

### Weekly Questionnaires

*Date: Session number:*

***Goal progress chart***

***Goal 1:***

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| ***Today I would rate my progress to this goal?***  *Please mark (e.g. bold or highlight) the appropriate number below*     |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |

***Goal 2:***

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| ***Today I would rate my progress to this goal?***  *Please mark (e.g. bold or highlight) the appropriate number below*   |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |

***Goal 3:***

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| ***Today I would rate my progress to this goal?***  *Please mark (e.g. bold or highlight) the appropriate number below*   |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |

***How are things***

***Please mark (e.g. bold or highlight) the appropriate answers below with reference to the past week***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  | ***0*** | ***1*** | ***2*** | ***3*** |
| *1* | *My child feels sad or empty* | *Never* | *Sometimes* | *Often* | *Always* |
| *2* | *Nothing is much fun for my child anymore* | *Never* | *Sometimes* | *Often* | *Always* |
| *3* | *My child has trouble sleeping* | *Never* | *Sometimes* | *Often* | *Always* |
| *4* | *My child has problems with his/her appetite* | *Never* | *Sometimes* | *Often* | *Always* |
| *5* | *My child has no energy for things* | *Never* | *Sometimes* | *Often* | *Always* |
| *6* | *My child is tired a lot* | *Never* | *Sometimes* | *Often* | *Always* |
| *7* | *My child cannot think clearly* | *Never* | *Sometimes* | *Often* | *Always* |
| *8* | *My child feels worthless* | *Never* | *Sometimes* | *Often* | *Always* |
| *9* | *My child feels like he/she doesn’t want to move* | *Never* | *Sometimes* | *Often* | *Always* |
| *10* | *My child feels restless* | *Never* | *Sometimes* | *Often* | *Always* |

***Brief Parental Self Efficacy Scales***

***The following are a number of statements about you and your child. Please mark how much you agree or disagree with each one.***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | ***Strongly disagree*** | ***Disagree*** | ***Neutral*** | ***Agree*** | ***Strongly agree*** |
| 1. *Even though I may not always manage it, I know what I need to do with my child* |  |  |  |  |  |
| 1. *I am able to do the things that will improve my child’s behaviour* |  |  |  |  |  |
| 1. *I can make an important difference to my child* |  |  |  |  |  |
| 1. *In most situations, I know what I should do to ensure that my child behaves* |  |  |  |  |  |
| 1. *The things I do make a difference to my child’s behaviour* |  |  |  |  |  |

***How is your child doing?***

***Thinking about the past week:***

*How much of an impact have my child’s* ***seizures*** *had on my child’s life?*

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| No impact |  | | | | | | | | Significant negative impact | |
| 1 | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | | **10** |

*Comments if any:*

***Thinking about the recent past:***

*Since the last phone call, are my child’s mental health difficulties:*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***Much worse*** | ***A bit worse*** | ***About the same*** | ***A bit better*** | ***Much better*** |
|  |  |  |  |  |

*How much have my child’s mental health difficulties been upsetting or distressing him/her?*

|  |  |  |  |
| --- | --- | --- | --- |
| ***Not at all*** | ***A little*** | ***A medium amount*** | ***A great deal*** |
|  |  |  |  |

*How much have my child’s mental health difficulties been interfering with his/her everyday life in the following areas?*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | ***Not at all*** | ***A little*** | ***A medium amount*** | ***A great deal*** |
| *Home life* |  |  |  |  |
| *Friendships* |  |  |  |  |
| *Ability to learn or work* |  |  |  |  |
| *Leisure activities* |  |  |  |  |

***Thinking about the future:***

*How much better do you think he/she will be in one month’s time?*

|  |  |  |  |
| --- | --- | --- | --- |
| ***No better, maybe worse*** | ***Only a little better*** | ***Quite a lot better*** | ***A great deal better*** |
|  |  |  |  |