ESO European School of Osteopathy

Research

Patient code _____
Date __/__/__
Time of treatment __:__

Practitioner Questionnaire

Please complete this questionnaire AFTER you have treated the patient

1. SMOKING Is the patient: (*please tick ONE box only*)

current smoker? ☐ past smoker? ☐ non-smoker? ☐

2. REGULAR MEDICATION ***CURRENTLY*** *(tick ANY that the patient is taking currently)*

analgesics/NSAIDS	☐	anti-migraine medication	☐
anti-diabetic agents	☐	anti-hypertensive agents	☐
anti-depressants	☐	cholesterol lowering agents	☐
oral contraceptives	☐	systemic corticosteroids	☐
HRT	☐		

other medication? ☐ please specify...

3. Treatment given (at this visit)
Tick ONE or more boxes for the techniques used in your treatment TODAY

Treatment approach	USED	NOT USED
1. High Velocity Low Amplitude (Hvla) Thrust Manipulations	☐	☐
2. Direct ie: Articulatory Techniques; Muscle Energy Techniques; Direct Soft Tissue (Kneading, Stretching, Inhibition, Trp)	☐	☐
3. Indirect ie: Functional Techniques Balanced Ligamentous Tension (Blt) Counterstrain	☐	☐
4. Other eg: Osteopathy In The Cranial Field Visceral Manipulation Chapman's Reflexes Lymphatic Technique	☐	☐

4. AREAS TREATED AT THIS VISIT *(please tick ONE or more boxes)*

Head/neck	☐	Upper limb	☐
Upper/mid back	☐	Chest	☐
Low back	☐	Pelvis/Hip/Buttock	☐
Lower limb	☐	Stomach/abdomen	☐
Other	☐		

please indicate where .....

PLEASE RETURN THIS FORM TO RECEPTION

Practitioner Questionnaire

AIDE MEMOIRE

- ✓ **Complete this form IMMEDIATELY after treatment**
- ✓ **Return this form to reception**
- ✓ **Make sure patient knows they must:**
  - **– complete orange form before leaving TODAY**
  - **– take folded form (Part 2) home with them**
  - **– return Part 2 (folded form) to reception at next visit (if within 2 weeks) or by post (in pre-paid envelope)**

ESO European School of Osteopathy **Research**

Patient code _____
Date __/__/__
Time of treatment __:__

Survey:
How do patients feel after their treatment?
Patient Questionnaire: Part 1

1. Your treatment today will be 'hands on'. Have you ever had this type of manual treatment (from an osteopath, chiropractor or physiotherapist) before?

Yes ☐ No ☐ (Please tick ONE box) If you answer Yes: How recently? ____ years

2. Your details: Age _____ years Height _____ (feet/ins.) or _____ (cm)

Male ☐ Female ☐ (Please tick) Weight _____ (st/lbs) or _____ (kg)

3. How would you say your health is generally? (excluding current complaint):

(Please tick ONE box) Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor ☐ Don't know ☐

4. Have you read the 'Information Sheet' and signed the consent form?

Yes ☐ No ☐ (If you answer NO, please see the receptionist)

BEFORE TODAY'S TREATMENT

5. What is your main complaint (the one you want treated today)?

(please tick ONE or more boxes) Pain ☐ Stiffness ☐ Lack of mobility ☐ Other* ☐

(*If other, please indicate what) _

6. Which ONE region is most affected (by your complaint)?

Head/neck ☐ Upper/mid back ☐ Low back ☐ Leg/foot ☐ Shoulder/arm ☐
Chest ☐ Pelvis/Hip/Buttock ☐ Stomach/abdomen ☐ Other* ☐
(*If other, please indicate where?) _

7. When did this complaint start? (please tick ONE box)

Within past 4 weeks ☐ Within past 6 months ☐ or Longstanding complaint ☐

8. Is this complaint: Continuous? ☐ or Comes and goes? ☐ (please tick ONE box)

9. Have you suffered from any of the following: (If yes, please TICK in each column)

	in the previous week?	in the past year?		in the previous week?	in the past year?
Headaches			Nausea/vomiting		
Fainting/dizziness/light headedness/ vertigo			Unexpected tiredness/fatigue/ exhaustion		
Ringing in ears/tinnitus			Disturbance of vision		
Stiffness/reduced mobility other than main complaint *please state which area .....*			Numbness/tingling in arm(s) / hand(s)		
			Numbness/tingling in leg(s) / feet		
Local pain or discomfort – other than main complaint *please state which area ...*			Radiating pain or discomfort *please state which areas...*		
Loss of muscle power/ strength *please state where ...*			Other symptom *please describe...*		

Please complete the next page AFTER you have been treated.

10 MINUTES AFTER TODAY'S TREATMENT

1.How are the symptoms of your main complaint NOW? (*please tick ONE box only*)

Much better ☐ A bit better ☐ Undecided ☐ A bit worse ☐ Much worse ☐

2. You ***might*** be feeling some additional effects of treatment. Please let us know about them by completing the table below.

