NEUROPTIMAL®
ADVANCED BRAIN TRAINING SYSTEMS
TRANSFORMING LIVES SINCE 2000

TRACKING YOUR SHIFTS

Fill this out before you start training and then every ten sessions.

NAME: _____ **DATE:** _____

SESSION (CIRCLE) 1 10 20 30 40

Medication I am on (how much, how often): _____
My quality of life on a scale of 0-10 is: _____

CONCERN Pick the concerns that you would most like to see shift	DURATION How long did it last? Do not count when you were sleeping	INTENSITY How strong was it 0-10	FREQUENCY How many times did you feel this way in the past week, or how many days out of 7?
1.			
2.			
3.			
4.			
5.			

Note: Any concerns mentioned are intended as examples only and not meant to suggest that NeurOptimal® treats, mitigates, cures, or diagnoses any listed concern. Instead, identified concerns and medication use are one of many ways to measure shifts in brain functioning and perception.

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MY WISHLIST

FILL THIS OUT BEFORE YOU START YOUR TRAINING WITH NEUROPTIMAL®

I would be pleased if the following shifts were to take place in my life:

1.
2.
3.

Put this in an envelope and don't look at it until after you have completed your training!

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