



NEUROPTIMAL[®]

ADVANCED BRAIN TRAINING SYSTEMS

TRACKING YOUR PROGRESS

Fill this out in combination with the checklist of concerns 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): _____

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

Put this in an envelope with your Checklist of Concerns and don't look at it until after you have filled in your next set of forms!