Févide
ESTIMULACIÓN CEREBRAL NO INVASIVA

Pediatric tDCS Follow-Up

Before & After Progress Form

For patients previously evaluated in person at Neorgana / Févide.

1. PATIENT INFORMATION

Child's name: _____ **Parent / caregiver:** _____

Age: _____ **Country / city:** _____

tDCS round dates: _____ **Sessions completed:** _____

2. PROTOCOL

Montage / target: _____

Intensity / duration / frequency: _____

3. BEFORE & AFTER 0-10 RATING SCALE

0 = absent / very difficult **5 = partial / inconsistent** **10 = functional / clearly improved**

Area / priority goal	Before	After	Change	Comments / examples
Priority goal 1:				
Priority goal 2:				
Priority goal 3:				
Attention / engagement				
Communication / language				
Motor / coordination				
Emotional regulation / behavior				
Sleep				
Tolerance to therapy				
Other:				

4. PARENT IMPRESSION

Most important improvement: _____

Main concern or no-change area: _____

Observation from therapist / teacher / family: _____

5. TOLERANCE / ADVERSE EVENTS

☐ No adverse events ☐ Skin irritation / burning ☐ Headache ☐ Sleep change ☐ Irritability

☐ Seizure ☐ Other: _____

Quick clinical interpretation

Positive response: +2 or more points in one or more priority goals with good tolerance.

Partial response: +1 point or small but consistent functional change. Negative response: worsening, seizures, marked irritability, or loss of skills.

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