BREAKTHROUGH NEUROFEEDBACK™
TRANSFORMATIONAL BRAIN OPTIMIZATION

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.w			
3.			
4.			
5.			