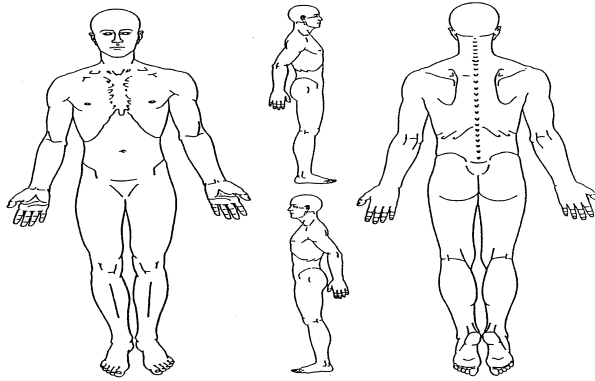


# Client Progress Form

Name: \_\_\_\_\_

Date: \_\_\_\_\_

- 1.) How is your pain level this week on a scale of 1-10? \_\_\_\_\_  
(1 = Least Pain & 10 = Severe Pain)
- 2.) Please indicate on the drawings below where you are feeling pain or discomfort, today.



- 3.) What changes have you noticed since your last visit? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- 4.) Do you have any specific questions or comments for me to address during this session?  
\_\_\_\_\_  
\_\_\_\_\_

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Therapist Notes:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

New Goals/Stretches/Home Program/:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_