1. **Please press REPLY on this email**
2. **Please complete the form prior to the session**
3. **Once the form is completed, please press SEND to submit the form**

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| NAME | Click here to enter text. | DATE | | Click here to enter a date. | |
| PHQ-9  **Over the last 2 weeks, how often have you been bothered by any of the following problems?** | | **Not at all**  **0** | **Several Days**  **1** | **More than half the days**  **2** | **Nearly every day**  **3** |
| Little interest or pleasure in doing things ? | |  |  |  |  |
| Feeling down, depressed, or hopeless? | |  |  |  |  |
| Trouble falling or staying asleep, or sleeping too much? | |  |  |  |  |
| Feeling tired or having little energy? | |  |  |  |  |
| Poor appetite or overeating? | |  |  |  |  |
| Feeling bad about yourself — or that you are a failure or have let yourself or your family down? | |  |  |  |  |
| Trouble concentrating on things, such as reading the newspaper or watching television? | |  |  |  |  |
| Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more? | |  |  |  |  |
| Thoughts that you would be better off dead or of hurting  yourself in some way? | |  |  |  |  |

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| **Risk Assessment responses** | | | | | | | | | | |
| **I have thoughts of killing myself:** | | | | | | | | | Y | N |
| **I have thoughts of killing myself, but I would not carry them out:** | | | | | | | | | Y | N |
| **I have thought of killing myself and I have made plans or preparations to act on these thoughts:** | | | | | | | | | Y | N |
| **What is the likelihood that you will act on these thoughts/plans?** | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

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| GAD-7  **Over the last 2 weeks, how often have you been bothered by any of the following problems?** | **Not at all**  **0** | **Several Days**  **1** | **More than half the days**  **2** | **Nearly every day**  **3** |
| Feeling nervous, anxious or on edge? |  |  |  |  |
| Not being able to stop or control worrying? |  |  |  |  |
| Worrying too much about different things? |  |  |  |  |
| Trouble relaxing? |  |  |  |  |
| Being so restless that it is hard to sit still? |  |  |  |  |
| Becoming easily annoyed or irritable? |  |  |  |  |
| Feeling afraid as if something awful might happen? |  |  |  |  |

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| **Are you prescribed medication for anxiety or depression** | Y | N |
| **Are you taking the medication prescribed for anxiety or depression?** | Y | N |

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| **IAPT Phobia Scales** | | | | | |
| Choose a number from the scale below to show how much you would avoid each of the situations or objects listed below. Then write the number in the box opposite the situation. | | | | | |
| 0\_ \_ \_ \_ \_ \_ \_1\_ \_ \_ \_ \_ \_ 2 \_ \_ \_ \_ \_ \_ \_3\_ \_ \_ \_ \_ \_ \_4\_ \_ \_ \_ \_ \_5 \_ \_ \_ \_ \_ \_6\_ \_ \_ \_ \_ \_ \_ 7\_ \_ \_ \_ \_ \_ \_8 | | | | | |
| Would not avoid it | Slightly  avoid it | Definitely  avoid it | Markedly  Avoid it | Always  Avoid it | |
| **Social situations due to a fear of being embarrassed or making a fool of myself** | | | | | Choose an item. |
| **Certain situations because of a fear of having a panic attack or other distressing symptoms such as loss of bladder control, vomiting or dizziness)** | | | | | Choose an item. |
| **Certain situations because of a fear of particular objects or activities (such as animals, heights, seeing blood, being in confined spaces, driving or flying).** | | | | | Choose an item. |

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| **Work and Social Adjustment** | | | | |
| **People's problems sometimes affect their ability to do certain day-to-day tasks in their lives. To rate your problems look at each section and determine on the scale how much your problem impairs your ability to carry out the activity.** | | | | |
| 1. **WORK** - if you are retired or choose not to have a job for reasons unrelated to your problem,   please tick N/A (not applicable). **N/A** | | | | |
| 0\_ \_ \_ \_ \_ \_ \_1\_ \_ \_ \_ \_ \_ 2 \_ \_ \_ \_ \_ \_ \_3\_ \_ \_ \_ \_ \_ \_4\_ \_ \_ \_ \_ \_5 \_ \_ \_ \_ \_ \_6\_ \_ \_ \_ \_ \_ \_ 7\_ \_ \_ \_ \_ \_ \_8 | | | | |
| Would not avoid it | Slightly  avoid it | Definitely  avoid it | Markedly  Avoid it | Always  Avoid it |
| **ANSWER 1-8** Choose an item. | | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 2. **HOME MANAGEMENT** – Cleaning, tidying, shopping, cooking, looking after home/children, paying bills etc. | | | | |
| 0\_ \_ \_ \_ \_ \_ \_1\_ \_ \_ \_ \_ \_ 2 \_ \_ \_ \_ \_ \_ \_3\_ \_ \_ \_ \_ \_ \_4\_ \_ \_ \_ \_ \_5 \_ \_ \_ \_ \_ \_6\_ \_ \_ \_ \_ \_ \_ 7\_ \_ \_ \_ \_ \_ \_8 | | | | |
| Would not avoid it | Slightly  avoid it | Definitely  avoid it | Markedly  Avoid it | Always  Avoid it |
| **ANSWER 1-8** Choose an item. | | | | |
| 3. **SOCIAL LEISURE ACTIVITIES** - With other people, e.g. parties, pubs, outings, entertaining etc. | | | | |
| 0\_ \_ \_ \_ \_ \_ \_1\_ \_ \_ \_ \_ \_ 2 \_ \_ \_ \_ \_ \_ \_3\_ \_ \_ \_ \_ \_ \_4\_ \_ \_ \_ \_ \_5 \_ \_ \_ \_ \_ \_6\_ \_ \_ \_ \_ \_ \_ 7\_ \_ \_ \_ \_ \_ \_8 | | | | |
| Would not avoid it | Slightly  avoid it | Definitely  avoid it | Markedly  Avoid it | Always  Avoid it |
| **ANSWER 1-8** Choose an item. | | | | |
| 4. **PRIVATE LEISURE ACTIVITIES** – Done alone, e.g. reading, gardening, sewing, hobbies, walking etc. | | | | |
| 0\_ \_ \_ \_ \_ \_ \_1\_ \_ \_ \_ \_ \_ 2 \_ \_ \_ \_ \_ \_ \_3\_ \_ \_ \_ \_ \_ \_4\_ \_ \_ \_ \_ \_5 \_ \_ \_ \_ \_ \_6\_ \_ \_ \_ \_ \_ \_ 7\_ \_ \_ \_ \_ \_ \_8 | | | | |
| Would not avoid it | Slightly  avoid it | Definitely  avoid it | Markedly  Avoid it | Always  Avoid it |
| **ANSWER 1-8** Choose an item. | | | | |
| 5. **FAMILY AND RELATIONSHIPS** – Form and maintain close relationships with others including the people that I live with. | | | | |
| 0\_ \_ \_ \_ \_ \_ \_1\_ \_ \_ \_ \_ \_ 2 \_ \_ \_ \_ \_ \_ \_3\_ \_ \_ \_ \_ \_ \_4\_ \_ \_ \_ \_ \_5 \_ \_ \_ \_ \_ \_6\_ \_ \_ \_ \_ \_ \_ 7\_ \_ \_ \_ \_ \_ \_8 | | | | |
| Would not avoid it | Slightly  avoid it | Definitely  avoid it | Markedly  Avoid it | Always  Avoid it |
| **ANSWER 1-8** Choose an item. | | | | |

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| **IAPT Employment Status Questions** | | |
| Please indicate which of the following options best describes your current status: | | |
| Employed full-time (30 hours or more per week | Employed part-time | Unemployed |
| Full-time homemaker or carer | Full-time student | Retired |
| **Are you currently receiving Statutory Sick Pay?**  **Y  N** | | |
| **Are you currently receiving Job Seekers Allowance, Income support or Incapacity benefit? Y  N** | | |