Date: ____/____/_____

Patient Satisfaction Survey

On a scale of poor to excellent, please rate the following	Excellent	Very Good	Good	Fair	Poor
1. How long you waited to get an appointment?					
2. Length of time waiting at the office?					
3. The personal manner (courtesy, respect, sensitivity, friendliness) of staff?					
4. Time spent with the person you saw?					
5. How would you rate your Clinician's sensitivity to your special needs or concerns?					
6. Plan of your care detailed and clear?					
7. Was your reason for coming taken care of to your satisfaction?					
8. How well this office communicates with other providers involved with your care?					
9. How do you feel about the quality of the visit overall?					
10. In general, how would you rate your overall health?					

11. If you could go anywhere to get health care, would you choose this office practice or would you prefer to go someplace else?

☐ Would choose this practice ☐ Might prefer someplace else ☐ Not sure

12. Is there anything our practice can do to improve the care and services for you?

☐ No, **I'm satisfied** with everything

☐ Yes, **some things** can be improved: (please specifiy)

_____

_____

13. What is your age?

☐ under 25 years ☐ 25-44 years ☐ 45-64 years ☐ 65 years or older

14. Are you male or female: ☐ Male ☐ Female

Your Doctor's name: _____

Your Name (Optional): _____