Name……. *Date*……

Your information is covered by medical secrecy and will be treated with strict confidentiality!!!

In order to have more time for the consultations, it makes sense to use questionnaires. They are also helpful for self-reflection.

The first part of the sheet is required for the first session (preferably download it before the first appointment and, if possible, have it filled in and put through the letterbox), the second part is required by at least the third session.

Sheet number 1 is needed for the diagnostic phase. Sheets number 2 onwards are used to support the "probatory" sessions and will be helpful when a request for therapy is needed. There are further questionnaires required for the fourth and fifth sessions and the formulation of goals pages. In an extra appointment before the third session, the most specific tests are carried out on the PC in the practice.

Sounds like bureaucracy? No, these sheets should also encourage self-reflection and get you used to the fact that therapy mainly takes place in everyday life, not only in the therapy sessions. It also frees up more time for the actual consultation.

It is in your own interest, so please complete the questionnaire honestly. Allow enough time for that. If you think there is no time for that then there is probably no time for therapy!

If you find that specific issues are difficult, then this can be of significance, so highlight this on the sheet.

Particulary difficult or unpleasant questions (traumas) can be answered with a question mark and, instead, we can talk about it in due course!

Feel free to use the reverse sides of the sheets.

Dr. Härtel-Petri

Basic Data:

Name:…….

Date of Birth:…….Age:……

Address:

……..

……..

General Practitioner

……..

Current Ailments (Symptoms):

Describe, in your own words, your most significant symptoms and problems and how long you have been suffering from them (Please feel free to use the reverse side):
a)

……

……

b)

……

……

c)

……

d)

……

Describe briefly when your symptoms occurred for the first time (in which life situation?) and how they have developed (improvement/deterioration) until now (possibly even what you have already "tackled" yourself). Please feel free to use the reverse side.:
a)

……

b)

……

c)

……

Symptom Checklist

Please tick as appropriate, E.g. [X] Yes ☐ No

Please complete this part of the questionnaire as honestly as possible because it is in your own interest to do so.

Many thanks

Do you have difficulties falling asleep? ☐ Yes ☐ No

Do you have difficulties staying asleep? ☐ Yes ☐ No

Are you tired or do you have little energy? ☐ Yes ☐ No

Do you have ☐ reduced or ☐ increased appetite? ☐ Yes ☐ No

In recent months have you lost weight unintentionally? ☐ Yes ☐ No

Do you have fewer friends and interests? ☐ Yes ☐ No

Do you feel low, melancholic, hopeless? ☐ Yes ☐ No

Do you doubt yourself and are you afraid to fail? ☐ Yes ☐ No

Do you find it more difficult to concentrate? ☐ Yes ☐ No

Do you feel slower than before? ☐ Yes ☐ No

Do you feel more nervous or tense? ☐ Yes ☐ No

Are you ruminating more lately? ☐ Yes ☐ No

Are you ruminating to such an extent that you are having difficulties falling asleep, staying asleep or are waking (too early) in the morning ruminating? ☐ Yes ☐ No

Is your mood worse in the morning? ☐ Yes ☐ No

Have you often recently thought that you just want to have peace, be it through death? ☐ Yes ☐ No

Have you often recently thought that it would be better if you were dead? ☐ Yes ☐ No

Have you recently thought about plans for how to end your life? ☐ Yes ☐ No

Have you made concrete preparations for your death? ☐ Yes ☐ No

Have you recently thought that it would be better for your family if you were dead? ☐ Yes ☐ No

Do you sometimes suffer from (please tick as appropriate)**:**

☐ Ringing in the ears, ☐ Dizziness, ☐ "Band around the head" (tension headache), ☐ Headaches, ☐ A feeling of pressure, ☐ Shortness of breath, ☐Feelings of anxiety, ☐Racing heartbeat, Irregular heartbeat, Palpitations, ☐ Chest pains, ☐ Heaviness in the chest, Feeling like there is a lump in the throat , ☐ Nausea, ☐ Vomiting, ☐ Diarrhoea, ☐ Sweating, ☐ Nervousness, ☐ Restlessness, ☐ Trembling and shaking, ☐ Stomach pain,☐ Back pain, ☐ Increased menstrual problems, ☐ Loss of libido ☐ Other pains, ☐ A feeling of going mad?

