Name: _____ Date: _____ **Office use**

File No: _____

Practitioner: _____

How many visits have you had with us since your first appointment for this current episode of your problem.
Please include this first appointment and if you are not sure give an approximation: _____

You previously recorded symptom 1 (as written below) as the most important in relation to your condition. Please circle on a score below to indicate how bad this symptom has been **over the last week** on a scale of 0 to 6, with **0** being **'as good as it can be'** and **6** being as **'bad as it can be'**.

Symptom 1 _____

as good as it can be **0 1 2 3 4 5 6** *as bad as it can be*

You previously recorded symptom 2 (as written below) as a second symptom associated with your condition. Please circle on a score below to indicate how bad this symptom has been **over the last week** on a scale of 0 to 6, with **0** being **'as good as it can be'** and **6** being as **'bad as it can be'**.

Symptom 2 _____

as good as it can be **0 1 2 3 4 5 6** *as bad as it can be*

If another symptomhas arisen (physical or mental) which you feel is associated with your condition, Please circle on a score below to indicate how bad this symptom has been **over the last week**.

Additional Symptom _____

as good as it can be **0 1 2 3 4 5 6** *as bad as it can be*

You previously recorded the activity (as written below) as something your symptom/s prevent or interfere with. Please circle on a score below to indicate how badly this activity has been affected **over the last week** on a scale of 0 to 6, with **0** being **'as good as it can be'** and **6** being as **'bad as it can be'**.

Activity _____

as good as it can be **0 1 2 3 4 5 6** *as bad as it can be*

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Continued from page 1

Finally. please circle on a score below to indicate your general wellbeing i.e. how you feel in yourself.

as good as it can be **0 1 2 3 4 5 6** *as bad as it can be*

The treatment you are receiving may not be the only thing affecting your problem. If there is anything else that you think is improtant, such as changes you have made yourself, or other things happening in your life, **Please enter in the space below.**

Are you taking medication **for this problem?** **Yes / No**

How would you describe your pain/complaint now, compared to how you were when you completed the questionnaire before your first visit to this clinic?
Please select one of the following:

1) Completely recovered.
2) Much improved.
3) Slightly improved.
4) No change.
5) Slightly worsened.
6) Much worsened.
7) Worse than ever.

Overall, how have you found the service and care you have received? This would include the way you have been treated by our reception, practitioners or any other contact from us.
Please select one of the following:

1) Unacceptably poor.
2) Not as good as I was expecting, I would be concerned if a friend wanted to come to you.
3) Reasonable but nothing special.
4) As I was expecting and I am satisfied with this.
5) Better than I was expecting.
6) Good, I would be happy to recommend to a friend to you.
7) A very high level, I would recommend friends with similar problems to consider you.

if there is anything else you would like to tell us, either about how your problem has progressed or about the care or service you received from us please use the space below.