

Patient Progress Questionnaire

1. Please list any activities that you CAN DO NOW that you had difficulty with or could not do before starting Physical Therapy. (i.e. combing hair, dressing, bending, getting in/out of car, etc.) _____

2. Please list the activities that you are STILL having difficulty with: _____

3. What percentage have you improved since beginning Physical Therapy? (circle answer)

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

4. Have you learned how to control your symptoms better? () yes () no () maybe

5. Please rate your current level of pain at the lowest and highest level by placing 2 marks on the line:

No Pain	Mild Pain	Moderate Pain	Extreme Pain

6. What is your general opinion of the Physical Therapy at Full Circle PT, Inc.? (circle answer)

1	2	3	4	5	6	7	8	9	10
Poor					Excellent				

7. What aspect of PT is most helpful to you? _____

8. What can Full Circle Physical Therapy, Inc. do to improve services? _____

9. What are your goals for the next 4 weeks? _____

Any other comments or suggestions? _____

Patient Name _____

Date _____

Thank you!