Albertan Osteoarthritis Experience Measure

Todays Date: D D / M M / Y Y Y Y

PLACE PATIENT IDENTIFICATION LABEL HERE
Or fill out necessary fields below

Name: Gender: Male Female

DOB (dd/mm/yyyy):

PHN:

Please reflect on your treatment or appointment.

1. I felt like an engaged partner in making decisions about my osteoarthritis management.

Not at All | Not Really | Somewhat | Very Much

2. There were enough choices/options to manage my osteoarthritis symptoms.

Not at All | Not Really | Somewhat | Very Much

3. I am comfortable with the information and education provided to me about managing osteoarthritis.

Not at All | Not Really | Somewhat | Very Much

4. I was treated with courtesy and respect.

Not at All | Not Really | Somewhat | Very Much

5. I feel better after this treatment/appointment.

Not at All | Not Really | Somewhat | Very Much

6. I was given the tools and information I needed to confidently manage my osteoarthritis.

Not at All | Not Really | Somewhat | Very Much

7. I would recommend this treatment/appointment to friends and family in a similar situation.

Not at all **Very Much**

1 2 3 4 5 6 7 8 9 10

Any further comments: