ENT Family

Smell Retraining Therapy Tracker

NAME _____ MONTH _____

Progress

Rate your sense of smell **before starting** this month's SRT.

○ ○ ○ ○ ○ ○ ○ ○ ○ ○

POOR EXCELLENT

Rate your sense of smell **after completing** this month's SRT.

○ ○ ○ ○ ○ ○ ○ ○ ○ ○

POOR EXCELLENT

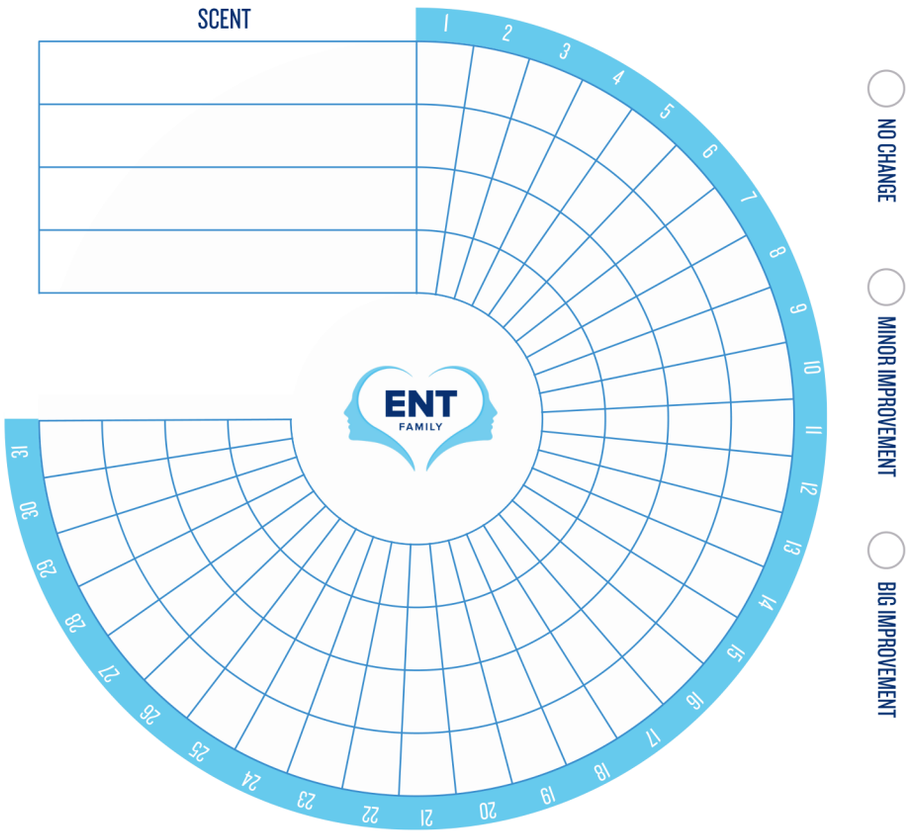
Daily Tracker

Complete **one-half circle** for each of the **two daily smell retraining therapy sessions,** resulting in a full circle by day's end.

WEEK 1	◐	◐	◐	◐	◐	◐	◐
WEEK 2	◐	◐	◐	◐	◐	◐	◐
WEEK 3	◐	◐	◐	◐	◐	◐	◐
WEEK 4	◐	◐	◐	◐	◐	◐	◐
WEEK 5	◐	◐	◐	◐	◐	◐	◐

Monthly Tracker

Assign **three colored pens** to monitor changes in your sense of smell: one for **no change**, one for **minor improvement**, and one for **major improvement**. Use them to track any shifts in your ability to detect scents.



Weekly Notes

WEEK 1 _____

WEEK 2 _____

WEEK 3 _____

WEEK 4 _____

WEEK 5 _____