PATIENT SATISFACTION SURVEY

Name (Optional): _____ Month: _____ Year: _____

We hope that you have been pleased with the quality of care you received at Rehab Partners Therapy Services. We would greatly appreciate your help In our quest for constant improvement, which you can Provide by answering the following questions honestly: Please circle your answers:

1. What were you seen for?

Back Neck Knee Hip Shoulder Elbow Wrist Hand Vertigo Pelvic Floor Balance Weakness
Other: _____

2. Did the same therapist or team of therapists (therapist/assistant) consistently treat you?

All the time Most of the time Sometimes Never

3. Which therapist(s) did you work with most often?

Donna Victoria Debbie Shasta Meredith Tony Julie Kyla Jordan Tom Paula Brian Ray
Missy Amelia Jane Ashley Trina Christine Rose

4. On average, how long from your scheduled appointment time did you wait to be seen?

All the time Most of the time Sometimes Never

5. Were you encouraged to participate in decisions concerning your treatment?

All the time Most of the time Sometimes Never

6. Did the office staff work to give you the most convenient appointment times?

All the time Most of the time Sometimes Never

7. Was the purpose and content of each treatment explained to you before it was carried out?

All the time Most of the time Sometimes Never

8. Was the demeanor of the staff professional and courteous?

All the time Most of the time Sometimes Never

9. Were the facility and equipment clean and in good working condition?

All the time Most of the time Sometimes Never

10. If you brought an issue to our attention, was it addressed in a timely manner?

Yes No If no, please explain the situation in the comments section below.

11. Would you recommend Rehab Partners Therapy Services to friends and family?

Yes No If no, please explain the situation in the comments section below

12. Did the treatment provided improve your condition?

-7 -6 -5 -4 -3 -2 -1 0 1 2 3 4 5 6 7
Worse Better

COMMENTS/SUGGESTIONS:

_____
_____
_____