

**Pre-Assessment Questionnaire 1: Information About You**

This questionnaire is for you to complete yourself (help from someone who knows you well might be useful)

Your name: ­

Date of Birth: ­­­­ Gender Identity: Pronoun/s: ­

Ethnic Origin: ­­­­

Address:

Email Address:

Telephone Number(s):

If you wish to give someone else permission to speak to SAANS on your behalf (either for queries or appointment making), please provide their details below:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Your Life Currently**

Who do you live with currently?

What is your relationship status? (Please tick)

Single In a relationship Married/ civil partner Divorced/Separated

Do you have any children? If so, please provide information below:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** | **Gender** | **Date of Birth** | **Do they live with you?** | **Do you have parental responsibility?** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

Please tell us about anyone else you have caring responsibilities for:

What is your current employment status? *(Please tick)*

Employed full-time Employed part-time In full-time education Unemployed

If you are in employment, what is your current job role?

Are you in receipt of any benefits? (If so, please state what type)

Do you have any of these Mental Health Conditions?

|  |  |  |  |
| --- | --- | --- | --- |
| **Diagnosis** | **Have you been formally diagnosed by a health professional?****Yes/ No**  | **Do you think you have symptoms?****Yes/ No** | **Have you received any support?** |
| Depression |  |  |  |
| Anxiety/ Panic Attacks |  |  |  |
| OCD |  |  |  |
| Eating Disorder |  |  |  |
| Personality Disorder |  |  |  |
| Auditory hallucinations/ Psychosis/ Schizophrenia  |  |  |  |
| Bipolar Disorder |  |  |  |
| Trauma/ PTSD |  |  |  |
| Drug/ Alcohol Problems |  |  |  |
| Other… |  |  |  |

Do you have any of these Neurodevelopmental Conditions?

|  |  |  |  |
| --- | --- | --- | --- |
| **Diagnosis** | **Have you been formally diagnosed by a health professional?****Yes/ No**  | **Do you think you have symptoms?****Yes/ No** | **Please list any support you have received/ are receiving for each diagnosis, if any.** |
| ADHD |  |  |  |
| Dyslexia  |  |  |  |
| Developmental Co-ordination Disorder (DCD/ Dyspraxia) |  |  |  |
| Learning **Disability\***  |  |  |  |
| Tourette’s Syndrome |  |  |  |
| Other: |  |  |  |

 **\*not a learning difficulty or difference. If you have a Learning Disability diagnosis or this is suspected, your referral will be discussed with the Specialist Community Learning Disability Service (SCLDS) and you may be transferred to their team. Please contact us should you not wish us to do this.**

Do you have any Physical Health Conditions? Please list below:

Do you have any difficulties in the following areas?

|  |  |  |  |
| --- | --- | --- | --- |
| **Area** | **Do you have difficulty in this area?****Yes/ no** | **Description of difficulty** | **Please list any support you have received/ are receiving for each area, if any.** |
| Managing the home (cleaning, cooking, weekly shopping) |  |  |  |
| Self-care (personal hygiene, dressing) |  |  |  |
| Managing your money |  |  |  |
| Healthcare (appointments, taking medicines) |  |  |  |
| Going out independently |  |  |  |
| Maintaining employment/ education |  |  |  |
| Maintaining close personal relationships and friendships |  |  |  |
| Engaging in or supporting family life |  |  |  |
| Organising and planning things |  |  |  |

Do you have any other mental health or physical difficulties that we have not asked about? (please state)

Do you experience your senses in a heightened or dulled way?

|  |  |  |  |
| --- | --- | --- | --- |
| **Sense** | **Is your experience of this heightened, sometimes causing you distress?****Y/N** | **Do you struggle to notice or experience sensations in this area?****Y/N** | **If you answered yes, please describe some of your experiences**  |
| Sounds/ noise |  |  |  |
| Visual details/ lights |  |  |  |
| Touch/ textures |  |  |  |
| Food textures/ tastes |  |  |  |
| Smells |  |  |  |
| Pain |  |  |  |
| Temperature |  |  |  |
| Feeling hungry/ thirsty/ full |  |  |  |
| Movement (repetitive hand/ body movements)  |  |  |  |

**Education**

Did you attend mainstream primary and secondary schools?

Did you receive any additional support at school? What for?

Did you attend any specialist school or unit? Which one and at what age?

Did you/do you attend college? What stage are you at?

Subject/s studied

Did you/do you attend university? What stage are you at?

Subject/s studied

What is the **highest** level of qualification you have achieved? (e.g. GCSE grade 4 / A level grade B, Masters degree etc )

Did you have any jobs while you were in education? (Please list)

Have you had any jobs since leaving education? (Please list)

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 Please tell us about any forensic history/convictions that you may have.

**Your Goals**

Why are you seeking this assessment?

What area/s of your life are you hoping to improve through this process? (e.g., Close personal relationships, friendships, family life, employment, education, going out of the house/ independence, accessing healthcare, managing stress levels/mental health, managing daily life, greater self acceptance) .