For each listed item, please tick one box ONLY

	Severity of effect				
New effect after clinic visit:	**NONE**	**SLIGHT**	**MODERATE**	**SEVERE**	**DON'T KNOW**
Worsening of main complaint (ie for which you were treated)	☐	☐	☐	☐	☐
Headaches	☐	☐	☐	☐	☐
Fainting/dizziness/light headedness / vertigo	☐	☐	☐	☐	☐
Ringing in ears/tinnitus	☐	☐	☐	☐	☐
Nausea/vomiting	☐	☐	☐	☐	☐
Disturbance of vision	☐	☐	☐	☐	☐
Unexpected tiredness/ fatigue / exhaustion	☐	☐	☐	☐	☐
Stiffness/reduced mobility in area of main complaint	☐	☐	☐	☐	☐
Stiffness/reduced mobility in some other area *Please state which area…*	☐	☐	☐	☐	☐
Local pain or discomfort in area that was treated	☐	☐	☐	☐	☐
Local pain or discomfort in some other area *Please state which area…*	☐	☐	☐	☐	☐
Radiating pain or discomfort *Please state which areas…*	☐	☐	☐	☐	☐
Numbness/tingling in arm(s)/hand(s)	☐	☐	☐	☐	☐
Numbness/tingling in leg(s)/feet	☐	☐	☐	☐	☐
Loss of muscle power/strength *Please state where…*	☐	☐	☐	☐	☐
Any other new symptom ? *Please describe it…*	☐	☐	☐	☐	☐

Thank you for you for participating in our survey

Please give this part of the questionnaire to the receptionist.

Part 2 of the questionnaire is for you to complete at home over the next few days.

1 DAY (24h) AFTER TREATMENT

1. In general, how is your main complaint (for which you were treated)? (*please tick ONE box only*)

Much better ☐ A bit better ☐ Undecided ☐ A bit worse ☐ Much worse ☐

2. You *might* be feeling some additional effects of treatment. Please let us know about them by completing the table below.

For each listed item, please tick one box ONLY

	Severity of effect				
New effect after clinic visit:	**NONE**	**SLIGHT**	**MODERATE**	**SEVERE**	**DON'T KNOW**
Worsening of main complaint (ie for which you were treated)	☐	☐	☐	☐	☐
Headaches	☐	☐	☐	☐	☐
Fainting/dizziness/light headedness / vertigo	☐	☐	☐	☐	☐
Ringing in ears/tinnitus	☐	☐	☐	☐	☐
Nausea/vomiting	☐	☐	☐	☐	☐
Disturbance of vision	☐	☐	☐	☐	☐
Unexpected tiredness/ fatigue / exhaustion	☐	☐	☐	☐	☐
Stiffness/reduced mobility in area of main complaint	☐	☐	☐	☐	☐
Stiffness/reduced mobility in some other area *Please state which area…*	☐	☐	☐	☐	☐
Local pain or discomfort in area that was treated	☐	☐	☐	☐	☐
Local pain or discomfort in some other area *Please state which area…*	☐	☐	☐	☐	☐
Radiating pain or discomfort *Please state which areas...*	☐	☐	☐	☐	☐
Numbness/tingling in arm(s)/hand(s)	☐	☐	☐	☐	☐
Numbness/tingling in leg(s)/feet	☐	☐	☐	☐	☐
Loss of muscle power/strength *Please state where...*	☐	☐	☐	☐	☐
Any other new symptom ? *Please describe it...*	☐	☐	☐	☐	☐

2 DAYS (48h) AFTER TREATMENT

1. In general, how is your main complaint (for which you were treated)? (*please tick ONE box only*)

Much better ☐ A bit better ☐ Undecided ☐ A bit worse ☐ Much worse ☐

2. You *might* be feeling some additional effects of treatment. Please let us know about them by completing the table below.

For each listed item, please tick one box ONLY

	Severity of effect				
New effect after clinic visit:	**NONE**	**SLIGHT**	**MODERATE**	**SEVERE**	**DON'T KNOW**
Worsening of main complaint (ie for which you were treated)	☐	☐	☐	☐	☐
Headaches	☐	☐	☐	☐	☐
Fainting/dizziness/light headedness / vertigo	☐	☐	☐	☐	☐
Ringing in ears/tinnitus	☐	☐	☐	☐	☐
Nausea/vomiting	☐	☐	☐	☐	☐
Disturbance of vision	☐	☐	☐	☐	☐
Unexpected tiredness/ fatigue / exhaustion	☐	☐	☐	☐	☐
Stiffness/reduced mobility in area of main complaint	☐	☐	☐	☐	☐
Stiffness/reduced mobility in some other area *Please state which area…*	☐	☐	☐	☐	☐
Local pain or discomfort in area that was treated	☐	☐	☐	☐	☐
Local pain or discomfort in some other area *Please state which area…*	☐	☐	☐	☐	☐
Radiating pain or discomfort *Please state which areas…*	☐	☐	☐	☐	☐
Numbness/tingling in arm(s)/hand(s)	☐	☐	☐	☐	☐
Numbness/tingling in leg(s)/feet	☐	☐	☐	☐	☐
Loss of muscle power/strength *Please state where…*	☐	☐	☐	☐	☐
Any other new symptom ? *Please describe it…*	☐	☐	☐	☐	☐

