OUTCOME ASSESSMENT

Name_____Date _____

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 may improve. _____
    _____
    _____

_____
Patient's Signature

Patient Evaluation

(All comments are confidential)

What appointment time would suit you most? _____

Dr. Courtesy/Efficiency

	Not well	Average	Well	Excellent
Explains problems	_____	_____	_____	_____
Answers questions	_____	_____	_____	_____
Understands needs	_____	_____	_____	_____
Develops rapport	_____	_____	_____	_____

Would you refer other people to out office? _____yes _____no
Why? Why not? _____
_____

Staff (not Dr) Courtesy/Efficiency

	Not well	Average	Well	Excellent
Reception Polite/Efficient	_____	_____	_____	_____
Insurance/Billing Polite/Efficient	_____	_____	_____	_____
Physical therapy Polite/Efficient	_____	_____	_____	_____
General experience	_____	_____	_____	_____

Office structure

	Not well	Average	Well	Excellent
Seating	_____	_____	_____	_____
Reception room appearance	_____	_____	_____	_____
Therapy room appearance	_____	_____	_____	_____
Examination room appearance	_____	_____	_____	_____

Explanation of your financial obligation was communicated:

_____ Poorly _____Confused _____ Adequate _____Clearly