☐ Additional information:……

……

Do you have **general** fears (*anxiety about the future, worries about family members, worries about health, being alone*?) ☐ Yes ☐ No

If yes, please describe (always?/a recent occurrence? - what is it that you can no longer do, how does this restrict your life, or the lives of your relatives? (Please use the reverse side)

……

……

……

Do you have anxiety attacks (panic attacks)? Do you have moments and situations in which, time and again and "out of the blue", you suddenly and "unforeseeably" have a rush of intense anxiety/fear of death/fear of fainting – fearing that you are going mad? ☐ Yes ☐ No

If yes, what are the physical **symptoms**: ☐ Racing heartbeat ☐ Breathlessness, A feeling of suffocation, ☐ Sweating, ☐ A feeling of anxiety ☐ Chest pain, ☐ Nausea/Intestinal problems, ☐ Numbness or tingling in parts of the body, ☐ Feeling beside yourself ☐ Fear of passing out ☐ Feeling/afraid that you may die/have a heart attack ☐ Feeling/afraid that you will go mad/or lose control of yourself

If so, please describe - what you are therefore unable to do anymore, what (places, situations) you must therefore avoid. (Please use the **reverse** side)

……

Do you have **specific fears**, i.e. phobias (*of spiders, confined spaces, fear of heights, or discomfort on a crowded bus, in public spaces, etc?*) ☐ Yes ☐ No
If so, please describe. What you are therefore unable to do anymore, what do you "have" to avoid. (Please use the reverse side)

……

Do you suffer from **obsessive** thoughts or compulsive acts? ☐ Yes ☐ No

- Do you have to repeatedly check things (*Switches, taps, handbrakes, doors, etc*) in a time-consuming manner, ☐ Yes ☐ No
- Do you have a fear of germs, poisoning, or similar? Or do you often have to wash yourself in a time-consuming manner, clean your household or similar?

☐ Yes ☐ No

- Do you have to adhere to specific routine acts (*move chairs, adjust things or count objects*) before you can do anything else? ☐ Yes ☐ No
- Do you have "nonsensical" thoughts *(images, intrusive, unacceptable thoughts of your own)* which torment you, that you cannot get rid of? ☐ Yes ☐ No

If yes, please describe each one in more detail. Therefore, what can you no longer do, what must you therefore avoid, what happens/could happen if you do not perform a forced ritual/compulsive act? (Please use the reverse side)

……

Were there **earlier** periods when you felt **hopeless**/ or were depressed?

☐ Yes ☐ No

(Please briefly describe and explain how you "came through" this. Please use the reverse side)

……

Have you ever tried to kill yourself? ☐ Yes ☐ No *When, how?*

……

Have you ever in your life *(except when in love)* been very **restless, hyper**, in an **elevated mood**, for a **long period of time**, where everything went wrong for you? Did you need hardly any sleep and possibly do unreasonable things? ☐ Yes ☐ No

……..

Have you ever lost control of yourself? ☐ Yes ☐ No (E.g. Flashes of anger, cried or behaved aggressively?) If yes, please describe:

……

Why are you coming now *and not years/months ago or at least within a year?*

……..

……..

……..

Who suggested the possibility of psychotherapy?

☐ General Practitioner, ☐ Advice Centre, ☐ Partner, ☐ Parents, ☐ Friends, ☐ I knew myself, ☐ Other:……..

Has your partner been informed that you are undergoing psychotherapeutic help?

☐ Yes ☐ No

……..

Specify those situations (and places/music) that enable you to be calm and relaxed.:

……

……

Have you **ever** undergone **outpatient psychotherapy** that has been financed by health insurance? ☐ No, ☐ Yes, more than 5 years ago, ☐ Yes, more than 2 years ago, ☐ Yes, in the last two years, ☐ currently with _____

Have you had any **serious illnesses** or operations in your life so far? If so, please state them here:

……

……

Allergies, Intolerances? □ Yes, □ No to which substances:

……

Current physical illnesses? □ Yes, □ No :

……

……

Preliminary Treatment:

What **medication** are you taking (dosage), including somatic medications such as blood pressure tablets, sleeping pills, painkillers, etc.?

……

……

……

Which **medication** do you take for the psychological problem (which ones were helpful, for how long, are still taking, which ones were effective but with (which) side effects, which ones were quite unpleasant and barely helpful)?

……

……

Formal preliminary treatment for your emotional problems as an **outpatient:** □ No

□ So far, "only" general practitioner discussions? □ Consultations at……

□ Therapy yes, at ……from ……..… until……

It was a matter of……. □ general discussion □ only medication, □ formal psychotherapy, this was □ depth psychological (psychodynamic) □ behavioural therapy.