3 DAYS (72h) AFTER TREATMENT

1. In general, how is your main complaint (for which you were treated)? (*please tick ONE box only*)

Much better ☐ A bit better ☐ Undecided ☐ A bit worse ☐ Much worse ☐

2. You *might* be feeling some additional effects of treatment. Please let us know about them by completing the table below.

For each listed item, please tick one box ONLY

	Severity of effect				
New effect after clinic visit:	**NONE**	**SLIGHT**	**MODERATE**	**SEVERE**	**DON'T KNOW**
Worsening of main complaint (ie for which you were treated)	☐	☐	☐	☐	☐
Headaches	☐	☐	☐	☐	☐
Fainting/dizziness/light headedness / vertigo	☐	☐	☐	☐	☐
Ringing in ears/tinnitus	☐	☐	☐	☐	☐
Nausea/vomiting	☐	☐	☐	☐	☐
Disturbance of vision	☐	☐	☐	☐	☐
Unexpected tiredness/ fatigue / exhaustion	☐	☐	☐	☐	☐
Stiffness/reduced mobility in area of main complaint	☐	☐	☐	☐	☐
Stiffness/reduced mobility in some other area *Please state which area…*	☐	☐	☐	☐	☐
Local pain or discomfort in area that was treated	☐	☐	☐	☐	☐
Local pain or discomfort in some other area *Please state which area…*	☐	☐	☐	☐	☐
Radiating pain or discomfort *Please state which areas…*	☐	☐	☐	☐	☐
Numbness/tingling in arm(s)/hand(s)	☐	☐	☐	☐	☐
Numbness/tingling in leg(s)/feet	☐	☐	☐	☐	☐
Loss of muscle power/strength *Please state where…*	☐	☐	☐	☐	☐
Any other new symptom ? *Please describe it…*	☐	☐	☐	☐	☐

1 WEEK AFTER YOUR TREATMENT

1. In general, how is your main complaint (for which you were treated)? (*please tick ONE box only*)

Much better ☐ A bit better ☐ Undecided ☐ A bit worse ☐ Much worse ☐

2. You *might* be feeling some additional effects of treatment. Please let us know about them by completing the table below.

For each listed item, please tick one box ONLY

	Severity of effect				
New effect after clinic visit:	**NONE**	**SLIGHT**	**MODERATE**	**SEVERE**	**DON'T KNOW**
Worsening of main complaint (ie for which you were treated)	☐	☐	☐	☐	☐
Headaches	☐	☐	☐	☐	☐
Fainting/dizziness/light headedness / vertigo	☐	☐	☐	☐	☐
Ringing in ears/tinnitus	☐	☐	☐	☐	☐
Nausea/vomiting	☐	☐	☐	☐	☐
Disturbance of vision	☐	☐	☐	☐	☐
Unexpected tiredness/ fatigue / exhaustion	☐	☐	☐	☐	☐
Stiffness/reduced mobility in area of main complaint	☐	☐	☐	☐	☐
Stiffness/reduced mobility in some other area *Please state which area…*	☐	☐	☐	☐	☐
Local pain or discomfort in area that was treated	☐	☐	☐	☐	☐
Local pain or discomfort in some other area *Please state which area…*	☐	☐	☐	☐	☐
Radiating pain or discomfort *Please state which areas…*	☐	☐	☐	☐	☐
Numbness/tingling in arm(s)/hand(s)	☐	☐	☐	☐	☐
Numbness/tingling in leg(s)/feet	☐	☐	☐	☐	☐
Loss of muscle power/strength *Please state where…*	☐	☐	☐	☐	☐
Any other new symptom ? *Please describe it…*	☐	☐	☐	☐	☐

Patient Questionnaire:Part 2

Please take this form home with you. We would like to know how you feel over the next few days.

Instructions for completing this survey form;
Please fill in the individual charts on pages 5 - 8 on the days shown (1 day, 2 days, 3 days and, if relevant,1 week after treatment).

It is important that you stick to this timing (after your treatment time) as closely as possible.

To make this easier to remember, enter the date and time of treatment at the clinic, below.

Date of Initial visit _ _ / _ _ / _ _ Time of initial visit _____ am/pm

THEN
Please return the completed survey form to the clinic.

Or
Bring it to the clinic on your next appointment

Or
Send it in the pre-paid addressed envelope provided

You may need treating again at the clinic within a week. If so, leave the questionnaire chart on page 4 blank and return your form when you attend.

Thank you for your participation