Forschungs- und
Behandlungszentrum für
psychische Gesundheit

**Research and Treatment Center
for Mental Health**
Massenbergstraße 9–13, 44787 Bochum

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**Psychotherapy Outpatient
Clinics for adults**

Pre-Treatment Assessment

This questionnaire contains a series of questions about your personal life situation and the problem areas that have prompted you to contact us.

Please fill out the questionnaire as accurately and completely as possible. This will help us to thoroughly prepare for a possible initial consultation. If you wish, you can add further comments in the margins or on the back.

All your information will, of course, be treated as strictly confidential. No outsider will have access to this information without your written permission.

Please return the completed questionnaire to: Ruhr University Bochum, Research and Treatment Center, Bochumer Fenster, Massenbergstr. 11, 44787 Bochum, Germany. Thank you for your cooperation.

I am interested in a treatment at the Research and Treatment Center at Ruhr University Bochum and would like you to contact me.

Date: ..... Signature: .....

Name in block letters:.....

Part 1: Personal details

1. Last name, first name:

   _____

2. Date of birth: _____

3. Gender: ☐ Male ☐ Female ☐ Diverse ☐ No response

4. Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

5. Living situation: ☐ Living alone ☐ Living with parents ☐ Living with partner
   ☐ Shared apartment ☐ Assisted living
   ☐ Other: _____

6. Children: ☐ No ☐ Yes If yes, how many? _____

7. Native language: ☐ German ☐ Turkish ☐ Polish ☐ Russian ☐ French ☐ English
   ☐ Other: _____

8. Professional Status: ☐ Full-time ☐ Part-time ☐ Casual work ☐ Housewife/husband
   ☐ Education/studies ☐ Unemployed ☐ retirement pension
   ☐ Disability pension ☐ Self-employed ☐ Other: _____
   ☐ Incapacity to work: Since when? _____
   For what reason? _____

9. Has an application for a pension been submitted? ☐ no ☐ yes
   If yes, for what reason? _____

10. Occupation learned:

    _____

11. Current occupation: _____

12. How many hours do you work per week on average? _____

13. How much time (hours per week) can you and would you like to spend on therapy (e.g., exercises between sessions, reading texts)?

    _____

    _____

14. When are you definitely unable to attend therapy sessions (weekdays, times)?

15. Health insurance: ☐ Statutory ☐ Private ☐ Eligible for assistance ☐ Accident insurance

Name of health insurance provider:

Address of health insurance provider:

If applicable, name and address of the subsidy office:

16. Do you have a legal gurdianship? ☐ No (continue with question 20) ☐ Yes

17. In which areas do you receive support?
(e.g., finances)

18. Name of guardian:

Guardian's phone number:

19. Since when has the support been in place?

20. Do you have a severely disabled person's pass: ☐ No ☐ Yes If yes, what is the percentage?

21. How can we reach you?
Address: Home phone:
Mobile:
Work phone:
Comments on availability:

We would like to point out that emails **do not** meet data protection requirements and therefore do not satisfy therapeutic confidentiality requirements. Nevertheless, in many cases, email makes it easier for us to contact you.
If you want to ensure that no one finds out that you are seeking therapy at the Research and Treatment Center, please do not enter your email address below.
However, if you agree that we may contact you by email to arrange an appointment, despite insufficient data security, please enter the relevant email address below. We will use the email address you provide exclusively for the purpose of arranging an appointment.
By providing your email address, you expressly consent to this use.

Email address:

22. Which of the following contact methods can we use to leave a message for you?

Part 2: Information on various problem areas

1. Which of the following *problem areas* applies most to you?
   (Multiple selections possible; each area will be asked about in more detail afterwards)

☐ I. Fears	☐ VII. Relationship problems
☐ II. Compulsions	☐ VIII. Sexual problems
☐ III. Depression	☐ IX. Pain or other physical disorders
☐ IV. Consequences of traumatic experiences	☐ X. Sleep problems
☐ V. Eating disorders	☐ XI. Problems caused by alcohol, drugs, medication use
☐ VI. Problems in dealing with other people	☐ XII. Other problems

2. What events have led you to want to start psychotherapy right now?

_____

_____

_____

_____

_____

You were able to select above which areas of disruption apply to you. Below you will find a series of questions on these problem areas. Please answer the questions on *all* problem areas, even if you do not have any difficulties in one or the other.

