NEUROFEEDBACK TRAINING CO.

CLINICS & RENTALS | LA NY CO

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 _____ or check: ☐ *1 - 5* ☐ *6 - 10* ☐ *11 - 15* ☐ *16 - 20* ☐ *21+* ☐ *30+* ☐ *40+*

Medication I am on
(how much, how often):

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

Put this paper away together with your CHECKLIST OF CONCERNS and don't look at it until you have filled in your next one.