

# 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? Why? Why not? _____	_____yes	_____no		

### 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

**Outcome Assessment**