I. Anxiety

A panic attack consists of sudden, intense anxiety, fear, or terror, often in connection with a feeling of imminent danger. This is often accompanied by very unpleasant physical symptoms, such as palpitations, dizziness, shortness of breath, sweating, or difficulty breathing.

3. Have you ever experienced such a panic attack?

☐ No (continue with question 6) ☐ Yes

If yes, how *often* do these panic attacks occur? _____

4. Do or did these panic attacks occur out of the blue? ☐ No ☐ Yes

5. Are there situations or activities that you *avoid* because you fear that such a panic attack could occur (e.g., driving, department stores, crowds, confined spaces, bridges, etc.)? ☐ No ☐ Yes

If so, what are these situations or activities?

_____

_____

_____

6. Have you ever been afraid or uncomfortable speaking, eating, or writing in front of other people?

☐ No ☐ Yes

If so, in what situations does this occur?

7. Are there other things you are afraid of, such as flying in an airplane, seeing blood, being in enclosed spaces, certain animals, or heights?

☐ No ☐ Yes

If so, what situations or things are you afraid of?

8. Would you describe yourself as someone who is constantly worried or anxious?

☐ No (continue with question 10) ☐ Yes

If yes, how does this manifest itself/what are you worried about?

9. Is it difficult for you to control your worries, i.e., do you have trouble stopping yourself from worrying?

☐ No ☐ Yes

If so, how does this manifest itself / what are you worried about?

II. Compulsion

10. Have you ever had recurring *ideas, thoughts, impulses*, *or images* that you found annoying or nonsensical, at least initially? For example, the idea of getting dirty or infected, the thought that you could harm another person, or constantly worrying that something bad might have happened?

☐ No ☐ Yes

If yes, please describe this in more detail:

11. Have you ever felt the urge *to do* certain things *over and over again*, even though you knew it was excessive or unreasonable, such as washing your hands repeatedly, checking repeatedly to see if you had turned off an electrical appliance, or feeling unable to stop saying certain number sequences or touching certain things?

☐ No ☐ Yes

If yes, please describe these actions:

III. Depression

12. Have you ever *felt down* or *depressed* almost every day for a long period of time, or lost *interest* or *pleasure* in things or activities that used to be important to you?

☐ No (continue with question 14) ☐ Yes

Please check which of the following feelings or conditions you experienced during this period:

- ☐ Significant weight loss or weight gain
- ☐ Decreased or increased appetite
- ☐ Insomnia or increased sleep
- ☐ Restlessness/constantly on the move
- ☐ Slowing of movements/speech
- ☐ Fatigue or loss of energy
- ☐ Feelings of worthlessness
- ☐ Feelings of guilt
- ☐ Loss of concentration
- ☐ Inability to make decisions
- ☐ Recurring thoughts of death
- ☐ Suicidal thoughts
- ☐ Suicide attempt

13. Are you currently suffering from this depressed or low mood?

☐ No ☐ Yes

IV. Consequences of traumatic experiences

14. Have you ever experienced extremely traumatic events, such as being in a life-threatening situation (e.g., disaster, serious accident, assault, rape/abuse, torture, victim of violence), or have you witnessed something like this happening to another person?

☐ No (continue with question 16) ☐ Yes

If yes, please describe these experiences in keywords:

15. Do you relive the horror of these events in nightmares, images, or thoughts that you cannot shake off, over and over again, or do you become very upset when something reminds you of these events?

☐ No ☐ Yes

If yes, please describe these experiences in keywords:

V. Eating habits

16. Height: _____cm Current body weight: _____kg

17. Please enter your highest and lowest body weight since the age of 14 below: Highest:_____kg

    at the age of _____years

    Lowest:_____kg at the age of _____years

18. Binge eating is when a large amount of food is eaten in a short period of time and you feel compelled to eat. Have you ever experienced binge eating?

    ☐ No (continue with question 20) ☐ Yes

19. After a binge eating episode, do you take measures such as *vomiting, taking laxatives, dieting, or fasting* to prevent weight gain?

