Follow Up Questionnaire

Name: _____ DOB: _____ Today's Date: _____

Since beginning the treatment, how would you describe the change (if any) in ACTIVITY LIMITATIONS, SYMPTOMS, EMOTIONS and OVERALL QUALITY OF LIFE, related to your painful condition? (**tick ONE box**).

No change (or condition has got worse)	☐	1
Almost the same, hardly any change at all	☐	2
A little better, but no noticeable change	☐	3
Somewhat better, but the change has not made any real difference	☐	4
Moderately better, and a slight but noticeable change	☐	5
Better, and a definite improvement that has made a real and worthwhile difference	☐	6
A great deal better, and a considerable improvement that has made all the difference	☐	7

In a similar way, please circle the number below, that matches your degree of satisfaction since beginning your care in the clinic:

Dissatisfied Neutral Very Satisfied

0 1 2 3 4 5 6 7 8 9 10

Since your last visit to the clinic, have you started new medications, changed your family physician, had a surgery or invasive procedures, diagnosed with new medical problem? NO / YES, please describe

_____

_____