NEUROFEEDBACK TRAINING CO.

CLINICS & RENTALS | LA NY CO

PRE-SESSION EVALUATION

Name: Date

How do you feel today? _____

_____

What symptoms do you have? (e.g. head stuffy, headache, feeling down etc.). _____

_____

_____ **Please rate your symptoms 0-10 :** _____

What medications are you taking? _____

How "good" do you feel overall? Rate 0 - 10: _____

☐ **PRE CC** ☐ **T CC** **Diff + / -** **SESSION#:** _____ **Reg** ☐ **Ext** **OTH** ☐ **enter times):** _____

POST-SESSION EVALUATION

How do you feel at the end of your session? _____

_____

Are any of your symptoms remaining? _____

Please rate them 0-10: _____ **How "good" do you feel now 0-10?:** _____ **Are you alert enough to drive?** _____

Do you feel your training is helping you? _____

Comments? _____

_____

☐ **PRE CC** ☐ **POST CC** **Diff + / -** **SESSION#:** _____ ☐ **Reg** ☐ **Ext** **OTHER (enter times):** _____