PLEASE DO NOT WRITE YOUR NAME ON THIS FORM

All of the information you give is anonymous and will be treated in strict confidence.

When you have completed the form, please post it in the box in Reception.

1. Where were the symptoms that caused you to consult an osteopath?

2. How long had you had those symptoms?

3. Were you able to ask the osteopath about anything connected with treatment? Yes No

4. Were you always seen promptly for your sessions? Yes No

5. Did you expect the treatment would remove your pain immediately? Yes No

6. Did the osteopath listen to what you had to say? Yes No

7. Did you have confidence that the osteopath knew what he/she was doing? Yes No

8. Did you expect to have to do exercises in addition to your treatment? Yes No

9. Did you do the exercises prescribed? Yes No

10. Was it important for you to see the same osteopath throughout your treatment? Yes No

11. Were the treatment sessions always at convenient times? Yes No

12. Did you feel the treatment was fully explained to you? Yes No

13. Were you able to easily contact the osteopath outside of treatment hours? Yes No

14. Would you recommend osteopathic treatment? Yes No

### Do you have any other comments? If yes, please add your comments below:

Thank you very much. We greatly appreciate your help