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Solstice-Mind Matters PTY Ltd Trustee
for the Solstice Discretionary Trust
ACN: 107 4 72720 ABN: 67 664 403 107

Directions:
Please pay attention to how you feel during the next 24-48 hours after your Neurofeedback session. Your participation and feedback is important in your progress. Please bring this completed form to each of your sessions.

Checklist of changes since last Neurofeedback session

Name: ______________________________ Session Date: __________________

Placement: ____________________ Date Form Completed: __________________

Please respond for any categories that apply based on any changes since your last treatment session. For categories that do not apply, leave blank.

1	*2*	*3*	*4*	*5*	*6*	*7*
Much Better	**Better**	**Somewhat Better**	**No Change**	**Somewhat Worse**	**Worse**	**Much Worse**

Impulsiveness *1 2 3 4 5 6 7*
Aggressiveness *1 2 3 4 5 6 7*
Hyper focus (over focus) ...*1 2 3 4 5 6 7*
Agitation........................*1 2 3 4 5 6 7*
Anxiety..........................*1 2 3 4 5 6 7*
Anger *1 2 3 4 5 6 7*
Obsessive thoughts *1 2 3 4 5 6 7*
Compulsive behaviours.....*1 2 3 4 5 6 7*
Difficulty falling asleep *1 2 3 4 5 6 7*
Nightmares *1 2 3 4 5 6 7*
Body tension..................*1 2 3 4 5 6 7*
Tics *1 2 3 4 5 6 7*
Headaches *1 2 3 4 5 6 7*
Racing thoughts.............*1 2 3 4 5 6 7*
Hyperactivity.................*1 2 3 4 5 6 7*
Feeling jumpy................*1 2 3 4 5 6 7*
Can't slow down...........*1 2 3 4 5 6 7*
Negative thoughts..........*1 2 3 4 5 6 7*
Skin crawling sensation.....*1 2 3 4 5 6 7*
Pain awareness *1 2 3 4 5 6 7*
Unhappiness *1 2 3 4 5 6 7*
Not being organised.......*1 2 3 4 5 6 7*
Less recall of dreams *1 2 3 4 5 6 7*
Unclear thinking *1 2 3 4 5 6 7*
Slow reaction time.........*1 2 3 4 5 6 7*
Poor attention *1 2 3 4 5 6 7*
Not having my act together..*1 2 3 4 5 6 7*
Problems reading *1 2 3 4 5 6 7*

Spaciness or foggy................*1 2 3 4 5 6 7*
Feeling or acting drunk.........*1 2 3 4 5 6 7*
Motivation...........................*1 2 3 4 5 6 7*
Energy.................................*1 2 3 4 5 6 7*
Depressed Mood...................*1 2 3 4 5 6 7*
Loss of emotional control *1 2 3 4 5 6 7*
Night terrors *1 2 3 4 5 6 7*
Ability in tasks requiring steps...*1 2 3 4 5 6 7*
Snoring................................*1 2 3 4 5 6 7*
Trouble staying asleep *1 2 3 4 5 6 7*
Pain threshold.......................*1 2 3 4 5 6 7*
Nausea.................................*1 2 3 4 5 6 7*
Irritability *1 2 3 4 5 6 7*
Feeling dull *1 2 3 4 5 6 7*
Confused thinking *1 2 3 4 5 6 7*
Memory...............................*1 2 3 4 5 6 7*
Punctuality *1 2 3 4 5 6 7*
Forgetfulness *1 2 3 4 5 6 7*
Cry Easily............................*1 2 3 4 5 6 7*
Feeling blue.........................*1 2 3 4 5 6 7*
Not feeling calm or relaxed.......*1 2 3 4 5 6 7*
Poor body awareness *1 2 3 4 5 6 7*
Lack of empathy for others.......*1 2 3 4 5 6 7*
Poor concentration................*1 2 3 4 5 6 7*
Fearfulness *1 2 3 4 5 6 7*
Lack of eye contact with others .*1 2 3 4 5 6 7*
Too talkative *1 2 3 4 5 6 7*
Voice tense or higher pitch ...*1 2 3 4 5 6 7*

Please list any additional symptoms, behaviours or comments: ____________________

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Have you had any changes in medication since your last visit? Yes No

If yes, describe: ____________________

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Have you had any major changes in supplements or herbs since your last visit? Yes No

If yes, describe: ____________________

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Have you had any major changes in your environment since your last visit? Yes No

(This could be change such as moving, or remodelling a house or office, which effects your physical environment. It could be personal changes such as changes in diet, relationships, jobs or school).

If yes, describe: ____________________

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Do you have any other comments about the training or its effects on you: ____________________

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Please list any comments others have made since your last session: ____________________

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Please have a family member, friend or co-worker write down any changes they have noticed since your last session (if applicable):

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