

Patient ID# & Initials: _____

Satisfaction Questionnaire

Date Completed: _____

Please fill in one circle for each question.

- 1) How much **relief** have you experienced during **this phase** of the study?

No Relief

Complete Relief

1	2	3	4	5	6	7
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

- 2) Overall, how **satisfied** have you been with your study treatment during **this phase** of the study?

0	1	2	3	4
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dissatisfied	Neutral	Somewhat Satisfied	Satisfied	Completely Satisfied

- 3) When considering the benefits and side effects you have experienced from your study treatment during **this phase** of the study, **would you choose to continue this same therapy?**

0	1
<input type="radio"/>	<input type="radio"/>
No	Yes