

Please answer all questions to the best of your ability

Patient Contact Information*					Today's Date:	
Name:					Date of birth:	
Address:			City:		State:	Zip:
Contact phone:			Contact email:			
Last date of service:			# of therapy hrs:		Clinic location:	
Please Note Improvement in Pain After Therapy 100% = No Pain After Therapy ► 0% = No Improvement						
Pelvic Pain	Intensity	%	Frequency	%	Duration	%
Relief / Change was:	Fair	Good	Excellent	Spectacular		
Details/comments:						
Abdominal Pain	Intensity	%	Frequency	%	Duration	%
Relief / Change was:	Fair	Good	Excellent	Spectacular		
Details/comments:						
Ovulation Pain	Intensity	%	Frequency	%	Duration	%
Relief / Change was:	Fair	Good	Excellent	Spectacular		
Details/comments:						
Menstrual Pain	Intensity	%	Frequency	%	Duration	%
Relief / Change was:	Fair	Good	Excellent	Spectacular		
Details/comments:						
Intercourse Pain	Intensity	%	Frequency	%	Duration	%
Relief / Change was:	Fair	Good	Excellent	Spectacular		
Details/comments:						
Other Pain (Please Specify Area)	Intensity	%	Frequency	%	Duration	%
Relief / Change was:	Fair	Good	Excellent	Spectacular		
Details/comments:						
Improved / Changed Body Function (Please Specify Improvements or Changes)						
Digestive						
Sexual						
Other (Please Specify Area)						
*Contact: CPT always keeps your identity confidential. Be assured, even if you note interest in speaking with potential patients or the media, we will contact you for specific occurrence authorization before sharing any identifying information.						
May we call on you to share your experience with potential patients?					Yes	No
May we call on you to share your experience with the media?					Yes	No
Please note your preferred method of contact (Phone # / fax # / email address):						
Please use the second page to note your story, comments and/or questions. Though we may use your comments anonymously, we always keep your identity confidential. You may print this response for your records. When completing online, please click "Submit Info to Clear Passage". When completing on hard copy, please send via fax (352-336-9980) or postal mail:						
3600 NW 43rd Street, Ste. A1 Gainesville, FL 32606						
Please feel free to contact us anytime for any reason by mail, email (info@clearpassage.com), phone (352-336-1433) or fax. Thank you for your feedback!						
-Clear Passage Therapies						

