

Renaissance Therapy Clinic Session Treatment Assessment

Name of Client: _____ Date: _____ Session #: _____

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	If you answered "yes" to any questions, please explain:				
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?											
Please explain any changes that you have noticed since last session:											