

BREAD AND BUTTER BACK PAIN PRE-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:

Strongly Disagree (1) Disagree (2) Neutral (3) Agree (4) Strongly Agree (5)

I use OMT regularly in my practice:

1 2 3 4 5

Low Back Pain can be quickly addressed in a standard office visit:

1 2 3 4 5

I am well prepared to evaluate Low Back Pain

1 2 3 4 5

I am well prepared to treat Low Back Pain:

1 2 3 4 5

I enjoy treating Low Back Pain patients:

1 2 3 4 5

I feel comfortable treating Low Back Pain with OMT:

1 2 3 4 5