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):

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