



Your Name (Optional): _____

PLEASE RATE YOUR OVERALL EXPERIENCE WITH OUR REHABILITATION PROVIDERS BY CHECKING (X) THE BOX THAT BEST ANSWERS EACH QUESTION.

ABOUT THE FACILITY:

	Excellent	Very Good	Good	Fair	Poor	Doesn't Apply
1. Convenience of the office location for you.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. The appearance and cleanliness of the office.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Parking.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ABOUT YOUR REHABILITATION:

	Excellent	Very Good	Good	Fair	Poor	Doesn't Apply
4. Thoroughness of the initial evaluation to determine your care.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Providing courtesy, respect and provisions for privacy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Giving you the attention you needed.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Giving you the information you needed about your condition.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Giving you the instructions you needed about self-care and exercises to continue on your own.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HOW WAS YOUR SERVICE:

	Excellent	Very Good	Good	Fair	Poor	Doesn't Apply
9. Ease of scheduling your appointment.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Waiting time for you to see your therapist once you arrived.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Explanation of your insurance benefits.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Communication between referring physician and therapist.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

YOUR OVERALL SATISFACTION:

	Excellent	Very Good	Good	Fair	Poor	Doesn't Apply
13. Were you satisfied with the results of your treatment.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. How likely would you be to choose this office if you needed rehabilitation services again?						
<input type="checkbox"/> Definitely would return						
<input type="checkbox"/> Probably would return						
<input type="checkbox"/> Probably would not return						
<input type="checkbox"/> Definitely would not return						
15. Would you recommend our office to your family and friends if they needed rehabilitation?						
<input type="checkbox"/> Definitely would not						
<input type="checkbox"/> Probably would not						
<input type="checkbox"/> Probably would						
<input type="checkbox"/> Definitely would not						

HOW DID YOU FIND US? (Circle One) Friend Relative Website Radio Doctor Other

Name of Referral Source _____

Any other comments about your experience with us? _____
