NEUROPTIMAL®
ADVANCED BRAIN TRAINING SYSTEMS

NAME:	
PHONE (H):	HOME UNIT:
PHONE (C):	RATE:
EMAIL:	REFERRED BY:
ADDRESS:	

ARE YOU CURRENTLY TAKING MEDICATIONS? Y / N IF YES, WHO IS YOUR PRESCRIBING DOCTOR? (NAME AND ADDRESS).

DATE	SESSION	COMMENTS / SHIFTS

Zengar Institute Inc. Victoria, BC, V8S 2T6
(866) 990-OPTIMAL (6784)

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DATE	SESSION	COMMENTS / SHIFTS

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CLIENT INFORMED CONSENT

I _____understand that NeurOptimal® is not a medical treatment, device or methodology. It is not used to diagnose medical disorders nor is it used as a medical treatment for disorders and has not been approved for any medical purpose by the FDA, Health Canada or any other governing agency. While Zengar users may or may not be licensed health care practitioners, their use of NeurOptimal® is solely as a tool for brain training and optimization and not as a means of diagnosis or as a medical intervention.

I am satisfied with the information I have been provided (verbal, written or otherwise) by my trainer on the effects I can expect during my NeurOptimal® training and my questions have been answered to my satisfaction. I understand that it is not possible to predict what my central nervous system will do with the information it is offered and consequently there can be no guarantee as to the results of my training.

I agree to cease training if I am less than happy with the results I am getting. I understand NeurOptimal® is purely a source of information and does not direct the response of the central nervous system. Consequently I agree to not hold Zengar Institute Inc or any of its users and trainers responsible for a less than desired outcome or any outcome that may be considered negative.

_____ _____

Your Signature Today's Date

_____

Your Printed Name

NEUROPTIMAL®
ADVANCED BRAIN TRAINING SYSTEMS
TRANSFORMING LIVES SINCE 2000

TRACKING YOUR SHIFTS: THE ONE HUNDRED

NAME:

DATE: **PRE/ONGOING/POST:**

Please check off any item that represents how you are feeling so you can track brain perception following your use of NeurOptimal®. If you are unsure, use the past week as your guide. It's fine to add comments if you wish. Please note that NeurOptimal® does not diagnose, treat, mitigate or cure any disease, disorder or abnormal physical state. This checklist is provided for tracking and reference purposes only. If you require a diagnosis or treatment for any of the below feelings, you should seek medical advice.

1. Itchy or irritated nose, sneezing
2. Wheezing
3. Catch cold too often
4. Run down
5. Tired
6. Awake too long when you go to bed
7. Waking up during the night
8. Waking up before you want to
9. Difficult to wake up in the morning
10. Bad dreams
11. Difficulty breathing at night
12. Out of bed but not knowing how you got there
13. Skin difficult to manage
14. Hair weaker or less lustrous than you'd like
15. Nails weak, flaking or tearing
16. Blurry vision at times
17. Areas where you can't see anything
18. Spots floating in front of you
19. Difficult to hear
20. Ringing in your ears
21. Ears hurt inside
22. Smells seem different or lost
23. Nose gets blocked
24. Grinding your teeth
25. Things taste different
26. Voice hoarse or sore
27. Can't get enough air
28. Heart too fast or jumpy
29. Pulsing or throbbing in your head
30. Heart skips a beat
31. World spinning around you
32. Might throw up
33. Tummy hurts
34. Gassy, bloated
35. Sensitive digestion
36. Upset stomach
37. Difficulty going to the bathroom
38. Eat when not hungry, or not feeling hungry
39. Trouble eating sweets
40. Urges to eat sweet things
41. Sensitive to heat or cold
42. Slowed down or speeded up
43. Moody at certain times of the month
44. Hot flashes
45. Problems from being of a "certain age"
46. Not interested in your partner
47. Too interested in your partner or other people?
48. Stiff and sore
49. Areas that really hurt when touched
50. Muscles hurt
51. Fatigued
52. Pains in your head
53. Going to pass out
54. Lose consciousness
55. Difficult to remember things
56. Difficult to find your words
57. Difficulty reading
58. Difficult to speak sometimes?
59. Shaky
60. Weak
61. Too active
62. Can't balance on one leg
63. Moving your head or saying words you don't intend
64. Difficulty paying attention
65. Easily distracted
66. Make a lot of mistakes
67. Disorganized
68. Difficult to complete tasks
69. Lose your train of thought
70. Difficult to complete studies or work
71. Get into trouble at school or work
72. Mix up numbers or letters sometimes
73. Difficult to know how things fit together
74. Difficulty with some subjects
75. Need to go to the bathroom but hard to start
76. Lose your urine sometimes
77. Difficult to control going to the toilet
78. Stinging sensations when going to the bathroom
79. Drink too much sometimes
80. Smoke cigarettes
81. Concerns about eating
82. Need caffeine to get going
83. Enjoy marijuana
84. Habits that concern you
85. Moody
86. Feeling low or flat
87. Feel sad
88. Concerned about things
89. Feel terrified sometimes
90. Mull about things
91. Thoughts you'd like to stop but can't
92. Need to do things over and over
93. Eat more food than you can comfortably eat
94. Careful to never eat too much
95. Make yourself throw up
96. Difficult to do things you'd like to do
97. Others are against you
98. Get into trouble for your behavior
99. Feeling angry
100. Overwhelmed

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. NOT FOR USE IN CANADA.

NEUROPTIMAL®
ADVANCED BRAIN TRAINING SYSTEMS

SETTING YOUR GOALS

FILL THIS OUT BEFORE YOU START YOUR TRAINING WITH NEUROPTIMAL®

I will know NeurOptimal® is working if....

1.
2.
3.

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

NEUROPTIMAL®
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PRE-SESSION EVALUATION

NAME: DATE:

1. How do you feel today?
2. What symptoms do you have? please rate them 0-10: (e.g. head stuffy, headache, feeling down etc).
3. What medications are you taking?
4. How "good" do you feel overall 0-10?
5. Have you noticed any effects since your last visit that you think might be related to your shifts?

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POST-SESSION EVALUATION

1. How do you feel at the end of your session?
2. Are any of your symptoms remaining? Please rate them 0-10:
3. How "good" do you feel now 0-10?
4. In what way do you feel your training is helping you?
5. Comments?

NEUROPTIMAL®
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PRE-SESSION EVALUATION

NAME: DATE:

1. How do you feel today?

VERY HAPPY | HAPPY | SAD | VERY SAD | ANGRY | DON'T KNOW

2. Did you fall asleep fast last night?
Did you stay asleep?

3. Did you wake up feeling happy?

NEUROPTIMAL®
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POST-SESSION EVALUATION

1. How do you feel after your session?

VERY HAPPY | HAPPY | SAD | VERY SAD | ANGRY | DON'T KNOW

2. Did you enjoy your session?

3. When would it feel good to come back for another session?

NEUROPTIMAL®
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TRACKING YOUR SHIFTS

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): _____
My quality of life on a scale of 0-10 is: _____

CONCERN Pick the items you circled that you would like to see shift the most. - Add any others you want to track	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.			

NEUROPTIMAL®
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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 with your Checklist of Concerns and don't look at it until after you have filled in your next set of forms!