# Checklist of Changes Since Last Neurofeedback Session

Please rate any changes you have observed since your last neurofeedback session. Compare how you felt after the session to how you felt the day before it. For the first 5-10 sessions, rate based on the remainder of the day of the session. After that, compare the 24-48 hours after the session to the day before the session. PLEASE RATE the item as better in relation to your overall goals. (For example, for flexibility, more is better; for anger, more is worse.

*Please complete Scale of 1-10 at your initial session. 1 is no problem and 10 severe.

Name_____ Today's Date_____

| Scale 1-10 | If No Change Leave Blank | Much Worse | Worse | Better | Much Better |
|---|---|---|---|---|---|
| | Sustained attention, Focus, Concentration | | | | |
| | Alertness, Mental Sharpness or Clarity, Spaciness, Fogginess | | | | |
| | Energy, Motivation, Persistence, Determination | | | | |
| | Mood, Sadness, Tearfulness, Crying Easily, Negative Thoughts | | | | |
| | Organization, Planning, Ability in Tasks Requiring Steps, Punctuality, Forgetfulness | | | | |
| | Trouble Staying Asleep, Sleeping Too Much, Quality of Sleep | | | | |
| | Irritability, Emotional Over-Sensitivity | | | | |
| | | | | | |
| | Anger, Agitation, Aggression, Frustration Tolerance | | | | |
| | Anxiety, Panic, Fear | | | | |
| | Muscle Tension, Teeth Grinding, or Clenching | | | | |
| | Hyperactivity, Feeling Jumpy, Racing Thoughts, Talking Too Fast or Too Much or Too Loud or High Pitched | | | | |
| | Trouble Falling Asleep, Physically Restless Sleep, Nightmares | | | | |
| | Flexibility in Thinking and Behavior, Accepting Change, Tolerating New or Unexpected Experiences | | | | |
| | Over-Focus, Ability to Shift Focus | | | | |
| | Impulsivity, Acting Without Thinking, Risk Taking | | | | |
| | Obsessive or Repetitive Thinking, Ruminating, Worrying, Compulsive Behavior, Repetitive Behavior | | | | |
| | Distractibility | | | | |
| | Interest in Communicating or Interacting, Awareness of Others, Empathy | | | | |
| | Tics, Headaches, Grinding Teeth, Skin Crawling Sensations | | | | |

**Please list any additional symptoms, behaviors or comments:**

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