**Patient Input into Treatment Team Review**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

We would like a few minutes of your time to provide us with some information that will help ensure we are giving you the best care possible. Please complete this form, which will be shared with the treatment team reviewing your care plan. This is your chance to provide your treatment team with information about how you think treatment in the clinic is going so far and about your goals for care.

1. How satisfied are you with the progress you have made in therapy so far?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Extremely satisfied** | **Very satisfied** | **Moderately satisfied** | **Slightly satisfied** | **Not at all satisfied** |
| **◯** | **◯** | **◯** | **◯** | **◯** |

1. List the biggest changes or successes you have made in therapy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Rate your agreement with the following statements:
2. My provider and I have similar goals/outcomes for therapy.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Strongly agree** | **Somewhat agree** | **Neither agree nor disagree** | **Somewhat disagree** | **Strongly disagree** |
| **◯** | **◯** | **◯** | **◯** | **◯** |

1. My provider and I work well together.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Strongly agree** | **Somewhat agree** | **Neither agree nor disagree** | **Somewhat disagree** | **Strongly disagree** |
| **◯** | **◯** | **◯** | **◯** | **◯** |

1. My provider seems to care about me and my goals.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Strongly agree** | **Somewhat agree** | **Neither agree nor disagree** | **Somewhat disagree** | **Strongly disagree** |
| **◯** | **◯** | **◯** | **◯** | **◯** |

1. Please estimate how many more sessions you feel are needed to meet your treatment goals?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **None** | **1-3** | **4-6** | **7-9** | **>10** |
| **◯** | **◯** | **◯** | **◯** | **◯** |

1. Do you think you need a change in your treatment plan? □ Yes □ No

If yes, what things would you like to see changed? Check all that apply:

**□** Therapist (please share why):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**□** Therapy approach (please share why):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**□** I would like to discuss ending therapy (please share why):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**□** Homework/assignments (please indicate □ More or □ Less)

**□** Appointment frequency (please indicate □ More or □ Less)

**□** Others:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Does your therapist assign homework between sessions? □ Yes □ No

If yes, how easy or difficult has it been for you to complete the homework from therapy?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Very easy** | **Somewhat easy** | **Neutral** | **Somewhat difficult** | **Very difficult** |
| **◯** | **◯** | **◯** | **◯** | **◯** |

If you feel it has been difficult to complete the homework, what things have made it harder? (Check all that apply)

\_\_\_ I am worried about someone seeing the homework sheets.

­\_\_\_ I don’t always understand the assignments.

\_\_\_ I don’t think the assignments apply to me.

\_\_\_ I don’t feel the assignments are helpful.

\_\_\_ I have not made homework a priority.

\_\_\_ I have no time to do the assignments.

\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Non-active duty patients, please stop here.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Active Duty and activated National Guard and Reserve Service members, please complete the items below.**

1. Rate your agreement with the following statements:
2. My provider thinks I should stay in the military.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Strongly agree** | **Somewhat agree** | **Neither agree nor disagree** | **Somewhat disagree** | **Strongly disagree** |
| **◯** | **◯** | **◯** | **◯** | **◯** |

1. I think I should stay in the military.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Strongly agree** | **Somewhat agree** | **Neither agree nor disagree** | **Somewhat disagree** | **Strongly disagree** |
| **◯** | **◯** | **◯** | **◯** | **◯** |