BREAD AND BUTTER BACK PAIN POST-SURVEY

DATE___________________

PRACTICING PHYSICIAN _________________

RESIDENT____________

FACULTY___________

STUDENT____________

MD________ DO________

If MD:
Is this your first OMT workshop? Yes No

If not, how many prior workshops have you attended? ___________

Please evaluate the following statements using this Likert Scale:
Stongly Disagree (1) Disagree (2) Neutral (3) Agree (4) Strongly Agree (5)

Prior to this workshop, I already was using OMT regularly in my practice:

1 2 3 4 5

After this workshop, I understand Low Back Pain better

1 2 3 4 5

I now believe that I can quickly assess and treat Low Back Pain in my office

1 2 3 4 5

I feel more confident about treating Low Back Pain patients:

1 2 3 4 5

I feel comfortable treating Low Back Pain with OMT

1 2 3 4 5