

Quick Assessment (QA) Neurotherapy Institute

Name of Client: _____ Name of Rater: _____ Date: _____

Please rate yourself, or the person you are assessing, for each of symptoms below. Check only one box on the rating scale for each symptom. If you don't know how to rate a symptom leave it blank.

Rating Scale (Frequency of Symptoms)

- Low Frequency Rating: 0 = None -- has not occurred during the last month.
 1 = Monthly -- has occurred one or more times during the last month, but not within the last week.
 High Frequency Rating: 2 = Weekly -- has occurred one or more times during the last week, but not daily.
 3 = Daily -- has occurred daily for the last seven days.

				None	Monthly	Weekly	Daily					None	Monthly	Weekly	Daily
Symptoms				0	1	2	3	Symptoms				0	1	2	3
Anxious, fearful, uneasiness, worry, concern								Racing Thoughts, many thoughts							
Inattention, daydreaming, hard to stay on task								Agitation, upset, disturbed							
Sad and Blue, guilt, helpless, hopeless feelings								Hyperactive, excessive movement							
Dull, slow to learn, not sharp								Difficulty Falling Asleep, insomnia							
Forgetful, failure to recall or remember								Impulsive, spontaneous urge							
Spaciness, fogginess, not tuned in								Physical Tension in Body, taut, nervous, tense							
Disrupted Sleep, wakes often, difficulty waking								Pressure in Chest, discomfort, pain in chest							
Cries Easily, sheds tears, weeps easily								Aggressive, hostile, overly assertive, bold							
Feelings Easily Hurt, vulnerable								Teeth Grinding, jaw clenching, tight jaw							
Low Self-esteem, poor self-confidence								Headaches, feeling discomfort, unusual feeling							
Lack of Motivation, discouraged								Crawling Sensations on Skin, leg twitches							
Confused Thinking, mixed up, baffled								Sensitivity to Touch, hands, feet, face							
Nausea, sickness, upset stomach								Pain Awareness, long unpleasant sensation							
Loss of Emotional Control, rage, wrath								Hyper Focused, overly attentive, very focused							
Lethargic, lazy, drowsy, sluggish, fatigue								Sad and Angry, agitated and feeling blue							
Left Subtotals								Right Subtotals							
Grand Total		Left Total						Right Total							
Questions				Yes				No	Comments						
Have you changed medication?															
Have you changed herbs, minerals, supplements, or vitamins?															
Have you had any changes at home?															
Have you had any changes at school?															
Have you had any changes at work?															
Have you had any changes in your personal relationships?															
If you answered yes to any question above, please explain:															
List other changes that you have noticed:															
Progress Note (sign and date):															