Checklist of changes noticed
Since last neurofeedback session

Child's Name:_____ **Today's Date:**_____

Parent Signature:_____

Please indicate, to the best of your ability, how your child has been since his/her last session. Mark next to the applicable symptoms using a scale of one to ten. Disregard any non-applicable symptoms. The success of your child's treatment depends on how well you communicate with us, any difficulty or improvement you have seen in him/her.

M – More L – Less

____Spacey
____Immature behavior
____Irritable
____Upset stomach
____Emotional explosions
____Disrupted sleep
____Lethargic
____Appetite
____Cries easily
____Losing things/forgetful
____Does not seem to listen
____Complains of nightmares

____Agitated
____Impulsive
____Aggressive behavior
____Difficulty going to sleep

____Hyperactive
____Restless, fidgety
____Complains of headaches
____Easily distracted
____Dangerous/risky play
____Playing quietly

____Plays more cooperatively
____Emotionally calm
____Anxiety/panic
____Anger
____Eye-contact
____Attentive
____Falls asleep easier
____Fear
____Compliant
____Accepts responsibility/fault
____Fidgety

____Happier

____Talkative
____Sound sleep
____Aware of more dreams

____Faster reaction time
____Energetic

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