Neurofeedback Reassessment Summary

Date: ____________________

Clinician: ____________________

Client Name: ____________________ Number of Sessions: _____ Family: ____________________

Test Results

Subject #: ____________ CPT #: ____ Time: ________

Performance Index	Speed of Response	Consistency of Response

Accuracy Index	Sustained Attention	Impulse Control

Reported Changes

Medications:

Ongoing Therapy:

Symptom Changes (Review Initial Symptoms):

Follow-up Plan

Remaining Concerns:

Recommended Training or Referral: