Checklist of changes since last Neurofeedback session

Name: ____ Date:______________

Please rate symptom changes since your last session. Leave blank any symptoms that do not apply.

"B" = better "W" = worse "NC" = no change

_____ Impulsiveness
_____ Aggressiveness
_____ Hyper focus (over focus)
_____ Agitation
_____ Anxiety
_____ Anger
_____ Obsessive thoughts
_____ Compulsive Behaviors
_____ Difficulty falling asleep
_____ Nightmares
_____ Body tension
_____ Tics
_____ Headaches
_____ Racing thoughts
_____ Hyperactivity
_____ Feeling jumpy
_____ Can't slow down
_____ Negative thoughts
_____ Skin crawling sensation
_____ Pain awareness
_____ Happiness
_____ Being organized
_____ Aware of more dreams
_____ Clear thinking
_____ Reaction time
_____ Attention, Concentration
_____ "Having your act together"
_____ Reading

_____ Spaciness or foggy
_____ Feeling or acting drunk
_____ Motivation
_____ Energy
_____ Depression
_____ Loss of emotional control
_____ Night
_____ Ability in tasks requiring steps
_____ Snoring
_____ Trouble staying asleep
_____ Pain threshold
_____ Nausea
_____ Irritability
_____ Feeling Dull
_____ Confused Thinking
_____ Memory
_____ Punctuality
_____ Forgetfulness
_____ Cry Easily
_____ Feeling blue
_____ Feeling calm or relaxed
_____ Body awareness
_____ Empathy for others
_____ Energy
_____ Fearfulness
_____ Eye contact with others
_____ Talkative
_____ Voice Calmer or Lower

YES __ NO ___ Have you had any changes in medication since your last visit? ____________________________________

YES __ NO ___ Have you had any major changes in supplements or herbs since your last visit? _____________________

YES __ NO ___ Have you had any major changes in your environment since your last visit? ________________________

<u>Please list any additional symptoms, behaviors or comments below and/or on back of page.</u>