Patient Motivation Survey

Patient Information

Patient Name:

Date of Birth:

Date of Visit:

Healthcare Provider:

Age:

Instructions:

Please answer the following questions honestly and to the best of your ability. Your responses will help us understand your motivation and preferences for your healthcare. This information will be kept confidential and will assist us in providing you with the best possible care.

Section 1: General Information

Gender:

- ☐ Male
- ☐ Female
- ☐ Non-binary
- ☐ Prefer not to say

How would you describe your current health status?

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

Section 2: Motivation for Health Improvement

On a scale of 1 to 10, with 1 being unmotivated and 10 being extremely motivated, how motivated are you to make positive changes to improve your health?

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10

What specific health goals or improvements are you motivated to achieve? (e.g., weight loss, better nutrition, increased physical activity, quitting smoking, managing a chronic condition, etc.)

What are the biggest obstacles or challenges to achieving your health goals?

Section 3: Preferred Motivation Strategies

Do you prefer to receive motivation and support in a specific way? Please select your preferred methods:

- ☐ One-on-one counselling
- ☐ Group therapy or support groups
- ☐ Written materials (brochures, handouts)
- ☐ Smartphone apps or digital tools
- ☐ Regular check-ins via phone or email
- ☐ Other (please specify):

Do any specific rewards or incentives motivate you to stick to your healthcare plan? (e.g., rewards for achieving certain milestones)

Section 4: Additional Comments

Is there anything else you would like to share with your healthcare provider regarding your motivation, concerns, or preferences related to your healthcare plan?

Thank you for completing this survey. Your input is valuable in helping us better understand your motivation and tailor your healthcare plan to meet your needs. Your responses will be confidential, and we will work together to support your health and well-being.

Patient's Signature:

Date:

Healthcare Provider's Signature:

Date: