

## Counselling Self-Assessment Questionnaire

This questionnaire is designed to help you decide if counselling would be beneficial to you at this time.

Answer the questions with *yes*, *no*, or *sometimes*, as applicable. In general, if you answer **yes** 5 to 6 times, or **sometimes** 8 times, you might be going through a difficult time and could benefit from counselling.

After filling in this questionnaire, if you wish to discuss your responses, send us an e-mail, listing the questions and your answers, and one of our counsellors will get in touch with you to discuss your situation.

If you wish to make an appointment with an ICC counsellor for an intake meeting, then call or e-mail us:

06 2259 0772

(please leave a message in English or in Dutch)

[info@icconnections.org](mailto:info@icconnections.org)

One of our counsellors will be in touch with you as soon as possible, usually within a week.

If you have questions about how we work or about costs and insurance, please refer to our FAQ sheet at [www.icconnections.org](http://www.icconnections.org).

### Questionnaire

Within the last two weeks have you had problems with

1. <b>Fatigue</b>	<input type="checkbox"/> Yes
	<input type="checkbox"/> No
	<input type="checkbox"/> Sometimes
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2. <b>Sleeping</b>	<input type="checkbox"/> Yes
	<input type="checkbox"/> No
	<input type="checkbox"/> Sometimes
<hr/>	
3. <b>Poor appetite</b>	<input type="checkbox"/> Yes
	<input type="checkbox"/> No
	<input type="checkbox"/> Sometimes
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4. <b>Nausea</b>	<input type="checkbox"/> Yes
	<input type="checkbox"/> No
	<input type="checkbox"/> Sometimes
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5.	<b>Dizziness</b>	<input type="checkbox"/> Yes
		<input type="checkbox"/> No
		<input type="checkbox"/> Sometimes

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6.	<b>Problems conversing</b>	<input type="checkbox"/> Yes
		<input type="checkbox"/> No
		<input type="checkbox"/> Sometimes

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7.	<b>A deterioration in your physical or mental condition</b>	<input type="checkbox"/> Yes
		<input type="checkbox"/> No
		<input type="checkbox"/> Sometimes

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8.	<b>Breathlessness</b>	<input type="checkbox"/> Yes
		<input type="checkbox"/> No
		<input type="checkbox"/> Sometimes

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9.	<b>Pain</b>	<input type="checkbox"/> Yes
		<input type="checkbox"/> No
		<input type="checkbox"/> Sometimes

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10.	<b>A reduction in everyday functioning</b>	<input type="checkbox"/> Yes
		<input type="checkbox"/> No
		<input type="checkbox"/> Sometimes

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11.	<b>Worrying</b>	<input type="checkbox"/> Yes
		<input type="checkbox"/> No
		<input type="checkbox"/> Sometimes

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12.	<b>Restlessness</b>	<input type="checkbox"/> Yes
		<input type="checkbox"/> No
		<input type="checkbox"/> Sometimes

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13.	<b>Feelings of loneliness or isolation</b>	<input type="checkbox"/> Yes
		<input type="checkbox"/> No
		<input type="checkbox"/> Sometimes

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14.	<b>Feelings of sadness</b>	<input type="checkbox"/> Yes
		<input type="checkbox"/> No
		<input type="checkbox"/> Sometimes

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15.	<b>Feelings of loss</b>	<input type="checkbox"/> Yes
		<input type="checkbox"/> No
		<input type="checkbox"/> Sometimes

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