5 Severely affected

c How long ago were you first concerned about this problem? (Please tick one box below.)

Under one month Between one and three months Over three months but under one year One to five years Over five years

Question 2

a Choose another problem that troubles you. (Please write it in the box below.)

b How much has it affected you over the last week? (Please tick one box below.)

Not at all affected 0 1 2 3 4 5 Severely affected

c How long ago were you first concerned about this problem? (Please tick one box below.)

Under one month Between one and three months Over three months but under one year One to five years Over five years

Question 3

a Choose one thing that is hard to do because of your problem (or problems). (Please write it in the box below.)

b How hard has it been to do this thing over the last week? (Please tick one box below.)

Not at all hard 0 1 2 3 4 5 Very hard

Question 4

How have you felt in yourself this last week? (Please tick one box below.)

Very good 0 1 2 3 4 5 Very bad



This questionnaire is called the Psychological Outcome Profiles questionnaire (PSYCHLOPS). It has been written by STaRNet, a primary care research network funded by the NHS.

Therapist Assessment Form – pre therapy

To be completed by therapist

surgery ID xx	client initials xx	client age years
therapist ID xx	client gender M / F	
referral date DD/MM/YY		
assessment date DD/MM/YY		
date pre-therapy PSYCHLOPS completed DD/MM/YY		

How does the client describe their ethnic group?
(Please tick one of the boxes below)

<p>Asian or Asian British</p> <p>Bangladeshi <input type="checkbox"/></p> <p>Indian <input type="checkbox"/></p> <p>Pakistani <input type="checkbox"/></p> <p>Other Asian background (please specify) <input type="checkbox"/></p>	<p>Chinese or Other ethnic groups</p> <p>Chinese <input type="checkbox"/></p> <p>Other ethnic group (please specify) <input type="checkbox"/></p>	<p>White</p> <p>British <input type="checkbox"/></p> <p>Irish <input type="checkbox"/></p> <p>Other White background (please specify) <input type="checkbox"/></p>
<p>Black or Black British</p> <p>Caribbean <input type="checkbox"/></p> <p>African <input type="checkbox"/></p> <p>Other Black background (please specify) <input type="checkbox"/></p>	<p>Mixed background</p> <p>White & Asian <input type="checkbox"/></p> <p>White & Black African <input type="checkbox"/></p> <p>White & Black Caribbean <input type="checkbox"/></p> <p>Other Mixed background (please specify) <input type="checkbox"/></p>	

client's first language

Medication question 1

Is the client taking antidepressants (at the time of **first** therapy session)? *(Please tick one box below.)*

Yes	No	Don't know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Medication question 2

Is the client taking tranquillisers (at the time of **first** therapy session)? *(Please tick one box below.)*

Yes	No	Don't know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Previous counselling question

Has the client had professional counselling prior to this referral? *(Please tick one box below.)*

Yes	No	Don't know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If YES, please could you provide details if available?
(number of sessions, type of therapy, etc.)