PATIENT SATISFACTION SURVEY

Please take time to fill out this brief survey. Give your honest opinion for **all** fields to help us better our services and facility to fit the needs of the general public**. Please give comments or suggestions for any rating below "Good"**. Your feedback is greatly appreciated. Thank you!

Patient Name:_____**DOB:**_____

Courtesy, Understanding and Care:

	Excellent	Good	Fair	Poor	Comments
Front Office Staff	O	O	O	O	_____
Therapist(s)	O	O	O	O	_____
Billing Staff	O	O	O	O	_____

Facility:

	Excellent	Good	Fair	Poor	Comments
Cleanliness	O	O	O	O	_____
Accessibility	O	O	O	O	_____
Availability of Resources	O	O	O	O	_____

Treatment and Services:

	Excellent	Good	Fair	Poor	Comments
Promptness of Appointment Time Kept by Therapist(s)	O	O	O	O	_____
Therapy Services Performed	O	O	O	O	_____
Improvement of Area Treated	O	O	O	O	_____
Overall Therapy Experience	O	O	O	O	_____

Do you feel you have been discharged too early? ____**Yes** _____**No**

Do you feel that you have met your Therapy goals? ____**Yes** _____**No**

Have you been given a Home Exercise Program by your Therapist? ____**Yes** _____**No**

Do you understand your Home Exercise Program? ____**Yes** _____**No**

Would you consider our facility for future services if needed? ____**Yes** _____**No**

Have you been informed about our Wellness Programs? ____**Yes** _____**No**

Is there anything we can do better?_____

Comments:_____

Patient Signature:_____Date:_____

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