# SYMPTOM REPORT FORM

Name:

Your most problematic symptoms are listed on this form. Please rate them from 0-10, where 0 represents the absence of the symptom or problem, and 10 represents the highest or worst level of the symptom. Rate the level of your symptoms since your last treatment session. On the lower note section, mention other factors or treatments that could affect your response to this treatment. (Asterisk our appointment dates)

| Most Prominent Symptoms: | Dates: | | | | | | |
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| Date: | Notes/Events/Other Treatments |
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