

MY JOURNAL: TRACKER

Start your journey here and track as you go.

NAME:

DATE:

SESSION #:

MY QUALITY OF LIFE ON A SCALE OF 0-10 IS:

ITEM Pick the items 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 NeuroOptimal[®] 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.