Outcome Measures

CLIENT INFORMATION

Name: _____ Date of Birth: _____ dd / mm / yyyy

Gender: _____ Address: _____

Phone Number: _____ Email Address: _____

Date of Consultation: _____ dd / mm / yyyy

I feel pain.

- ◯ (1) - Strongly Disagree
- ◯ (2) - Disagree
- ◯ (3) - Neutral
- ◯ (4) - Agree
- ◯ (5) - Strongly Agree

I can move more easily.

- ◯ (1) - Strongly Disagree
- ◯ (2) - Disagree
- ◯ (3) - Neutral
- ◯ (4) - Agree
- ◯ (5) - Strongly Agree

I feel strong.

- ◯ (1) - Strongly Disagree
- ◯ (2) - Disagree
- ◯ (3) - Neutral
- ◯ (4) - Agree
- ◯ (5) - Strongly Agree

I feel coordinated.

- ◯ (1) - Strongly Disagree
- ◯ (2) - Disagree
- ◯ (3) - Neutral
- ◯ (4) - Agree
- ◯ (5) - Strongly Agree

I feel tired.

- ◯ (1) - Strongly Disagree
- ◯ (2) - Disagree
- ◯ (3) - Neutral
- ◯ (4) - Agree
- ◯ (5) - Strongly Agree

I can sleep.

- ◯ (1) - Strongly Disagree
- ◯ (2) - Disagree
- ◯ (3) - Neutral
- ◯ (4) - Agree
- ◯ (5) - Strongly Agree

I can do activities of daily living.

- ◯ (1) - Strongly Disagree
- ◯ (2) - Disagree
- ◯ (3) - Neutral
- ◯ (4) - Agree
- ◯ (5) - Strongly Agree

I can return to work or sports.

- ◯ (1) - Strongly Disagree
- ◯ (2) - Disagree
- ◯ (3) - Neutral
- ◯ (4) - Agree
- ◯ (5) - Strongly Agree

I am satisfied with my care.

- ◯ (1) - Strongly Disagree
- ◯ (2) - Disagree
- ◯ (3) - Neutral
- ◯ (4) - Agree
- ◯ (5) - Strongly Agree

I would recommend physical therapy to others.

- ◯ (1) - Strongly Disagree
- ◯ (2) - Disagree
- ◯ (3) - Neutral
- ◯ (4) - Agree
- ◯ (5) - Strongly Agree

Total Score: _____

Interpretation/Summary:

Recommendation:

Conclusion: