Questionnaire for the Psychotherapeutic Counselling Service

Dear client,

You have come to the Psychotherapeutic Counselling Service to seek advice and professional help. Please be aware that we need you to help us help you.

Please complete this questionnaire and provide all of the information asked for. We have a duty of confidentiality, and all information you provide us will remain strictly confidential. No information will be passed on to anybody outside the Psychotherapeutic Counselling Service without your explicit and written permission. Neither the University or other institutions nor your relatives and friends or your doctor will receive your information without your written permission.

1. Personal information:

First name, surname _____

Completed on (date) _____

Date of birth _____ Place of birth _____

Semester-time address _____

Home address _____

Email _____ Phone _____

Religion _____ Occupation _____

Degree subjects _____ Semester _____

University _____

2. Reasons why you are seeking help:

Please explain in your own words the main problems that brought you here and since when you have had them:

How are your problems affecting you and your environment?

Who have you consulted about your present problems before?

What have you done so far to cope with your problems? What was the result?

Where did you hear or read about the Psychotherapeutic Counselling Service?

How would you know that the counselling has helped you?

3. Psychological factors affecting you:

Please indicate if and how strongly you have recently been affected by the issues or problems listed:

		Not at all	Slightly	Moderately	Strongly
1.	Problems with learning or achievement (e.g. concentration, motivation)	☐	☐	☐	☐
2.	Test anxiety	☐	☐	☐	☐
3.	Inhibitions about speaking in public (e.g. presentations, discussions)	☐	☐	☐	☐
4.	Fear of losing your livelihood, fear of failure, anxiety about the future	☐	☐	☐	☐
5.	Problems relating to social relationships (e.g. fears relating to people and intimacy, fears about rejection)	☐	☐	☐	☐
6.	Problems initiating contact with other people	☐	☐	☐	☐
7.	Isolation, loneliness	☐	☐	☐	☐
8.	Not having or not finding a romantic partner	☐	☐	☐	☐
9.	Problems in your relationship or after a breakup	☐	☐	☐	☐
10.	Problems relating to sex or your sexuality	☐	☐	☐	☐
11.	General fears, panic attacks, inexplicable fears	☐	☐	☐	☐
12.	Specific fears (e.g. of specific animals, illnesses)	☐	☐	☐	☐
13.	Feelings of low self-esteem or inferiority	☐	☐	☐	☐
14.	Discontentment with your physical appearance	☐	☐	☐	☐
15.	Depressive moods, rumination, depression, mood swings	☐	☐	☐	☐

Not at all Slightly Moderately Strongly

16.	Problems making decisions	☐	☐	☐	☐
17.	Suicidal thoughts	☐	☐	☐	☐
18.	Suicide attempts	☐	☐	☐	☐
19.	Self-injurious behaviour	☐	☐	☐	☐
20.	Problems with your parents or other relatives	☐	☐	☐	☐
21.	Compulsive obsessive behaviours or thoughts	☐	☐	☐	☐
22.	Eating disorders	☐	☐	☐	☐
23.	Addiction (e.g. alcohol, drugs, internet, gambling)	☐	☐	☐	☐
24.	Financial problems	☐	☐	☐	☐
25.	Problems relating to your housing situation	☐	☐	☐	☐
26.	Problems with family members who have physical or mental health problems	☐	☐	☐	☐
27.	Traumatic experiences	☐	☐	☐	☐
28.	Other problems _____	☐	☐	☐	☐

If you ticked more than one problem or issue, please look at your current situation as a whole and indicate how strongly you are being affected by all of your problems taken together:

☐ Not at all ☐ ☐ ☐ Strongly

Are you currently receiving or have you ever received treatment from a psychiatrist, neurologist or psychotherapist? If yes, please indicate by whom, for what conditions and when.

4. Physical health problems:

Below, you will find a list of physical symptoms. Please indicate if and how strongly you have been affected by the problems listed:

		Not at all	Slightly	Moderately	Strongly
1.	Shortness of breath	☐	☐	☐	☐
2.	Feelings of physical weakness	☐	☐	☐	☐
3.	Palpitations, chest pain	☐	☐	☐	☐
4.	Fatigue	☐	☐	☐	☐
5.	Nausea	☐	☐	☐	☐
6.	Stomachaches, digestive disorders	☐	☐	☐	☐
		Not at all	Slightly	Moderately	Strongly
7.	Excessive sweating	☐	☐	☐	☐

8.	Backaches	☐	☐	☐	☐
9.	Uneasiness, nervousness	☐	☐	☐	☐
10.	Itching	☐	☐	☐	☐
11.	Leg heaviness or tiredness	☐	☐	☐	☐
12.	Restless legs	☐	☐	☐	☐
13.	Excessive sleepiness	☐	☐	☐	☐
14.	Insomnia, difficulties falling asleep or staying asleep throughout the night	☐	☐	☐	☐
15.	Dizziness	☐	☐	☐	☐
16.	Trembling, blushing	☐	☐	☐	☐
17.	Neck or shoulder pain	☐	☐	☐	☐
18.	Loss of appetite, unintentional weight loss	☐	☐	☐	☐
19.	Increased appetite, weight gain	☐	☐	☐	☐
20.	Fainting spells	☐	☐	☐	☐
21.	Gait or balance problems	☐	☐	☐	☐
22.	Vision problems	☐	☐	☐	☐
23.	Headaches, migraines	☐	☐	☐	☐
24.	Feelings of pressure in the head	☐	☐	☐	☐
25.	Numbness (e.g. tingling, burning) in the hands or feet	☐	☐	☐	☐
26.	Symptoms of paralysis	☐	☐	☐	☐
27.	Other physical health problems				
	_____	☐	☐	☐	☐

Height _____ Weight _____

Are you receiving medical treatment for your physical health problems?

Are you currently taking any medication? If yes, please indicate what you are taking:

Many thanks!

studierendenwerk würzburg

Psychotherapeutic Counselling Service
Declaration of consent

Surname, first name _____

☐ **Data processing**

I consent to my personal data being collected, stored and processed by the Studentenwerk Würzburg for the purpose of psychotherapeutic counselling until I withdraw my consent. This consent also includes the collection, storage and processing of special categories of personal data (for example data concerning my health) in the context of psychotherapeutic counselling.
I can assert my rights as a data subject at any time by emailing the Studentenwerk Würzburg at datenschutz@swerk-wue.de.

☐ **Unencrypted email communication**

I am aware of the risks of unencrypted email communication. I consent to communicating via unencrypted email.

My email address: _____

☐ **Video counselling**

I consent to my personal data being collected and processed for the purposes of providing video counselling.

_____ _____

Date Signature