Patient Daily Progress Note

Myofascial Real Ease Therapy

Patient name: ____ Date: ____/____/____

Has your condition been aggravated? Yes No

Do you have a new condition? Yes No

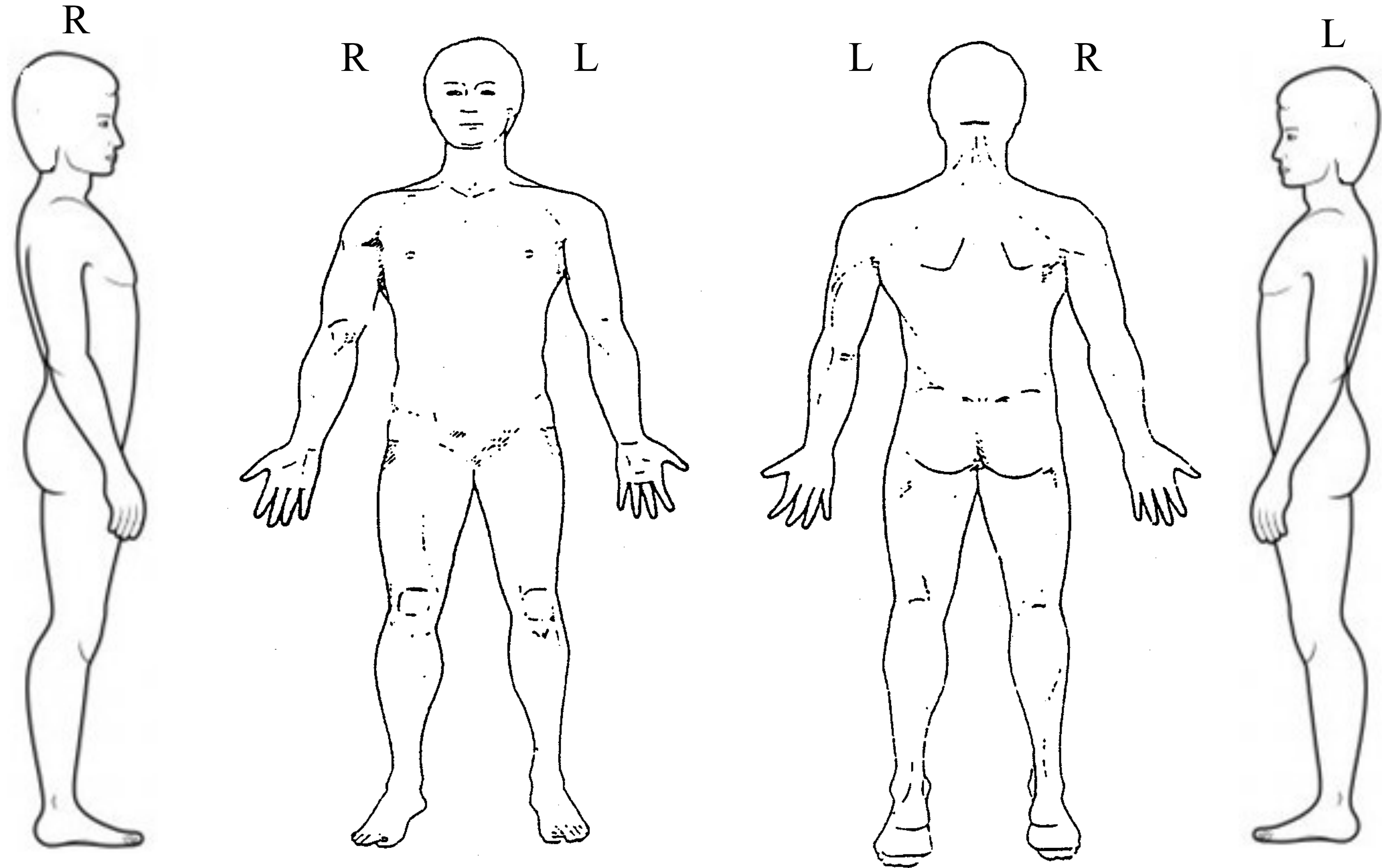
Please explain: ___________________________
____
____
____

What feels better today? ___________________
____
____

How else has your current condition changed?
____
____
____
____
____
____
____
____

On the drawings below, please indicate areas of *any* symptom—pain, ache, tightness, tingling, pins and needles, numbness, etc. Then, rate the intensity of each symptom area using the following scale. Use a single number for a symptom that is constant; use a range of numbers for a symptom that varies.

	NONE		MILD		MODERATE				SEVERE		
SYMPTOM LEVEL	0	1	2	3	4	5	6	7	8	9	10



Signature: ____

©2022 MRET