Kim Hill
art of wellbeing

Private and confidential Pre-assessment

This pre-assessment is designed to help you begin to make connections between what has happened in your life and your symptoms.

Your completed forms will remain confidential.

Completing it is voluntary but will help provide useful information for your wellbeing journey.

N.B. Completing these forms may trigger some uncomfortable emotions so do take your time and take breaks as required.

PERSONAL DETAILS:

Name: **Date of Birth:**

Address:

Postcode:

Telephone Number:

Mobile Number:

Email address:

Emergency contact name and telephone number:

General Practitioner - name and surgery address:

Your Occupation and briefly what it entails:

PRESENT CONDITION: Your Symptoms and Presenting Issues

Please list your MAIN 2 symptoms/presenting issues:

1)

2)

On a scale from 0 (no symptom) to 10 (unbearable), how would you rate the level of intensity of your symptom, at its best and worst? (please underline scores)

Please name
Symptom 1
0…..1…..2…..3…..4…..5…..6…..7…..8…..9…..10

Please name
Symptom 2
0…..1…..2…..3…..4…..5…..6…..7…..8…..9…..10

List the specialists/therapists you have seen and any treatments you have had for these symptoms/conditions.

List any other symptoms that are bothering you, noting times of day, week, month or other triggers…

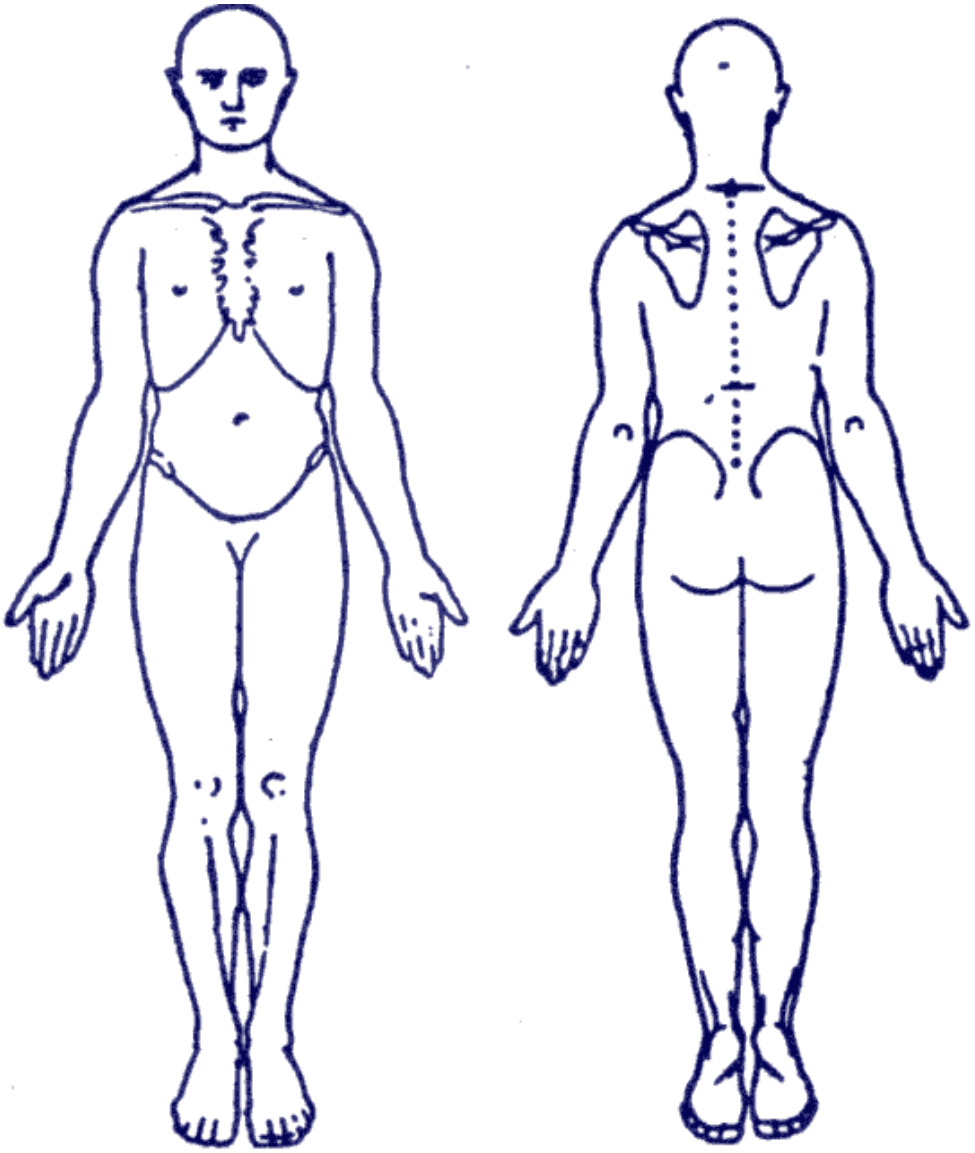
Do you feel that all or some of your symptoms may have been caused by conflicts, feelings or emotions?

