Neurofeedback Reassessment Summary

Date: ______________________________

Clinician: ______________________________

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

Test Results

Subject #: ______________ CPT #: ____ Time: ________

Sustained Attention	Impulse Control	Speed of Response	Consistency of Response

Reported Changes

Medications:

Ongoing Therapy:

Symptom Changes (Review Initial Symptoms):

Follow-up Plan

Remaining Concerns:

Recommended Training or Referral: