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Instructions: We would like you to indicate below how much you believe, RIGHT NOW, that the type of therapy offered to you in the therapy session will help to reduce your IBS SYMPTOMS. This questionnaire is confidential; your responses will not be disclosed to your therapist.

do you really feel will occur?

20%

30%

10%

0%

Subject ID	Month	Da
0 0 0	0 0	0
1 1 1 1	1 1	1
2 2 2 2	2 2	2
3 3 3 3	3 3	3
4 4 4 4	4 4	4
5 5 5 5	5 5	5
6 6 6 6	6 6	6
7777	77	7
8 8 8 8	88	8
9999	99	9



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		how suc		y do you thin	k this	s treatm	ent will	be in red	lucing	
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40

40%

50

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70

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80

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90

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