What, if anything, have you done so far with respect to using a mindbody approach for your symptom/condition?

Has there been any change so far?

If you could flick a switch and your symptoms disappeared what would love to be able to do again?

Add to the body chart below with a very brief description: (N.B. If the full chart doesn't show, just click on it and move it until it is all on one page)



Please complete the chart below answering the questions for each of the main 2 problems/symptoms you are presenting with.

SYMPTOM	1) Name your Symptom	2)Name your Symptom
When did this symptom begin?		
Do you/did you link this to a particular physical cause?		
What was happening in your life when it began?		
Give a brief history of how it has been since the onset and whether you can		

link this with any particular stresses.		
Is there a particular time of day or night when it is usually at it's worst?		

What diagnoses/reasons have you been given for the current condition/symptoms you are experiencing?

Briefly note down the results of any test results you have had for these conditions.

What medications do you take presently?

History of stressors

Tick appropriate boxes below

	Yes	Record any symptoms at the time where appropriate
Major or minor traumas/pressures during childhood		

Major or minor traumas/pressures during teenage years		
Change in family unit during childhood/teenage years		
Accident or injury		
Change in relationship or marriage		
Difficulties or change in job		
Gain/change in family setup		
Change in financial situation		
Change in living situation		
Violent experiences		
Sexual difficulties		
Relationship difficulties with friend/colleague/family member/neighbour		
Religious pressures		
Other family pressure		
Time pressures – no time for yourself		
Illness or death in the family		

Legal problems		
Anything else?		

Symptoms that are often stress-induced

Please tick any of the conditions/symptoms below that you have experienced in your life and then use the list to help you complete the chart above.

N.B. Add any symptomsnot on the list that you have experienced

Abdominal pain
Allergies/hay fever
Anxiety symptoms or panic attacks
Back, neck or other aches and pains
Bell's palsy, facial paralysis
Body dysmorphic disorder
Carpal Tunnel Syndrome
Changes in voice
Constipation or diarrhoea
Depression
Eczema
Eating disorders
Fatigue/tiredness
Fibromyalgia
Other skin problems
Obsessive, compulsive thoughts
Palpitations, rapid heart rate/low BP
Phobias
Prostate problems
Pain in the pelvic region
Reflex Sympathetic Disorder
Repetitive cough
Restless leg Syndrome
Repetitive Strain Injury
Self-mutilation or self-cutting
Spastic bladder
Stomach – ulcers, reflux, heartburn etc
Food intolerances
Frequent infections e.g. bladder, thrush, chest, ear
Hiatus hernia or heartburn/reflux
Hyperventilation or shortness of breath
IBS/colitis/spastic colon
Insomnia
Interstitial cystitis
ME/CFS

Migraines
Nausea or vomiting
Numbness, itching, burning, tingling
Swallowing difficulties or gagging
Joint Syndrome
Tendonitis
Tension headache
Tinnitus
Trigeminal Neuralgia
Ulcer symptoms
Undiagnosed chest pain
Vertigo/dizziness
Veruccas and/or warts
Vitiligo History of stressors

PAST MEDICAL HISTORY

Please list any conditions/symptoms/operations you have experienced in your childhood and since, including allergies, intolerances, and phobias.

Have you ever seen a mental health practitioner and if so when and what for?
e.g. Counsellor, Psychotherapist, Psychiatrist, CBT etc

Social History

Do you smoke?	Yes/No
Do you drink alcohol?	Yes/No
If yes, do you ever use alcohol to deal with your problem in any way?	Yes/No
Have you ever thought you should cut down on the amount of alcohol you drink?	Yes/No
Have you ever used illicit drugs?	Yes/No
Do you use illicit drugs?	Yes/No
If yes, do you ever use illicit drugs to deal with your problem in any way?	Yes/No

Religion (past and present, if any):

Family History

Your Mother

How would you describe your mother's personality?

(e.g. Low self-esteem, Perfectionist, High expectations of herself, Need to be good and/or liked, Conscientious, Self-critical, Analytical, overly responsible, Volatile, Resentful, Feeling anxious, Reliable, Competitive, Driven, Non-confrontational, Like to be in control, Strong drive to be helpful, People-pleaser.)
Please highlight/make bold or write below any of the above that describe your Mother as well as anything else you think is relevant.

