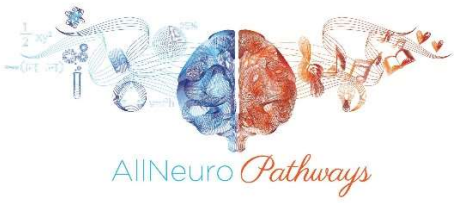
Scanned: ___/___/_____



Client Feedback Regarding Changes

Next Appointment: _____ , ___ - ___ - ___ @ ___:___ AM/PM

Client Name: _____ **Date:** _____ / _____ / _____

Please respond to all categories that indicate changes you experienced **up to** 48 hours after your session, **BUT NOT** beyond 48 hours. What you are looking for is an **INCREASE** or **DECREASE** in any of the items listed below. If other events occur in your life that impact changes in the items below, **PLEASE base your evaluation on how your response to the event after the session is different than it would have been before neurofeedback treatment.**

- **Write "M"** when this response occurred **MORE** frequently 1-48 hours after session
- **Write "L"** when this response occurred **LESS** frequently 1-48 hours after session
- **Leave Blank if you experienced NO CHANGE** in the particular response
- **Write "✓"** if this item improved since you started NFB and you are maintaining that improvement
- **Symptoms that are not listed on the sheet can be added in the blank spaces**

COGNITIVE PROCESSING

_____Attention Deficits--Easily Distracted
_____Short Term Memory Problems
_____Getting Homework Done
_____Slowness of Thought—Easily Confused
_____Dyscalculia—Problems Calculating
_____Dyslexia—Letter Reversal
_____Concentration Problems
_____Organization/Planning Problems
_____Reading Comprehension
_____ _____

MOOD

_____Depression-(Sad--Don't enjoy daily Activities)
_____Anxiety
_____Irritable
_____Hyperarousal & Fear responses
_____Empathy for Others
_____Social Activity
_____Hopefulness
_____Self Confidence
_____Guilt
_____ _____

EMOTIONAL CONTROL

_____Anger & Loss of Control
_____Obsessive Thoughts or Hyper-Focused
_____Impulsive or Compulsive Behaviors
_____Communication Skills
_____Oppositional/Defiant Behavior
_____Emotional Expression
_____Positive Interactions with Others
_____Hyperactivity
_____Mood Swings or Manic Episodes
_____Self Esteem
_____ _____

PERFORMANCE and SLEEP

_____Getting Things Done
_____Fast Reaction Time
_____Performance: Insert Type:_____
_____Eye/Hand Coordination
_____Easy to Fall Asleep
_____Staying Asleep Through the Night
_____Feeling Rested in the Morning
_____Remembering Dreams
_____Headaches
_____Pain: Insert type:
_____ _____

Medication Changes/Notes: _____

_____

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