Name: _____ **Therapist:** _____

Clinic: _____ **Number of visits:** _____

What was your overall change of symptoms from when you began treatment until now

-7	a great deal worse	0	no change	1	a tiny bit better
-6	a great deal worse			2	a little bit better
-5	quite a bit worse			3	somewhat better
-4	moderately worse			4	moderately better
-3	somewhat worse			5	quite a bit better
-2	a little bit worse			6	a great deal better
-1	a tiny bit worse			7	a great deal better

How much did you feel the therapist listened to you and your symptoms while in care?

0 1 2 3 4 5 6 7 8 9 10

How much did you feel the therapist assessed and diagnosed your problem?

0 1 2 3 4 5 6 7 8 9 10

How well did you feel you were educated on your symptoms and learned in a way you understood?

0 1 2 3 4 5 6 7 8 9 10

How involved did you feel in the rehabilitation process?

0 1 2 3 4 5 6 7 8 9 10

How likely are you to return to ReShape Physical Therapy for future care?

0 1 2 3 4 5 6 7 8 9 10

How likely are you to recommend ReShape Physical Therapy to a family, friend, or college?

0 1 2 3 4 5 6 7 8 9 10

What did you like most?

What could be improved?