

Appointment with the POH-GGZ (mental health practitioner of the general practitioner)

Dear sir or madam,

The doctor has given you this letter about the POH-GGZ (*praktijkondersteuners GGZ*, or: mental health practitioner). These *praktijkondersteuners* are part of the general practice, but are located in two different locations in Katwijk. With this letter we would like to explain what you can expect from these mental health practitioners.

People can come to the doctor for different reasons. Sometimes because of physical complaints, but people can also come because of emotional difficulties. The doctor performs an exam to find the cause of the complaints. Sometimes there is no physical explanation. There may be psychological or social factors at play that can cause or maintain the complaints. In that case, more time is needed to assess the situation.

To do this well, the general practitioner has appointed the *praktijkondersteuners GGZ* and *Jeugd (youth)*. These mental health practitioners are employed by all general practitioners within Zorggroep Katwijk. Our mental health practitioners have all been educated and trained in mental health in the general practice. Their primary goal is to assess the situation with you. Through conversations and questionnaire(s) he or she will assess your complaints and questions and discuss these with you. Subsequently he or she will advise you and the doctor about a possible approach. This could be a referral to a different mental health caregiver, but could also be a number of appointments with him or her. The *praktijkondersteuners* have an extensive overview of the possibilities for support or therapy.

Attached to this letter is a questionnaire (the 4DSQ).

Please fill out this questionnaire and bring it with you to the first appointment.

If you have any questions, you can discuss these with your doctor or the doctor's assistant. For more information you can also visit the site of Zorggroep Katwijk: www.zgkatwijk.nl/poh-ggz

You have an appointment on: at with

The address is:

0 Medisch Centrum De Coepel, Randweg 47, 2225 PJ Katwijk.

Floor -1 (after you enter the building, take the stairs on the right to go downstairs and follow the signs that say POH-GGZ).

Telephone number: 06-12131820

0 Parlevink, Vinkeweg 70, 2223 JR Katwijk.

You can take place in the waiting room, immediately after the second door.

Telephone number: 06-30032371

If you unexpectedly cannot make the appointment, please reschedule or cancel via above-mentioned telephone number.

Appointments can be rescheduled through our assistant, preferably between 8:45-11:30. If you cannot reach us, you can leave a message on the voicemail. Please state your name, date of birth and telephone number so we can call you back as soon as possible.

Four-Dimensional Symptom Questionnaire (4DSQ)

The following is a list of questions about various complaints and symptoms you may have. Each question refers to the complaints and symptoms that you had **in the past week (the past 7 days, including today)**. Complaints you had before then, but no longer had during the past week, do not count.

Please indicate for each complaint how often you noticed that you had it in the past week by putting an "X" in the box under the answer that is most appropriate.

	no	sometimes	regularly	often	very often or constantly
During the past week, did you suffer from:					
1. dizziness or feeling light-headed? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. painful muscles? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. fainting? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. neck pain? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. back pain? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. excessive sweating? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. palpitations? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. headache? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. a bloated feeling in the abdomen? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. blurred vision or spots in front of your eyes? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. shortness of breath? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. nausea or an upset stomach? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
During the past week, did you suffer from:					
13. pain in the abdomen or stomach area? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. tingling in the fingers? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. pressure or a tight feeling in the chest? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. pain in the chest? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. feeling down or depressed? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. sudden fright for no reason? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. worry? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. disturbed sleep? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. a vague feeling of fear? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. lack of energy? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. trembling when with other people? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. anxiety or panic attacks? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
During the past week, did you feel:					
25. tense? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. easily irritated? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. frightened? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	no	sometimes	regularly	often	very often or constantly
During the past week, did you feel:					
28. that everything is meaningless? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. that you just can't do anything anymore? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. that life is not worth while? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31. that you can no longer take any interest in the people and things around you? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32. that you can't cope anymore? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33. that you would be better off if you were dead? ---	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34. that you can't enjoy anything anymore? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35. that there is no escape from your situation? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
36. that you can't face it anymore? -- -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
During the past week, did you:					
37. no longer feel like doing anything? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
38. have difficulty in thinking clearly? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
39. have difficulty in getting to sleep? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
40. have any fear of going out of the house alone? ---	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
During the past week:					
41. did you easily become emotional? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
42. were you afraid of anything when there was really no need for you to be afraid? ----- (for instance animals, heights, small rooms)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
43. were you afraid to travel on buses, streetcars/ trams, subways or trains? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
44. were you afraid of becoming embarrassed when with other people? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
45. did you ever feel as if you were being threatened by unknown danger? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
46. did you ever think "I wish I was dead"? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
47. did you ever have fleeting images of any upsetting event(s) that you have experienced? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
48. did you ever have to do your best to put aside thoughts about any upsetting event(s)? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
49. did you have to avoid certain places because they frightened you? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
50. did you have to repeat some actions a number of times before you could do something else? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>