The Children's Reflexology Programme

MYMOP2 FOLLOW UP FORM

Please fill in the form in as much detail as possible.

All information is held in strict confidence

Full name

Today's date DD/MM/YY

Practitioner seen

Your own name, if you are filling in this form for someone else

Please circle the number to show how severe your problem has been IN THE LAST WEEK

Symptom 1		1 2 3 4 5 6	As GOOD as it could be / As BAD as it could be
Symptom 2		1 2 3 4 5 6	As GOOD as it could be / As BAD as it could be
Activity		1 2 3 4 5 6	As GOOD as it could be / As BAD as it could be
How would you rate your general feeling of wellbeing during the last week?		1 2 3 4 5 6	As GOOD as it could be / As BAD as it could be

If an important new symptom has appeared please describe it and mark how bad it is. Otherwise skip this box.

Symptom 3		1 2 3 4 5 6	As GOOD as it could be / As BAD as it could be

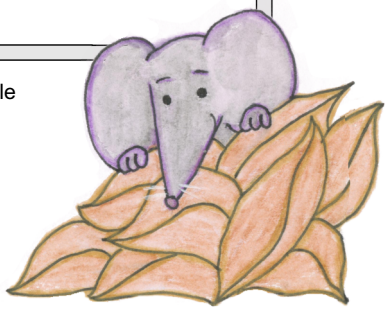
The treatment you are receiving may not be the only thing affecting your problem. If there is anything else that you think is important, such as changes you have made yourself, or other things happening in your life, please write it here (write overleaf if you need more space):

Are you taking any medication FOR THIS PROBLEM? Yes ☐ No ☐

IF YES: Please write in name of medication, and how much a day/week

Thank you for your time.

MYMOP: Measure Yourself Medical Outcome Profile



Please return to:

Susan Quayle
Complementary Healthcare