

## Post-Treatment Patient Evaluation of Resident

**Resident name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Please fill out the following survey to help our residents get better at the care they provide. Thank you for your time!

	Yes	No	I don't know
1. If you have not had osteopathic treatment before, did your resident physician explain what osteopathic manipulative treatment (OMT) is prior to performing it?			
2. Did the physician ask permission to perform osteopathic manipulation?			
3. Did you feel comfortable during the treatment?			
4. Did your condition change after the treatment?			
5. Did you receive clear instructions for your follow-up care?			
<b>COMMENTS:</b>			