GP Screening Questionnaire

NAME___________________ DOB:____________ DATE OF REFERRAL:___________

Please consider that all the information given below is confidential to the GP and the personnel involved in your care.

1. Please try to think about your daily life and try identify (in a few words) your problems and to rate their level of severity according to the following scale:

1. Normal/mild *2. Moderate* *3. Severe* *4. Extremely severe*

Identified Problems	Severity
1.	
2.	
3.	
4.	

Were you able to identify the nature of your concerns?

YES -- NO

2. How do these concerns affect you in your daily life?

3. Do you think that therapy could help you to understand your difficulties?

DEFINITELY --- DEFINITELY NOT

4. Are you willing and able to commit to weekly sessions of therapy?

DEFINITELY --- DEFINITELY NOT

5. Do you appreciate that therapy will be hard work psychologically and emotionally?

DEFINITELY --- DEFINITELY NOT

6. Will you be able to also work on the process of change between therapy sessions?

DEFINITELY --- DEFINITELY NOT

7. Can you think of being responsible for trying to change in a self-motivated and independent manner?

DEFINITELY --- DEFINITELY NOT