

**IAPT Self-Referral Form**

**First name:** **D.O.B:**

***Please answer the following to give us an idea of how we might be able to support you***

# Reasons for accessing our service

**What is the main problem or difficulty you would like some help with and how long has this affected you?**

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**How does this problem affect you? (How does this problem affect the way you think and feel? What symptoms are you experiencing? How does it affect what you do?)**

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**How would you like things to be different?**

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**Do you have thoughts that you would be better off dead, or of hurting yourself, or someone else in some way?**

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**Do you have any plans to act on these thoughts?**

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**What would stop you from acting on these thoughts?**

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**Have you ever acted on these thoughts in the past and, if so, when was this?**

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**Are you self-harming or have you ever self-harmed?**

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| **Patient Health Questionnaire****Over the last 2 weeks, how often have you been bothered by the following problems?** | **Not at all** | **Several days** | **More than half the days** | **Nearly every day** |
| 1. Little interest or pleasure in doing things.
 | [ ]  | [ ]  |  [ ]   | [ ]  |
| 1. Feeling down, depressed, or hopeless.
 | [ ]  | [ ]  | [ ]  | [ ]  |
| 1. Trouble falling or staying asleep, or sleeping too much.
 | [ ]  | [ ]  | [ ]  | [ ]  |
| 1. Feeling tired or having little energy.
 | [ ]  | [ ]  | [ ]  | [ ]  |
| 1. Poor appetite or overeating.
 | [ ]  | [ ]  | [ ]  | [ ]  |
| 1. Feeling bad about yourself — or that you are a failure or have let yourself or your family down.
 | [ ]  | [ ]  | [ ]  | [ ]  |
| 1. Trouble concentrating on things, such as reading the newspaper or watching television.
 | [ ]  | [ ]  | [ ]  | [ ]  |
| 1. 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.
 | [ ]  | [ ]  | [ ]  | [ ]  |
| 1. Thoughts that you would be better off dead or of hurting yourself in some way.
 | [ ]  | [ ]  | [ ]  | [ ]  |

**Generalised Anxiety Disorder**

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

# About You

**Have you currently been prescribed any medication for your mental health?**

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**If so, what have you been prescribed and since when?**

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**Do you find yourself using alcohol or taking recreational drugs to help you cope with your problems?**

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**If Yes, please give the details of these and dates if possible:**

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**Is there anything else we should know before we make any appointments for you?**

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**How did you hear about the service?**

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**Are you a Refugee/Asylum Seeker?**

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**Do you have plans to end your life?**

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**Do you have a disability?**

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| **If you have a Long-Term Health Condition, please let us know what it is:** |
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**If other, please specify**

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**Are you a member or ex-member of the British Armed Forces?**

**Ethnicity**

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**How would you describe your sexual orientation?**

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**Marital Status:**

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**Please can you tell us who you live with? (Include any children’s names and their date of birth)**

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**Are you or your partner expecting a baby, or do you have a child under 24 months old?**

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**If yes to the above:**

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# **Contact Details**

**Name:**

Click or tap here to enter text.

**Date of birth:**

Click or tap here to enter text.

**Gender:**

Click or tap here to enter text.

**Mobile:**

Click or tap here to enter text.

**Email:**

Click or tap here to enter text.

**Address:**

Click or tap here to enter text.

**Postcode:**

**Gp Name**

Click or tap here to enter text.

**and Surgery:**

**Can we contact you by: (yes or no)**

Phone Text : Voicemail: Letter: Email:

Is there anybody else we leave messages with? If so please provide their name and details:

We will not discuss appointments with or confirm attendance to persons unless they are named below unless required to by law. This includes family members or partners.

**Please send completed forms to:** **counselling@smchh.co.uk**