ReStore Patient Feedback

Version A

Patient ID:		Therapist:	

To be completed by therapist to document patient responses

Use the responses in this table to provide your answers to the questions below:

1	2	3	4	5
Not satisfied at all	Not very satisfied	More or less satisfied	Quite satisfied	Very satisfied

How satisfied are you with :

1. How safe and secure you feel in the ReStore device? Comments:	1	2	3	4	5
2. The ease of setup of the ReStore device? Comments:	1	2	3	4	5
3. How easy it is to walk in the ReStore device? Comments:	1	2	3	4	5
4. How comfortable do you feel in the ReStore device? Comments:	1	2	3	4	5
5. The weight of the ReStore device? Comments:	1	2	3	4	5

Below is the list of the same 5 satisfaction items. PLEASE SELECT **TWO** ITEMS that you consider to be the most important to you. Please put an X in the 2 boxes of your choice.

- ☐ Safety
- ☐ Ease of Set up
- ☐ Ease of Walking
- ☐ Comfort
- ☐ Weight

Explain why the 2 satisfaction items were chosen:

Additional Comments:

Therapist Signature: _____