    ☐ No ☐ Yes

If yes, what measures do you take?

_____

_____

_____

20. Do you try to keep your body weight below a certain *limit*?

    ☐ No ☐ Yes

    If yes, what is this limit? _____ kg

21. What do you do to prevent weight gain?

_____

_____

_____

22. Do you consider your eating habits to be problematic?

    ☐ No ☐ Yes (please explain)

_____

_____

_____

VI. Problems in dealing with other people

23. Do you suffer from interpersonal problems?

    ☐ No ☐ Yes

If yes, please check the appropriate category and explain briefly:

☐ Frequent arguments with others: _____

☐ Frequently being taken advantage of:

_____

☐ Others do not appreciate my achievements enough/appropriately:

_____

☐ Other people are often annoyed by me: _____

☐ Frequently not being taken seriously: _____

☐ Friendships often break apart: _____

☐ I often want to be the center of attention

_____

☐ I have difficulty asserting myself/saying "no": _____

☐ I often feel misunderstood: _____

☐ I find it difficult to subordinate myself:

_____

☐ I want to be right too often: _____

☐ Relationships often break up: _____

☐ Other difficulties: _____

VII. Relationship

(if you are not currently in a partnership, continue with question 27)

24. How long have you been in a relationship?

_____

25. How *unhappy* or *happy* would you say your marriage/partnership is at the moment?

☐	☐	☐	☐
Unhappy	Rather unhappy	Somewhat happy	Happy

26. In which areas are there problems, what do you argue about?

_____

_____

_____

_____

_____

VIII. Sexual problems

27. Do you suffer from sexual problems? ☐ no ☐ yes

If yes, please tick:

- ☐ Lack of or insufficient arousal
- ☐ Erectile problems
- ☐ Pain during sexual intercourse
- ☐ Premature ejaculation
- ☐ Orgasm disorders
- ☐ Feelings of guilt
- ☐ Special preferences
- ☐ Other: _____

IX. Pain or other physical disorders

28. Have there been times when you have experienced recurring pain for *at least six months*?
    ☐ No ☐ Yes

29. Do you often experience pain so severe that you find it difficult to concentrate on anything else?
    ☐ No ☐ Yes

If yes, please describe your pain in your own words:

_____

_____

_____

30. If yes, where do you feel pain? (Please tick which of the following body parts are affected.)

- ☐ Mouth / face / head
- ☐ Neck / throat area
- ☐ Shoulders / Arms / Hands
- ☐ Chest / upper back
- ☐ Abdomen
- ☐ Lower back/buttocks
- ☐ Hips / Legs / Feet
- ☐ Pelvic area
- ☐ Genitals / Anus
- ☐ Other: _____

Are there any known medical causes?

_____

_____

_____

X. Sleep problems

31. Do you have trouble *falling asleep*?
    ☐ No ☐ Yes

If yes, how long does it usually take you to fall asleep after going to bed?

_____

32. Do you have trouble *staying asleep* (restless sleep, frequent waking)?
    ☐ No ☐ Yes

If yes, how many hours do you sleep *in total* at night? _____ hours

33. Do you often find yourself suddenly *falling asleep for short periods during the day*?

☐ No ☐ Yes

34. Do you suffer from frequent nightmares?

☐ No ☐ Yes, topics: _____

XI. Problems caused by alcohol, drug, or medication use

35. *How many days* a week do you usually drink alcohol?

_____

36. *How much* alcohol (and what type) do you drink on a day when you drink alcohol?

_____

_____

37. Has there been a time in your life when you drank *more* alcohol than other people thought you should?

☐ No ☐ Yes

If yes, how much alcohol did you drink at that time? _____

When was that? _____

38. Have you ever taken any drugs for a period of at least one month?

☐ No ☐ Yes, namely: _____

If so, have you taken any drugs during the last month?

☐ No ☐ Yes

39. Have you ever been addicted to medication or taken more than was prescribed?

☐ no ☐ Yes: _____

If so, have you also taken medication in this way during the last month?

☐ No ☐ Yes

XII. Other problems and additional information

40. Have you ever heard things (e.g., noises or voices) or seen things that other people could not perceive?

☐ No ☐ Yes

Please indicate when these experiences occurred and how they manifested themselves exactly:

_____

_____

_____

41. Have you ever had a phase where you felt so good that others thought something was wrong or you got into trouble because of it?

