F.A.I.R. COUNSELING

Checklist of Psychological/Physiological/Behavioral 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
____ Spaciness or foggy
____ Aggressiveness
____ Feeling or acting drunk
____ Hyper focus (over focus)
____ Motivation
____ Agitation
____ Energy
____ Anxiety
____ Depression
____ Anger
____ Loss of emotional control
____ Obsessive thoughts Night
____ Compulsive Behaviors
____ Ability in tasks requiring steps
____ Difficulty falling asleep
____ Snoring
____ Nightmares
____ Trouble staying asleep
____ Body tension
____ Pain threshold
____ Tics
____ Nausea
____ Headaches
____ Irritability

____ Racing thoughts
____ Feeling Dull
____ Hyperactivity
____ Confused Thinking
____ Feeling jumpy
____ Memory
____ Can't slow down
____ Punctuality
____ Negative thoughts
____ Forgetfulness
____ Skin crawling sensation
____ Cry Easily
____ Pain awareness
____ Feeling blue
____ Happiness
____ Feeling calm or relaxed
____ Being organized
____ Body awareness
____ Aware of more dreams
____ Empathy for others
____ Clear thinking
____ Energy
____ Reaction time
____ Fearfulness
____ Attention, Concentration

____ Eye contact with others
____ Having your act together
____ Talkative
____ Reading
____ 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? _____

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