IBS TREATMENT SUITABILITY AND PATIENT EXPECTATION FORM
Therapist Version

Therapist	Subject ID	Month	Day	Year	Week
0 0 0	0 0 0 0	0 0	0 0	0 0	0 0
1 1 1	1 1 1 1	1 1	1 1	1 1	1 1
2 2 2	2 2 2 2	2 2	2 2	2 2	2 2
3 3 3	3 3 3 3	3 3	3 3	3 3	3 3
4 4 4	4 4 4 4	4 4	4 4	4 4	4 4
5 5 5	5 5 5 5	5 5	5 5	5 5	5 5
6 6 6	6 6 6 6	6 6	6 6	6 6	6 6
7 7 7	7 7 7 7	7 7	7 7	7 7	7 7
8 8 8	8 8 8 8	8 8	8 8	8 8	8 8
9 9 9	9 9 9 9	9 9	9 9	9 9	9 9

1. How suitable do you think the assigned treatment is for this patient's IBS symptoms?

0 1 2 3 4 5 6 7 8 9 10

Not at all **Moderate** **Extremely Suitable**

---

2. How successful do you think the assigned treatment will be for this patient's IBS symptoms?

0 1 2 3 4 5 6 7 8 9 10

Not at all **Moderate** **Completely Successful**

---

3. Based on your experience treating IBS patients, your clinical skills, and approach, what treatment condition would provide this patient the greatest likelihood of therapeutic benefit for his/her IBS symptoms? :

1 **Standard CBT**

2 **Education and Supportive Psychotherapy**

3 **Minimal Contact CBT**