□ Other procedure: …….

Result……

Psychotherapy/outpatient discussions

at ……from …….… until……

It was a matter of……. □ general discussion □ only medication, □ formal psychotherapy, this was □ depth psychological (psychodynamic) □ behavioural therapy.

□ Other procedure: …….

Result……

As well as

at ……from …….… until……

It was a matter of……. □ general discussion □ only medication, □ formal psychotherapy, this was □ deep psychological □ behavioural therapy.

□ Other procedure: …….

Result……

Hospital preliminary treatments for your psychological problems as **inpatient** **(**Psychiatry, Psychosomatic, Treatment): □ No, □ Yes,

in ……from …….… until……

Result……Duration of the improvement……..

Therapy continued thereafter as an outpatient? □ No □ Yes

If no, why not?

……

Do you have letters from your doctor? Where can you obtain these, if I request them?

…… ……

Further **inpatient** treatment in

……from …….. until……

Result…… Duration of the improvement ……..

Therapy continued thereafter as an outpatient? □ No □ Yes

Do you have letters from your doctor? Where can you obtain these, if I request them?.....

Do you have experience with….

Autogenic training? □ No □ Yes, helpful, □ Yes, not helpful □ Yes, actively using

muscular relaxation/Jacobson? □ No □ Yes, helpful, □ Yes, not helpful □ Yes, actively using

Mindfulness training? □ No □ Yes, helpful, □ Yes, not helpful □ Yes, actively using

yoga or similar? □ No □ Yes, helpful, □ Yes, not helpful □ Yes, actively using

Do you use counselling centres (family counselling, a psychosocial counselling centre, a social psychiatric service (SPDI) etc? □ Yes, □ No

which?.....

Do you attend self-help groups? □ Yes, □ No which?.....

……..

Do you use online offers/forums for your illness? □ Yes, □ No: which?

……..……

Other help (alternative practitioner) □ Yes, □ No which?.....

……

Other help (general spiritual welfare) □ Yes, □ No which?.....

Addictive substances and behavioural addictions:

Do you smoke, if so, how much? □ No □ No, not since…….year(s) ago □ Yes,

……

Have you had any experiences with drugs if so, which ones? □ Yes, □ No, when, for how long?.....……

……

Do you have a drug problem? □ Yes, □ No

……

Have you taken drugs in the last 30 days? □ Yes, □ No if so, which ones.……

Do you have an alcohol problem? □ Yes, □ No

Have you been tipsy in the last 30 days? □ Yes, □ No

Have you been drunk in the last 30 days? □ Yes, □ No

When was the last time that you consumed alcoholic beverages?

□ today, □ yesterday, □ > 2 days , □ > 5 days , □ > 1 week, □ or longer, □ abstinent, □ abstinent after being manifestly dependent [ ]

How much did you drink the last time you had alcohol?

……

Has anyone advised you to stop drinking? □ Yes, □ No

Do you get annoyed when someone criticises you regarding your alcohol consumption? □ Yes, □ No

Do you sometimes need an alcoholic drink to "get going" in the morning?

□ Yes, □ No

Have you been drinking more often in the mornings or even at work?

□ Yes, □ No

Have you been hung-over in the morning? □ Yes, □ No

Have you stayed away from school or work lately because you drank the night before? □ Yes, □ No

Do you sometimes feel guilty about your alcohol consumption? □ Yes, □ No

Are you having trouble interacting with other people because of drinking?

□ Yes, □ No

Have you ever driven a car after drinking a few glasses of alcohol? □ Yes, □ No

Have you already tried to reduce your alcohol consumption? □ Yes, □ No

Do you take benzodiazepines (Tavor, Diazepam, Bromazepam or other substances to help with sleep or anxiety? □ Yes, □ No
Addiction? □ Yes, □ No

……

Do you regularly take painkillers containing opioids (Tramal, Valoron, Fentanyl) or other substances? □ Yes, □ No Addiction? □ Yes, □ No

……

Are you having trouble dealing with gaming halls or other gambling? □ Yes, □ No
……

……

Are you having difficulties limiting your media use? □ Yes, □ No

……

Are you having difficulties with the length of time you spend on your computer? □ Yes, □ No

……

Do you have problems controlling the duration and intensity of your use of online social networks (Facebook etc.)? □ Yes, □ No ……..

Do you have problems with the duration of your "computer games"? □ Yes, □ No ……..

