

Patient ID:	Date:	Session No:	Therapist ID:
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	CHOICE	Yes	No	N/A
1.	Were you given information about options for choosing a treatment that is appropriate for your problems?			
2.	Do you have a preference for any of the treatments among the options available?			
3.	Have you been offered your preference?			

	SATISFACTION	Completely Satisfied	Mostly	Neither Satisfied nor Dissatisfied	Not Satisfied	Not at all Satisfied
4.	How satisfied were you with your assessment?					

Please use this space to tell us about your experience of our service so far

PHQ 9

Over the **last 2 weeks**, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. 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 than usual?	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Total PHQ 9 Score:

*** If you have answered 'several days' or more to Q9. please also answer the following questions:**

1. Do you ever feel so bad that you think about harming or killing yourself?	Yes	No									
2. Do you ever feel that life is not worth living?	Yes	No									
3. Have you made any plans to end your life?	Yes	No									
4. Do you know how you would kill yourself?	Yes	No									
5. Have you made actual preparations to kill yourself?	Yes	No									
6. Have you ever attempted suicide in the past?	Yes	No									
7. How likely is it that you will act upon such thoughts and plans?	0	1	2	3	4	5	6	7	8	9	10
8. What is preventing you from killing or harming yourself at the moment?											

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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	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Total GAD 7 Score:

IAPT Employment

Please tick which of the following options best describes your current status:

<input type="checkbox"/> Employed full-time	<input type="checkbox"/> Unemployed (seeking work)	<input type="checkbox"/> Student (full time)	<input type="checkbox"/> Retired
<input type="checkbox"/> Employed part-time	<input type="checkbox"/> Unemployed	<input type="checkbox"/> Student (part time)	<input type="checkbox"/> Volunteer
<input type="checkbox"/> Self employed	<input type="checkbox"/> Benefits	<input type="checkbox"/> Homemaker	

Are you currently receiving Statutory Sick Pay? ☐ Yes ☐ No ☐ Don't know

Are you suitable for or do you feel you would benefit from receiving employment support? ☐ Yes ☐ No

Work & Social Adjustment

Please look at the questions below and give a number between 0 and 8 to describe how much your problems affect you in each area:

1. Work (If you are retired or choose not to have a job for reasons unrelated to your problem please tick N/A ☐

0	1	2	3	4	5	6	7	8
							Very severely affected	

2. Home Management (cleaning, tidying, shopping, cooking, looking after home/children, paying bills etc.)

0	1	2	3	4	5	6	7	8
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3. Social Leisure Activities (with other people – e.g. parties, pubs outings, entertaining, etc.)

0	1	2	3	4	5	6	7	8
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4. Private Leisure Activities (done alone, e.g. reading, gardening, sewing, hobbies, walking, etc.)

0	1	2	3	4	5	6	7	8
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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
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Total W&SAS Score:

IAPT Phobia

Please choose a number from the scale below to show how much you would avoid each of the situations for the reasons given:

1. Social situations because I fear being embarrassed or making a fool of myself

0	1	2	3	4	5	6	7	8
Would not avoid							Would always avoid	

2. Certain situations because I fear having a panic attack or other distressing symptoms (such as loss of bladder control, vomiting or dizziness)

0	1	2	3	4	5	6	7	8
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3. Certain situations because I fear particular objects or activities (such as animals, heights, seeing blood, being in confined spaces, driving or flying)

1	2	3	4	5	6	7	8
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Total Score: