5a Coleshill Street
Sutton Coldfield
B72 1SD
Tel: 0121 301 5990 Fax: 0121 301 5991

Code:

Self-Assessment Form

Personal information: *(Please answer each question as fully as possible. We will share any relevant information with your GP).*

Acacia has a duty of care to ensure you and others are safe. Please note if you tell us anything that suggests you or someone else is at risk, this information will be shared with an appropriate agency.

If you have had no contact from Acacia within 7 working days of returning your form please contact the office on 0121 301 5990 to confirm receipt.

Title:	First name:	Last name:
Date of birth:	Date:	Email:
Current address:		Address for correspondence if different:
Postcode:		Phone No:
Mobile:		Gender: Male / Female / Trans / Other
GP's name:		GP's phone No:
GP surgery:		

Can we send you text message reminders for appointments? ❍ Yes ❍ No

Is it ok to leave a message on your voicemail and say it is Acacia ❍ Yes ❍ No

Mon	Tues	Weds	Thurs	Fri

Consent to contact by *(please tick all relevant)*

❍ Mobile ❍ leave a voicemail ❍ text ❍ landline ❍ leave ansaphone message ❍ email

❍ letter to home address ❍ letter to alternative address: ……

……

Are you a refugee or asylum seeker? ❍ Yes ❍ No

Do you have a disability? ❍ Yes ❍ No

How would you describe your sexual orientation? ❍ Heterosexual ❍ Bisexual

❍ Gay ❍ Lesbian ❍ Other ❍ I do not wish to disclose my sexual orientation

Ethnic background: *(please tick)*

❍ White – British	❍ Mixed – Other	❍ Black/Black British - African
❍ White – Irish	❍ Asian/Asian British - Indian	❍ Black/Black British - Other
❍ White – Other	❍ Asian/Asian British – Pakistani	❍ Chinese
❍ Mixed – White and Black Caribbean	❍ Asian/Asian British - Bangladeshi	❍ Any other Ethnic group
❍ Mixed – White and Black African	❍ Asian/Asian British – Other	❍ Not stated

Marital Status: *(please tick)*

❍ Co-habitee	❍ Divorced/civil partnership dissolved	❍ Married/civil partner
❍ Separated	❍ Single	❍ Widowed/surviving civil partner
❍ Not disclosed		

Please note, Acacia Family Support is <u>not</u> a crisis service. If you are currently experiencing distressing thoughts and feel you might be at risk of harming yourself or someone else, please contact one of the following:

- Your GP or out-of-hours service,
- NHS Direct on 0845 46 47,

- the Samaritans on 08457 90 90 90 or 0121 666 6644, or
- in an emergency dial 999 or visit A&E.

What happens next? We will contact you once we have reviewed this form.

Please use a separate sheet if you wish to provide further information

1.	**(a) Please can you tell us who you live with? Include any children and their ages.** **(b) What support networks do you currently have in place ie friends/family who are of help/support (perhaps emotionally and/or practically)?** **(c) What agencies/medical professionals work with you (eg social services, Family Support Worker, Health visitor, befriending services, psychiatrist etc).**

2.	**What is the main problem or difficulty you would like some help with?** ***Please include how you 'feel' including your emotions, thoughts and behaviours, and any recent life events that have made things worse.*** **How does it affect you?** **What sort of help would you like?**
3.	**What normally helps you cope when life is difficult?** ***For example, your strengths, resources, family, friends, interests etc.***

4.	**Have you currently been prescribed any medication for your mental health?** ***If so, what have you been prescribed and since when?***
5.	**Do you find yourself using alcohol or taking recreational drugs to help you cope with your problems?** ***If so, please tell us more …***
6.	**Have you had previous contact with mental health services, or therapy/counselling? (Please give the details eg dates, name of organisation and any diagnosis)** **❍ Yes ❍ No**
7.	**Tell us about your daily routine? Please include activities and times, eg get up at 7 am.**
	THANK YOU VERY MUCH for completing these questions. Once you have checked that you have included everything you wish to, please continue to the questionnaires overleaf. ***We greatly appreciate your co-operation.***

Additional notes by Acacia:

NAME: _____ DATE: _____

Further questions

We ask everyone using the Acacia Family Support service to complete certain questionnaires, like the ones below, every time they see one of our befrienders. The scores from these questionnaires help us to decide the best service for people. We also use them so that we can track improvements in your wellbeing.

Patient health questionnaire (PHQ)

Please could you complete the PHQ questionnaire below? This form will measure any signs or symptoms of low mood and depression.

Please tick the boxes below that best show how you have felt over the last TWO weeks:
Please answer all questions.

	Not at all	Less than half the days	More than half the days	Nearly every day
1 Little interest or pleasure in doing things.	❍	❍	❍	❍
2 Feeling down, depressed, or hopeless.	❍	❍	❍	❍
3 Trouble falling or staying asleep, or sleeping too much.	❍	❍	❍	❍
4 Feeling tired or having little energy.	❍	❍	❍	❍
5 Poor appetite or over eating.	❍	❍	❍	❍
6 Feeling bad about yourself, or that you are a failure, or have let yourself or your family down.	❍	❍	❍	❍
7 Trouble concentrating on things, such as reading the newspaper or watching television.	❍	❍	❍	❍
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	❍	❍	❍	❍
9 Thoughts that you would be better off dead or of hurting yourself in some way.	❍	❍	❍	❍

9a) Do you have any current plans to end your life?

9b) What stops you acting on these thoughts?

9c) Have you ever acted on these types of thoughts in the past?
If so, please tell us more including <u>when this was …</u>

9d) Are you self-harming, or have you ever self-harmed? If so, please give further details, eg method, frequency, approximate date of last attempt.

Generalised anxiety disorder scale (GAD)

Please could you complete the GAD questionnaire below? This form measures any signs or symptoms of general anxiety.

Please tick the boxes below that best shows how you have felt over the last <u>TWO</u> weeks:
Please answer all questions.

	Not at all	Less than half the days	More than half the days	Nearly every day
1 Feeling nervous, anxious or on edge.	❍	❍	❍	❍
2 Not being able to stop or control worrying.	❍	❍	❍	❍
3 Worrying too much about different things.	❍	❍	❍	❍
4 Trouble relaxing.	❍	❍	❍	❍
5 Being so restless that it is hard to sit still.	❍	❍	❍	❍
6 Becoming easily annoyed or irritable.	❍	❍	❍	❍
7 Feeling afraid as if something awful might happen.	❍	❍	❍	❍

Client's signature …… Date ……...