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A questionnaire about you and how you are feeling

You filled in a questionnaire before you started Dramatherapy. This is the follow-up questionnaire that will help us see if anything has changed since you started therapy. Please answer the four questions below and use the last page to do a drawing, and then return this form to your Teacher, SENCO or Dramatherapist. Remember there are no right or wrong answers.

Question 1

a. This is what you said you were most worried about last time we asked

(Teacher/SENCO or Therapist - please write it in the box below)

b. How much has it affected you over the last week?

(Please tick one box below)

0

1

2

3

4

5

Not at all



Very much



Question 2

a. This is the other problem you said you were worried about last time we asked *Teacher/SENCO or Therapist - please write it in the box below.*

b. How much has it affected you over the last week?

(Please tick one box below)

0

1

2

3

4

5

Not at all



Very much





Question 3

a. This is what you said was hard to do because of the problem (or problems)? (Teacher/SENCO or therapist - please write it in the box below.)



a. How hard has it been to do this thing over the last week?

(Please tick one box below.)

0	1	2	3	4	5
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Not at all hard					very hard
					

Question 4



How have you felt this last week? (Please tick one box below.)

0	1	2	3	4	5
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Very good					Very bad
					

Question 5

How do you feel now compared to how you felt before you had Dramatherapy?

(Please tick one box below.)

0	1	2	3	4	5
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Much better	better	little better	about the same	worse	much worse
					

Please use this space for any other comments/drawings or doodles

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Therapist Assessment Form – post-therapy

School ID

Young person's gender

M/F

Therapist ID

Young person's age

years

Young person's initials

Number of sessions attended:

Date therapy ended (DD/MM/YY):

Date post-therapy PSYCHLOPS completed (DD/MM/YY):

Validation question

Now that the therapy has finished, how would you describe the client overall? *(Please tick one box below.)*

0	1	2	3	4	5
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Much better

better

little better

about the same

worse

much worse