ABLE BIONICS USA

Bridging Bionics FOUNDATION

CLIENT SURVEY

CLIENT'S NAME: _____ DATE: _____

(Please note, your full name will be used ONLY for our records. Your name will be kept anonymous for all other purposes including information for the grant.)

DATE OF BIRTH: _____ AGE: _____

CITY YOU RESIDE IN: _____ COUNTY:_____

STATE: _____ DISABILITY DIAGNOSIS: _____

MOBILITY AID(S): _____Manual Wheelchair _____Electric Wheelchair _____Walker _____Cane

First date you participated in our program: *(Approximate if you can't remember the exact date)* _____

We recognize that the information you will provide is subjective. We value your personal feedback.

Physical/Functional Changes

Since you began participating in our program, have you experienced the following physical or bodily changes:

(check/*briefly* describe all that apply)

PHYSICAL	YES	NO	SAME	N/A	COMMENT
Decreased number of falls					
Decreased urinary tract infections (overall since commencing the program)					
Improved circulation					
Decreased swelling/edema					
Decreased muscular pain					
Decreased neuropathic (nerve) pain					
Improved sleep					
Increased muscular strengthening					

Decreased spasticity/tone					
Improved range of motion					
Decreased prevalence of skin irritation or pressure sores					
Decreased usage of medications					
Able to stand/weight bear for longer periods					
Overall, have you experienced ***fewer secondary complications*** often associated with neurological impairment or paralysis compared to when you commenced the program?					

Emotional – Social Gains

Since participating in our program have you experienced:

	YES	NO	SAME	DESCRIBE HOW
Increased confidence?				
Changes in behavior in daily living activities?				
Changes in attitude?				
Social connectedness?				
Overall, has your mental and emotional well-being improved since participating in our program?				

Final Request to follow up with *after* you have completed and emailed the survey back to Amanda:

Please take the time to write a personal testimonial. We will use your *first name only*, your *age* and your *type of disability* for grant reporting and donor acknowledgements. Your testimonials help us provide feedback and report on the successes of our program to our donors and grantors. Thanks for making the time to complete the survey and write a follow-up testimonial. Please have the **survey completed by August 15th**, and your **testimonial completed by August 31st**.