☐ No ☐ Yes

Please indicate when these experiences occurred and how exactly they manifested themselves:

_____

_____

42. Do you have a problem with exhibiting excessive ("addictive") behavior?

☐ No ☐ Yes

If yes, please check the behaviors that apply to you and explain them briefly:

☐ Excessive spending: _____

☐ excessive use of the internet (chatting, surfing, etc.): _____

☐ excessive sexual activity: _____

☐ excessive computer gaming: _____

☐ excessive television viewing:

_____

☐ excessive gambling: _____

☐ Other addictive behavior: _____

43. Have you ever tried to take your own life, or have you ever had a firm intention to do so?

☐ No (continue with question 45) ☐ Yes, once ☐ Yes, several times. How often?

_____

44. Please indicate when this was (in each case) and what reasons led you to do so:

_____

_____

_____

_____

_____

45. Have you ever hurt yourself?

☐ No (continue with question 47) ☐ Yes

If yes, in what way (e.g., cutting, scratching)?

_____

_____

46. Please indicate when this was and what reasons led you to do so:

_____

_____

_____

_____

_____

47. Please check which of the following feelings or behaviors you suffer from and explain them briefly:

☐ Loneliness: _____
☐ I find it difficult to concentrate on tedious tasks: _____
☐ I am aggressive too often:

_____
☐ Sluggishness/laziness:

_____
☐ I conform too often: _____
☐ Self-esteem issues: _____
☐ Anger about...:_____
☐ Shame about: _____
☐ Sadness about:

_____
☐ Other things of this nature:

_____
☐ Nothing of this nature

48. Have you already undergone **outpatient psychotherapy** treatment?

☐ No (continue with question 52) ☐ Yes, once ☐ Yes, several times. How often? _____

49. When did you receive outpatient psychotherapy treatment (in each case)?

From: _____ to: _____ ☐ Regularly completed ☐ Terminated prematurely

From: _____ to: _____ ☐ Regularly completed ☐ Terminated prematurely

From: _____ to: _____ ☐ Regularly completed ☐ Terminated prematurely

50. Which therapy method were you treated with?

☐ Behavioral therapy ☐ Psychoanalysis/psychodynamic therapy ☐ Other ☐ Don't know

51. What were the reasons for the treatment(s) at that time?

_____

_____

_____

_____

52. Have you already received **outpatient medical** or **other** treatment (including addiction treatment) for your problems?

☐ No ☐ Yes, namely: _____

53. Have you ever received **inpatient** psychiatric or psychotherapeutic treatment (including addiction treatment)?

☐ No (continue with question 56) ☐ Yes, once ☐ Yes, several times. How often? _____

54. From when to when were you in inpatient treatment (in each case)?

Clinic: _____ Period: _____

Clinic: _____ Period: _____

Clinic: _____ Period: _____

Clinic: _____ Period: _____

55. What were the reasons for the treatment(s) at that time?

56. Do you have any physical illnesses? If so, which ones and since when?

57. Please provide the names and full addresses of your *current* treating physicians and psychotherapists (and other practitioners, if applicable):

Name: Address/Phone: Since when in treatment:

58. Are you ***currently*** taking any *medication* (both prescription and non-prescription)? **If so,** please list all the medication you are taking. In the columns provided, please indicate the name of the medication, the daily dosage, how long you have been taking the medication, and the nature of your symptoms.

Medication (name)	Daily dosage	From when to when?	Type of symptoms

59. Have you taken any *medication* for mental health issues ***in the past***?
If so, please list all medications you have taken for mental health issues. In the columns provided, please note the name of the medication, the dosage (amount), and the period during which you took the medication.

Medication (name)	Dosage per day	From when to when?	Type of disorder

60. Finally, please describe once again in your own words *the problems* for which you are seeking treatment:

61. In which areas of your life do these problems limit you (e.g., work, relationships)?

62. What would you like to achieve for yourself in therapy?

Thank you **very much!** Please check again to make sure you have answered all the questions and don't forget to sign the first page. Then please return the questionnaire to:

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Massenbergstr. 9-13
44787 Bochum