24 Hour Report

Client: _____ Date: _____ Scanned: ___/___/____

1. How did you sleep last night? _____
2. Did you go to bed at the usual time? Yes: ___ No: ___
3. Did it take more or less time to fall asleep? More: ___ Less: ___
4. Did you sleep through the night? Yes: ___ No: ___
5. If not when did you first wake up? _____
6. Is that a normal time or a normal amount of sleep before you first wake up? Yes: ___ No: ___
7. How would you rate your anxiety over the last 24 hours on a scale of 0-10? _____

   What was the lowest/highest? Lowest: _____ Highest: _____
8. How was your mood? _____
9. How was your emotional regulation? _____
10. Did your sensitivity diminish or heighten? Dimish: ___ Heighten: ___
11. Did you have more fun or felt more positive in the last 24 hours than you have recently?

    Yes: ___ No: ___
12. Did you feel more negative or depressed in the last 24 hours than you have recently?

    Yes: ___ No: ___
13. Were you irritable? Yes: ___ No: ___
14. Did you behave impulsively in the last 24/48 hours? Yes: ___ No: ___

    If yes, please

explain:_____
15. How was your appetite? Did you eat more or less in the last 24 hours?

    More: ___ Less: ___ Same: ___
16. Did you feel hungry? Yes: ___ No: ___

    If yes, on a scale of 1-10 how hungry were you? _____
17. Did you have nausea? Yes: ___ No: ___
18. Did you have cramping in your stomach? Yes: ___ No: ___
19. Were there other stomach area discomforts? Yes: ___ No: ___

    If yes, please explain: _____

20. Did you feel more or less mentally sharp in the last 24 hours? More: ___ Less: ___

21. How was reading? Were you able to maintain the usual reading speed? Yes: ___ No: ___

How is your understanding/Comprehension of the material? _____

22. Was your stool more loose or stiff? Loose: ___ Stiff: ___

23. Did you have more bowel movements than usual? Yes: ___ No: ___

24. Did you have a headache? Yes: ___ No: ___

If so, on a scale of 0-10 how painful was it? _____

25. Were you dizzy? Yes: ___ No: ___

26. Were you more clumsy than usual? Yes: ___ No: ___

27. Did you have trouble getting a full breath? Yes: ___ No: ___

28. Did you have persistent pain or muscle tightness in your neck, shoulders, or low back?

Yes: ___ No: ___

29. Did you have persistent pain or muscle tightness in any other part of your body?

Yes: ___ No: ___ If yes, where? _____

29. Did you have a strong reaction to sounds? Yes: ___ No: ___

If yes, was this the same, more or less than usual? Same: ___ More: ___ Less: ___

30. Was there anything unusual that happened in the last twenty-four hours that happened even if you think it was unrelated to neurofeedback? Yes: ___ No: ___

If yes, please explain: _____