PATIENT-REPORTED OUTCOME MEASURE (POST-TREATMENT)

CLINIC USE ONLY: Patient Reference Number: _____

CLINIC USE ONLY: Clinician Name and Clinic Name/Number: _____

This questionnaire is about THIS PRESENT EPISODE of the COMPLAINT THAT YOU HAVE BEEN TREATED FOR IN THIS CLINIC. It does NOT refer to any previous episodes of a similar complaint that you may have been treated for either in this clinic or elsewhere. By completing this form, you consent to your information being used, anonymously and in confidence, to evaluate your treatment for research purposes. It may also be used by your clinician to monitor your progress. TICK ONE BOX for EACH question unless instructed otherwise.

Q1 **PATIENT: START HERE. YOUR SURNAME:**

Q2 TODAY'S DATE (dd/mm/yyyy):

Q3 Over the past few days, how BOTHERSOME or TROUBLESOME has this complaint been?

Not at all ..... ☐ Slightly..... ☐ Moderately .... ☐ Very much ..... ☐ Extremely ..... ☐

Q4 Over the past few days, on average, how would you rate your pain on a scale where '0' is 'no pain' and '10' is 'worst pain possible'?

	0	1	2	3	4	5	6	7	8	9	10
No pain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Q5 Over the past few days, on average, how has this complaint interfered with your daily activities (housework, washing, dressing, lifting, walking, reading, driving, climbing stairs, getting in/out of bed/chair, sleeping) on a scale where '0' is 'no interference' and '10' is 'completely unable to carry on with normal daily activities'?

	0	1	2	3	4	5	6	7	8	9	10
No interference	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Q6 Over the past few days, on average, how has this complaint interfered with your normal social routine including recreational, social and family activities, on a scale where '0' is 'no interference' and '10' is 'completely unable to participate in any social and recreational activity'?

	0	1	2	3	4	5	6	7	8	9	10
No interference	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Q7 Over the past few days, on average, how anxious (uptight, tense, irritable, difficulty in relaxing/concentrating) have you been feeling, on a scale where '0' is 'not at all anxious' and '10' is 'extremely anxious'?

	0	1	2	3	4	5	6	7	8	9	10
Not at all anxious	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Q8 Over the past few days, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, lethargic) have you been feeling, on a scale where '0' is 'not at all depressed' and '10' is 'extremely depressed'?

	0	1	2	3	4	5	6	7	8	9	10
Not at all depressed	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Q9 Over the past few days, how do you think your work (both inside the home and/or employed work) has affected this complaint, on a scale where '0' is 'make it no worse' and '10 is 'make it very much worse'?

	0	1	2	3	4	5	6	7	8	9	10
Make it no worse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Q10 Over the past few days, on average, how much have you been able to control (help/reduce) and cope with your pain on your own, on a scale where '0' is 'I can control it completely' and '10' is 'I have no control whatsoever'?

	0	1	2	3	4	5	6	7	8	9	10
I have complete control over my pain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

PLEASE TURN OVER

THIS SECTION is about how your complaint has been SINCE YOU STARTED TREATMENT AT THIS CLINIC FOR THIS PRESENT EPISODE. Please remember, it does NOT refer to treatment for episodes you may have had in the past either in this clinic or elsewhere.

Q11 Are you in PAID EMPLOYMENT(includes SELF-EMPLOYED)?

Yes .... ☐ Go to Q12 and continue No..... ☐ Go to Q13 and continue

Q12 If YES, SINCE STARTING TREATMENT AT THIS CLINIC, have you taken any TIME OFF WORK for this complaint?

Yes ..... ☐ No..... ☐

Q13 SINCE STARTING TREATMENT AT THIS CLINIC, how has your use of medication (painkillers) for this complaint changed?

I NEVER, or HARDLY EVER, used any painkillers..... ☐

I have REDUCED my use of painkillers .. ☐

I am taking about the SAME, or INCREASED, my use of painkillers..... ☐

Q14 SINCE STARTING TREATMENT AT THIS CLINIC, have you had any of the following for this complaint? (tick as many as apply)

X-ray..... ☐ Injection..... ☐

MRI/CT scan ..... ☐ Surgery..... ☐

Q15 SINCE STARTING TREATMENT AT THIS CLINIC, have you seen your GP for this complaint?

Yes ..... ☐ No..... ☐

Q16 SINCE STARTING TREATMENT AT THIS CLINIC, have you attended any of the following hospital clinics for THIS COMPLAINT? (tick as many as apply)

Accident and Emergency ..... ☐

Physiotherapy..... ☐

Orthopaedics or Rheumatology..... ☐

Pain Clinic..... ☐

Overnight stay in hospital ..... ☐

Q17 IN OVERALL TERMS, how would you describe this complaint NOW compared to how you were at THE START OF TREATMENT AT THIS CLINIC?

Very much improved..... ☐

Much improved ..... ☐

Minimally improved..... ☐

No change ..... ☐

Minimally worse ..... ☐

Much worse ..... ☐

Very much worse..... ☐

Q18 IN OVERALL TERMS, how satisfied are you with the care you have received at this clinic?

Very satisfied ..... ☐

Satisfied..... ☐

Unsure ..... ☐

Dissatisfied ..... ☐

Very dissatisfied ..... ☐

Q19 DURING TREATMENT AT THIS CLINIC, have you been given advice to help you self-manage this complaint (e.g exercises, prevention of future episodes, care when lifting, awareness of posture)?

Yes, ample information..... ☐

Yes, some information but would have liked more ..... ☐

No ..... ☐

Q20 Finally, have you experienced any TEMPORARY WORSENING of your symptoms, stiffness, soreness or general discomfort IMMEDIATELY or SHORTLY AFTER any of the treatments at this clinic?

No ..... ☐

Not sure ..... ☐

Yes, but I could carry on with my usual activities/work ..... ☐

Yes, and I could NOT carry on with my usual activities/work ..... ☐

THANK YOU VERY MUCH FOR YOUR TIME IN COMPLETING THIS FORM

THE FOLLOWING QUESTIONS TO BE COMPLETED BY CLINICIAN AT FINAL DISCHARGE FROM SERVICE .

Q21 Service/Pathway Provider:

Chiro ..... ☐ Osteo ..... ☐ Physio .... ☐

Q22 Total number of treatments received by patient:

Q23 Did the treatment include acupuncture?

Yes ..... ☐ No..... ☐

Q24 Patient recommended for secondary care/MDT?

Yes ..... ☐ No..... ☐