

Neurofeedback Assessment Summary

Date: _____

Clinician: _____

Client Name: _____ Age: _____ DOB: _____

Referred by: _____ Family: _____

Symptoms:

Test Results

Subject #: _____ CPT #: 1 Time: _____

Sustained Attention	Impulse Control	Speed of Response	Consistency of Response

Developmental and Trauma History:

Genetic History:

Medications:

Ongoing Therapy:

Recommended Training or Referral: