Date:
Therapist Name:
StopSO Admin ID Number:
NB Please ensure the same number is used as on the pre-therapy evaluation form

StopSO Post Therapy Evaluation Form

This form is for you to complete at the end of your therapy, so that StopSO will be able to see what changes have happened.

When you have filled in this form, please seal it in the envelope and give it back to the person who gave it to you.

Please be as honest as possible.

Your therapist will also give a copy of your form to StopSO. StopSO will put an ID number on your form but it will NOT have your name on it and your name will NOT be shared with ANYONE ELSE. The information on this form is strictly ANONYMOUS and CONFIDENTIAL. StopSO will use the information on this form for research and evaluation, but *WE WILL ONLY KNOW THE NAME OF YOUR THERAPIST, WE WILL NOT KNOW YOUR NAME OR ANY IDENTIFYING INFORMATION ABOUT YOU*.

Where you are asked to choose a number from 0 to 10:
0 = not at all
10 = extremely

1) ***What are the problems that have led to you coming for therapy?***

2) ***How stressed are you feeling these days?***

0 1 2 3 4 5 6 7 8 9 10

3) ***How much are you at risk of sexually offending (breaking the law)?***

0 1 2 3 4 5 6 7 8 9 10

4) ***How many sessions of StopSO therapy have you had?***

Over what period of time?

5) ***Currently, having had therapy, how much impact is your previous behaviour having on your life, in the following areas?***

Your job	0	1	2	3	4	5	6	7	8	9	10
Your home-life	0	1	2	3	4	5	6	7	8	9	10
Your relationship with your partner	0	1	2	3	4	5	6	7	8	9	10
Your sex-life	0	1	2	3	4	5	6	7	8	9	10
Family-members	0	1	2	3	4	5	6	7	8	9	10
Your finances	0	1	2	3	4	5	6	7	8	9	10
Your friends and social life	0	1	2	3	4	5	6	7	8	9	10

6) ***Sometimes behaviour can be confusing. How well do you feel you understand your own behaviour?***

0 1 2 3 4 5 6 7 8 9 10

7) ***There are many different reasons why people have problem behaviour. How much do you feel you understand about why YOU have these problems?***

0 1 2 3 4 5 6 7 8 9 10

8) ***Do you feel you are addicted to your behaviour (for example, you can't stop looking at images on the internet, even though you want to stop)?***

NO I SOMETIMES FEEL THIS WAY I ALWAYS FEEL THIS WAY

9) ***Do you have other addictions (for example, problems with alcohol, drugs, compulsive sex)?***

NO YES, MAYBE YES, DEFINITELY

If yes, please describe what addictive behaviours you have.

10) ***How strongly do you feel sexual attraction towards the following?***

	low										high
Men	0	1	2	3	4	5	6	7	8	9	10
Women	0	1	2	3	4	5	6	7	8	9	10
Teenage boys	0	1	2	3	4	5	6	7	8	9	10
Teenage girls	0	1	2	3	4	5	6	7	8	9	10
Younger boys	0	1	2	3	4	5	6	7	8	9	10
Younger girls	0	1	2	3	4	5	6	7	8	9	10
Toddlers or babies	0	1	2	3	4	5	6	7	8	9	10
Animals	0	1	2	3	4	5	6	7	8	9	10

11) ***How important is sex in your life?***

Low 0 1 2 3 4 5 6 7 8 9 10 High

12) ***How important is pornography in your life?***

Low 0 1 2 3 4 5 6 7 8 9 10 High

13) ***Do you have any other sexual difficulties?***

NO YES, BUT NOT MUCH YES

If yes, please specify the difficulty or difficulties.

14) ***When you masturbate, do you think about ….***

Children you know in real life?	0	1	2	3	4	5	6	7	8	9	10

Children you don't know in real life?	0	1	2	3	4	5	6	7	8	9	10
Animals?	0	1	2	3	4	5	6	7	8	9	10
Rape in fantasy?	0	1	2	3	4	5	6	7	8	9	10
Rape in real life?	0	1	2	3	4	5	6	7	8	9	10
Hurting someone (hitting, cutting, using weapons, torture, strangling)?	0	1	2	3	4	5	6	7	8	9	10
Killing?	0	1	2	3	4	5	6	7	8	9	10
Exposing yourself?	0	1	2	3	4	5	6	7	8	9	10
Having sex where others can see you?	0	1	2	3	4	5	6	7	8	9	10
Voyeurism, watching others?	0	1	2	3	4	5	6	7	8	9	10
Rubbing yourself against strangers?	0	1	2	3	4	5	6	7	8	9	10

15) ***Do you take pictures secretly?***

NO YES, BUT NOT MUCH YES

16) ***Have you made someone do sexual acts they didn't want to do?***

NO YES, BUT NOT MUCH YES

17) ***Since therapy began, have you had any new incidences of trouble with the law?***

YES NO

If yes, please describe.

18) ***When you feel tempted to break the law, what do you do to stop yourself?***

19) ***How helpful did you find this StopSO therapy***

Not helpful 0 1 2 3 4 5 6 7 8 9 10 Very helpful

Any other comments?

20) ***Which county do you live in? Or if London, which part (north, south, east, west, central, etc)***

21) ***Which age group are you?***

Under 12 12-15 16-18 19-25 26-35 36-45 46-55 56-65 66-75 over 75

22) ***Are you …***

Male Female Trans / Other

23) ***How would you describe yourself?***

White Mixed / dual heritage Black Asian Other (please state)

24) *How would you describe your sexual orientation?*

Heterosexual Homosexual Bisexual Asexual Other (please state)

Thank you for completing this form, and for being as honest as possible in your answers. Your answers will make it easier for your therapist to understand and help you.

Now please put this form into the envelope provided, and hand it to the person who gave you the form.