CranioSacral Therapy 'OUTCOME' Questionnaire

Please complete after 6th or earlier final treatment

Patient's date of birth: Therapist' s name:
No. treatments received: Date final (or 6th) treatment:

Therapist please complete above this line

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1. What was the main problem for which you were seeking help?

2. Was any other (secondary) problem helped by treatment?

3. Please chose a score between +4 and -4 for each of the next three questions reflecting any changes since starting treatment:

a. change in main problem _____

b. change in secondary problem? _____

c. change in general well being? _____

+4 Cured /Back to normal
+3 Major Improvement
+2 Moderate improvement, affecting daily living
+1 Slight improvement, no effect on daily living
0 No change/Unsure
-1 Slight deterioration, no effect on daily living
-2 Moderate deterioration, affecting daily living
-3 Major deterioration
-4 Disastrous deterioration

4. Please indicate to what extent you feel these changes are related to the CranioSacral Therapy treatment.

5. Have you decreased any regular medication as a result of treatment?

6. Please use the other side of the sheet to make add any further comments.

Many thanks for your help