

The Rock Clinic Association

INITIAL INTERVIEW FORM

REDUCED / LOW / INTERMEDIATE / FULL COST COUNSELLING AND
PSYCHOTHERAPY / GROUP

Name:

Date:

Address:

Telephone number:

E-mail:

Age:

GP Name and
Address:

Work: full/part-time/low waged
unemployed/student

Ethnic Origin:

How did you hear of the Rock Clinic:

PLEASE COMPLETE THE TIMETABLE BELOW

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
9.00 – 10.00						
10.00 – 11.00						
11.00 – 12.00						
12.00 – 1.00						
1.00 – 2.00						
2.00 – 3.00						
3.00 – 4.00						X
4.00 – 5.00						X
5.00 – 6.00						X
6.00 – 7.00						X
7.00 – 8.00						X
8.00 – 9.00						X

Please indicate the TIMES WHEN YOU ARE AVAILABLE by ticking the appropriate boxes. It is important to give as many free times as you possibly can – otherwise you may have to wait for regular counselling or therapy sessions.

Client Information Sheet

Ethical Policy

- The Rock Clinic Association endeavours to provide a safe and confidential service, operating within the limits of the law. It is committed to the principles of equal opportunities and open access. Confidentiality is held within the Rock Clinic Association team.
- Rock Clinic practitioners adhere to ethical guidelines of the professional bodies to which we belong, copies of which are available at Reception.

Evaluation

The Rock Clinic Association uses a standard evaluation system, which has been developed to help providers of other counselling and psychological therapies to deliver and develop the best possible services to clients seeking help for their difficulties and concerns. As part of the system, all clients are asked to complete a brief questionnaire before, during and after contact with the service. The information helps us to understand your difficulties and the degree to which we help you with those problems.

About our evaluation:

- The first questionnaire is attached. You are asked to comment on how you have been feeling over the past week.
- Completing the questionnaire is entirely voluntary and you are free to choose whether or not you wish to fill it in. If you decide not to complete it this will not affect your counselling/therapy in any way. However the more people completing the questionnaire, the more comprehensive the information is for improving the service.
- The information from the questionnaires will be treated as strictly confidential. No names are used on any questionnaire and no one outside the Rock Clinic Association will have access to your responses.

Enquiries

If you have any queries or require a copy of our complaints procedure, please ask the Receptionist, currently available weekday mornings between 10.00-1.00pm, or leave a message on the **01273 621841** outside these hours.

CLINICAL OUTCOMES in ROUTINE EVALUATION

OUTCOME MEASURE

Site ID	<input type="text"/>	<input type="text"/>	Male	<input type="checkbox"/>	
letters only	<input type="text"/>	numbers only	Age	Female	<input type="checkbox"/>
Client ID	<input type="text"/>	<input type="text"/>	Stage Completed	Stage	<input type="text"/>
Therapist ID	<input type="text"/>	numbers only (1)	S Screening		
	<input type="text"/>	numbers only (2)	R Referral		
Sub codes	<input type="text"/>	<input type="text"/>	A Assessment		
	<input type="text"/>	<input type="text"/>	F First Therapy Session		
	<input type="text"/>	<input type="text"/>	P Pre-therapy (unspecified)		
	<input type="text"/>	<input type="text"/>	D During Therapy		
	<input type="text"/>	<input type="text"/>	L Last therapy session	Episode	<input type="text"/>
Date form given	<input type="text"/>	<input type="text"/>	X Follow up 1		
	<input type="text"/>	<input type="text"/>	Y Follow up 2		

IMPORTANT - PLEASE READ THIS FIRST

This form has 34 statements about how you have been **OVER THE LAST WEEK**.
Please read each statement and think how often you felt that way last week.
Then tick the box which is closest to this.
Please use a dark pen (not pencil) and tick clearly within the boxes.

Over the last week

	Not at all	Only Occasionally	Sometimes	Often	Most or all the time	OFFICE USE ONLY
1 I have felt terribly alone and isolated	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> F
2 I have felt tense, anxious or nervous	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
3 I have felt I have someone to turn to for support when needed	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> F
4 I have felt O.K. about myself	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> W
5 I have felt totally lacking in energy and enthusiasm	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
6 I have been physically violent to others	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> R
7 I have felt able to cope when things go wrong	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> F
8 I have been troubled by aches, pains or other physical problems	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
9 I have thought of hurting myself	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> R
10 Talking to people has felt too much for me	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> F
11 Tension and anxiety have prevented me doing important things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
12 I have been happy with the things I have done.	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> F
13 I have been disturbed by unwanted thoughts and feelings	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
14 I have felt like crying	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> W

Please turn over

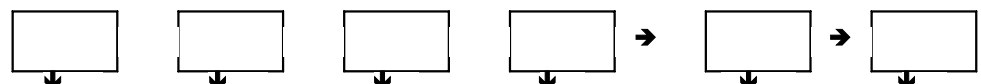
Over the last week

Not at all Only Occasionally Sometimes Often Most or all the time OFFICE USE ONLY

15	I have felt panic or terror	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>	P
16	I made plans to end my life	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>	R
17	I have felt overwhelmed by my problems	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>	W
18	I have had difficulty getting to sleep or staying asleep	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>	P
19	I have felt warmth or affection for someone	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/>	F
20	My problems have been impossible to put to one side	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>	P
21	I have been able to do most things I needed to	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/>	F
22	I have threatened or intimidated another person	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>	R
23	I have felt despairing or hopeless	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>	P
24	I have thought it would be better if I were dead	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>	R
25	I have felt criticised by other people	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>	F
26	I have thought I have no friends	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>	F
27	I have felt unhappy	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>	P
28	Unwanted images or memories have been distressing me	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>	P
29	I have been irritable when with other people	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>	F
30	I have thought I am to blame for my problems and difficulties	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>	P
31	I have felt optimistic about my future	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/>	W
32	I have achieved the things I wanted to	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/>	F
33	I have felt humiliated or shamed by other people	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>	F
34	I have hurt myself physically or taken dangerous risks with my health	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>	R

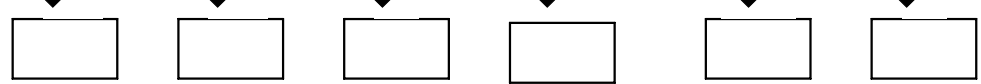
THANK YOU FOR YOUR TIME IN COMPLETING THIS QUESTIONNAIRE

Total Scores



Mean Scores

(Total score for each dimension divided by number of items completed in that dimension)



(W) (P) (F) (R) All items All minus R