SPA

SHORT PROGRESS ASSESSMENT ©

Bruno A. Cayoun
University of Tasmania, 2003

CLIENT FORM - 1

Name: _____

Date of Birth: _____

Today's Date: _____

Date at start of therapy (if different): _____

Have you been treated before for the same difficulties?_____

Are you currently being treated for the same difficulties (For example, are you seeing a counsellor, doctor, nurse, or psychiatrist)?_____

If you have answered yes to either of the questions above, please describe the other treatment below:

_____

_____

_____

_____

DIRECTIONS

On the other side of this page is a list of five areas of life in which people can experience discomfort (behaviours, thoughts, physical sensations, feelings, and relationships). There are also two ways of assessing your experience. One is the strength of the experience; the other is how much you can manage the discomfort.

Please follow carefully the instructions below and ask your assessor for more detail if needed.

Try not to spend too long on your answers. There is no right or wrong answer.

SPA© - ASSESSMENT BEFORE THERAPY Actual FORM 1

FULL NAME:…….. DATE…….

How strong or upsetting were your

Circle one number in each column in the section below according to **how strong or upsetting your experiences were** IN THE PAST 7 DAYS, INCLUDING TODAY

	Not at all or a little	Moderate	Strong but bearable	Sometimes unbearable	Unbearable most of the time
UNWANTED BEHAVIOURS / ACTIONS	0	1	2	3	4
UNPLEASANT THOUGHTS	0	1	2	3	4
UNPLEASANT BODY SENSATIONS	0	1	2	3	4
UNPLEASANT FEELINGS / EMOTIONS	0	1	2	3	4
UNPLEASANT RELATIONS WITH OTHERS	0	1	2	3	4

How manageable were your

Circle one number in each column in the section below according to **how you coped with the above experiences (how manageable were they)**
IN THE PAST 7 DAYS, INCLUDING TODAY

	Easily manageable	Moderately manageable	Managed with difficulty	Sometimes unmanageable	Unmanageable most of the time
UNWANTED BEHAVIOURS / ACTIONS	0	1	2	3	4
UNPLEASANT THOUGHTS	0	1	2	3	4
UNPLEASANT BODY SENSATIONS	0	1	2	3	4
UNPLEASANT FEELINGS / EMOTIONS	0	1	2	3	4
UNPLEASANT RELATIONS WITH OTHERS	0	1	2	3	4

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CLIENT FORM - 2

Name: _____

Date of Birth: _____

Today's Date: _____

Date at start of therapy (if different): _____

Have you been given another treatment for the same difficulties since you started therapy?_____

If yes, please describe the other treatment and the reason for it below:

_____

_____

_____

_____

DIRECTIONS

On the other side of this page is a list of five areas of life in which people can experience discomfort (behaviours, thoughts, physical sensations, feelings, and relationships). There are also two ways of assessing your experience. One is the strength of the experience; the other is how much you can manage the discomfort.

 Please follow carefully the instructions below and ask your assessor for more detail if needed.

 Try not to spend too long on your answers. There is no right or wrong answer.

SPA© - ASSESSMENT BEFORE THERAPY Retrospective FORM 2

FULL NAME:…….. DATE…….

How strong or upsetting were your

Circle one number in each column in the section below according to **how strong or upsetting your experiences were** BEFORE YOUR FIRST THERAPY SESSION

	Not at all or a little	Moderate	Strong but bearable	Sometimes unbearable	Unbearable most of the time
UNWANTED BEHAVIOURS / ACTIONS	0	1	2	3	4
UNPLEASANT THOUGHTS	0	1	2	3	4
UNPLEASANT BODY SENSATIONS	0	1	2	3	4
UNPLEASANT FEELINGS / EMOTIONS	0	1	2	3	4
UNPLEASANT RELATIONS WITH OTHERS	0	1	2	3	4

How manageable were your

Circle one number in each column in the section below according to **how you coped with the above experiences (how manageable were they)** BEFORE YOUR FIRST THERAPY SESSION

	Easily manageable	Moderately manageable	Managed with difficulty	Sometimes unmanageable	Unmanageable most of the time
UNWANTED BEHAVIOURS / ACTIONS	0	1	2	3	4
UNPLEASANT THOUGHTS	0	1	2	3	4
UNPLEASANT BODY SENSATIONS	0	1	2	3	4
UNPLEASANT FEELINGS / EMOTIONS	0	1	2	3	4
UNPLEASANT RELATIONS WITH OTHERS	0	1	2	3	4