How would you describe your relationship with her as a child and now?

Was your mother loving and affectionate with you, or the opposite? Was her love conditional?

(please describe)

Did she have high expectations of you or was she critical?

Your Father

How would you describe your father?

(e.g. Low self-esteem, Perfectionist, High expectations of himself, Need to be good and/or liked, Conscientious, Self-critical, Analytical, overly responsible, Volatile, Resentful, Feeling anxious, Reliable, Competitive, Driven, Non-confrontational, Like to be in control, Strong drive to be helpful, People-pleaser) Please highlight/make bold or write below any of the above that describe your Father, as well as anything else you think is relevant.

How would you describe your relationship with him as a child and now?

Was your father loving and affectionate with you, or the opposite? Was his love conditional?
(please describe)

Did he have high expectations of you or was he critical?

Your Step Parents

Do you have any stepparents and if so when did they come into your life and what influence do you feel they had on you?

Your Siblings

Do you have siblings and if so, where do you come in the family? Briefly explain what sort of relationship you have/had with them.

Please list significant relationships in date order and give a brief description of the relationship you had with them.

If you are currently in a relationship, please describe the relationship briefly and list any presenting concerns with your partner.

Children

Do you have children and if so, how old are they? Please list any presenting concerns with your children.

Do you have any stepchildren or adopted children? Please list any presenting concerns with your stepchildren or adopted children?

Changes in your early years

Did you have a number of changes during your childhood – such as moving house/school/area, being adopted etc? Please describe them briefly and the impact they may have had on you.

On a scale from 0 - 10, on average how much stress do you now believe you were you under as a:

Child –
Teenager -

Next to the appropriate person please list any physical health or mental health concerns that run in your family.

Father:

Mother:

Sisters:

Brothers:

Children:

SELF-INDUCED PRESSURES

Please underline or tick any of the following that you feel relate to you;

Low self-esteem	Perfectionist	High expectations of yourself
Need to be good and/or liked	Conscientious	Self critical
Analytical	Overly responsible	Resentful
Feeling anxious	Reliable	Competitive
Driven	Non-confrontational	Like to be in control
Strong drive to be helpful	People-pleaser	

Do you find it difficult to express vocally how you feel? Yes/No

Do you find it difficult to notice emotions within you? Yes/No

What changes do you notice if you become more stressed? e.g. behaviour, symptoms, thoughts, fears etc

PHQ-9				
Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**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 score:				

From the Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD PHQ). Reproduced with permission

(If these charts overlap, just use the return tab to move them and it should open up again)

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	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 Score:				

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BRIEF SYMPTOM INVENTORY

1. Please rate your symptoms by circling the one number that best describes your symptom at its worst in the last week.

0 1 2 3 4 5 6 7 8 9 10 *No symptom, Symptom as bad as you can imagine*

2. Please rate your symptoms by circling the one number that best describes your symptom at its least in the last week.

0 1 2 3 4 5 6 7 8 9 10 *No symptom, Symptom as bad as you can imagine*

3. Please rate your symptoms by circling the one number that best describes them on the average for the last week.

0 1 2 3 4 5 6 7 8 9 10 *No symptom, Symptom as bad as you can imagine*

4. Please rate your symptom by circling the one number that tells how much symptom you have right now.

0 1 2 3 4 5 6 7 8 9 10 *No symptom, Symptom as bad as you can imagine*

For the next set of questions, choose the one number that describes how, during the past week, pain has interfered with the following activities.

Please use the 0 to 10 scale, where a 0 means that "symptom does not interfere with that activity" and a 10 means that "symptom completely interferes." Does not interfere Completely interferes

a) General Activity……..0 1 2 3 4 5 6 7 8 9 10

b) Mood…….....0 1 2 3 4 5 6 7 8 9 10

c) Mobility (ability to get around)…… …0 1 2 3 4 5 6 7 8 9 10

d) Normal Work (includes both work outside the home and housework) 0 1 2 3 4 5 6 7 8 9 10

e) Relations With Other People……..……....0 1 2 3 4 5 6 7 8 9 10

f) Sleep…….....0 1 2 3 4 5 6 7 8 9 10

g) Enjoyment Of Life……..…….....0 1 2 3 4 5 6 7 8 9 10

h) Self Care (taking care of your daily needs)…….....0 1 2 3 4 5 6 7 8 9 10

i) Recreational Activities…….....0 1 2 3 4 5 6 7 8 9 10

j) Social Activities…….……..…0 1 2 3 4 5 6 7 8 9 10

k) Communication With Others……..……....0 1 2 3 4 5 6 7 8 9 10

l) Learning New Information or Skills…….....0 1 2 3 4 5 6 7 8 9 10