Stationary games… Yes □

which ones……

Online games…… Yes □

which ones……

Prefer online games such as WOW , Second Life? □ Yes, □ No
……

Prefer online gambling such as Poker □ Yes, □ No ……

Do you have problems controlling the duration of your "console games"/mobile phone games? □ Yes, □ No ……..

Are there conflicts with relatives due to the length of your media consumption (TV, PC, mobile phone, games) □ Yes, □ No with:……

Would you have difficulties giving up going onto the Internet **privately**? □ Yes, □ No

Would you have difficulties giving up using your smart phone (except for professional activities and address management) **privately**? □ Yes, □ No

Do you have problems with Internet pornography? □ Yes, □ No

Would you consider yourself as addicted to sex? □ Yes, □ No

Would you consider yourself as addicted to work? □ Yes, □ No

Other possible behavioural addictions?? □ Yes, □ No ……..

Do you have debts (or other consequential social damage) because of these behavioural addictions? □ Yes, □ No

…….

Are you happy with your appearance/body image □ Yes, □ No, □ neither?

……

Weight:……kg……..Height…….cm BMI: ……..

Do you often **eat** (too) large amounts of food? □ Yes, □ No

……..

Do you have problems controlling how much you eat? □ Yes, □ No

……..

Do you take laxatives for weight control or make yourself vomit? □ Yes, □ No (if vomiting, please describe any feelings during/afterwards and the sequences)

……

……

Do you often fast, do you have fluctuations in weight or take part in an extreme amount of sport? □ Yes, □ No

……

Are you currently dieting or on a special type of diet? □ Yes, □ No

……

Are you taking medication/supplements to support you? □ Yes, □ No

……

Did you have periods with eating disorders in your youth or later? □ Yes, □ No

……

General Data

Your phone number for possible appointment cancellations on my part:

Landline:…….. Mobile:……

Are the people who would possibly take the call aware that you are being treated by me? ☐ Yes ☐ No

Prescription fee exempt? ☐ Yes ☐ No

Marital Status:

☐ Married ☐ living separately ☐ living together, ☐ cohabitation relationship, ☐ divorced_____times, ☐ remarried, ☐ Single, ☐ currently unattached,

Children…… (age and gender)

Children …… (age and gender)

Children ……..

☐ heterosexual, ☐ homosexual, ☐ bisexual, ☐ transgender

Highest **school-leaving** qualification:

☐ still at school, ☐ no leaving qualifications, ☐ special type of school with graduation, ☐ primary/elementary school, ☐ qualification, ☐ secondary school/ USA high school diploma or the UK GCSE level of education☐ Polytechnic high school, ☐ school leaving examination – e.g. United Kingdom A Levels/ vocational baccalaureate diploma, ☐ other

Highest vocational qualification/vocational/academic degree……

Original **education** (if it is a later qualification):

……

☐ still/again in training/studying?:.....

Your occupation:……

Currently **employed**? ☐ Yes ☐ No: ☐ Parental leave, ☐ Unemployed, ☐ ALG 1 (insurance-based unemployment benefit), ☐ ALG 2 (state unemployment benefit), ☐ family care, ☐ other:……..

Are you **currently** "unable to work" on sick leave, □ No,

□ Yes , currently for _____weeks

For what reason?

……

By whom?

……

Inability to work in the last 12 months □ none

□ less than 3 months

□ 3-6 months

□ more than 6 months

For what reason?

……

By whom?

……

Are you currently retired? □ No, □ Yes If yes, since when?, for how much longer?, and for what reason?

……

……

Have you applied for a pension? □ No, □ Yes: Since when and why?

……

Is it a pension request on your part, or an application for severe disability that is the reason for contacting me? □ No, □ Yes, because……

……

Current occupation/occupations (also, jobs that are not formally paid, such as “housewife/house husband")…….

:……

……

Weekly working hours ……..hours

Activity: □ more physical, □ more mental,

Are you satisfied with your current job? □ Yes □ No (if not, in which way are you dissatisfied?)

……

……..

Special workloads?:

□ changing workplaces □ shift work □ other stress factors: …….

……

□ poor working environment: ……..

□ additional care of relative: ……

□ "double burdens"……...

Income:…….€/Monthly (*voluntary information*) adequate? □ Yes □ No

Other financial worries?.....

Problematic debts?:……

Current stresses, separations, illnesses, deaths? □ No

□ Yes, namely:

……

……..

Many thanks.