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CLIENT FORM - 3

Name: _____

Date of Birth: _____

Today's Date: _____

Date at start of therapy: _____

Have you been given another treatment for the same difficulties since you started therapy?_____

If yes, please describe the other treatment and the reason for it below:

_____

_____

_____

_____

DIRECTIONS

This assessment is identical to the one you were given when you started therapy. On the other side of this page is a list of five areas of life in which people can experience discomfort (behaviours, thoughts, physical sensations, feelings, and relationships). There are also two ways of assessing your experience. One is the strength of the experience; the other is how much you can manage the discomfort.

Please follow carefully the instructions below and ask your assessor for more detail if needed.

Try not to spend too long on your answers. There is no right or wrong answer.

SPA© - ASSESSMENT DURING/POST THERAPY

FORM 3

FULL NAME:…….. DATE…….

How strong or upsetting were your

Circle one number in each column in the section below according to **how strong or upsetting your experiences were** IN THE PAST 7 DAYS, INCLUDING TODAY

	Not at all or a little	Moderate	Strong but bearable	Sometimes unbearable	Unbearable most of the time
UNWANTED BEHAVIOURS / ACTIONS	0	1	2	3	4
UNPLEASANT THOUGHTS	0	1	2	3	4
UNPLEASANT BODY SENSATIONS	0	1	2	3	4
UNPLEASANT FEELINGS / EMOTIONS	0	1	2	3	4
UNPLEASANT RELATIONS WITH OTHERS	0	1	2	3	4

How manageable were your

Circle one number in each column in the section below according to **how you coped with the above experiences (how manageable were they)**
IN THE PAST 7 DAYS, INCLUDING TODAY

	Easily manageable	Moderately manageable	Managed with difficulty	Sometimes unmanageable	Unmanageable most of the time
UNWANTED BEHAVIOURS / ACTIONS	0	1	2	3	4
UNPLEASANT THOUGHTS	0	1	2	3	4
UNPLEASANT BODY SENSATIONS	0	1	2	3	4
UNPLEASANT FEELINGS / EMOTIONS	0	1	2	3	4
UNPLEASANT RELATIONS WITH OTHERS	0	1	2	3	4

SPA© - PERCEIVED OUTCOME

FORM PI

Name: _____

Date of Birth: _____

Today's Date: _____

Date at start of therapy: _____

DIRECTIONS

Below is a list of five areas of life in which people can experience improvement (behaviours, thoughts, physical sensations, feelings, and relationships). Please circle one number in each column in the section below according to HOW MUCH IMPROVEMENT **you have experienced in each of these five areas**.

Please ask your assessor if you need more detail.

Try not to spend too long on your answers. There is no right or wrong answer.

How do you perceive your improvement with

	Have worsened	No improvement noted	Small improvements	Clearly visible improvement overall	Significant improvement, goal reached
UNWANTED BEHAVIOURS / ACTIONS	0	1	2	3	4
UNPLEASANT THOUGHTS	0	1	2	3	4
UNPLEASANT BODY SENSATIONS	0	1	2	3	4
UNPLEASANT FEELINGS / EMOTIONS	0	1	2	3	4
UNPLEASANT RELATIONS WITH OTHERS	0	1	2	3	4

SPA© - PERCEIVED OUTCOME

FORM ST

Name: _____

Date of Birth: _____

Today's Date: _____

Date at start of therapy: _____

DIRECTIONS

Below is a list of five areas related to therapy. Please circle one number in each column in the section below according to HOW SATISFIED YOU ARE **with each part of the therapy you have had**.

Please ask your assessor if you need more detail.

Try not to spend too long on your answers. There is no right or wrong answer.

How satisfied are you with	Not at all satisfied	A little satisfied	Moderately satisfied	Very satisfied	Extremely satisfied
TREATMENT TYPE	0	1	2	3	4
TREATMENT LENGTH	0	1	2	3	4
RELATIONSHIP WITH THERAPIST	0	1	2	3	4
THE SKILLS YOU LEARNED	0	1	2	3	4
COST (IF APPLICABLE)	0	1	2	3	4