NAME/ADDRESS of CLINIC/PROVIDER

OUTCOME ASSESSMENT/PROGRESS- PATIENT OUESTIONNAIRE

Name of Patient_____Date _____

Patient DOB _____

NO SYMPTOMS ——————————————————————— EXTREME SYMPTOMS

Please place an "X" on the line above to indicate your level of problem.

1. What was the chief symptom or reason you visited the office? (low back pain, neck pain, etc.) _____

2. How do you classify your improvement so far since beginning your care?
   Excellent _____Good _____Fair _____Poor _____

3. On a scale of 1 to 10 with 10 being the best, how would you rate your improvement?_____

4. What symptoms have improved? _____
   _____

5. What symptoms do you still have? _____
   _____

6. What changes have been made in your general feelings? Are you: (check those indicated)
   Stronger _____ More Relaxed _____More Alert _____
   Less Nervous_____ Sleep Better _____Appetite Improved _____

7. Do you find it easier: (check those indicated)
   Walking _____ Riding _____ Working _____ Bending____
   Standing_____ Sitting _____ Lifting _____ Same _____

8. Is there any other condition you have that we have not discussed that you would like to discuss at this time?____If yes, please explain _____
   _____

9. Is there any confusion or question about any phase of your progress? _____
   _____

10. Do you intend to continue care to avoid problems in the future (check one)
    Yes_____ No_____Will follow my doctor's recommendations _____

11. Have you had an opportunity to refer anyone to the Doctor? (check one)
    Yes_____ No____ Intend to do so _____

12. Your honest evaluation of the Doctor's office is always appreciated. Please comment on any areas where the Doctor or Office may improve. _____
    _____
    _____

Reviewed by _____
Printed Name of Provider_____

Patient/Guardian Signature _____