Today's Date: ____________________ Referring MD: ______________________
Diagnosis/Body Part:
Primary Therapist: ____________________ Secondary Therapist: ______________
What type of insurance do you have? ____

This Questionnaire concerns the physical therapy and occupational therapy you received at our facility. Your answers will help us to improve our services. Please answer each item by checking the most appropriate box. There are no right or wrong answers. Your answers will be treated confidentially.

Quality of Care

	Yes certainly	Somewhat yes	Not sure	Somewhat not	Certainly not
Did you feel confident that your therapist was knowledgeable and skilled in treating your condition?	1	2	3	4	5
Do you feel your treatment was adapted for your specific needs?	1	2	3	4	5
Did you feel comfortable in the room where therapy was provided?	1	2	3	4	5
Do you feel you were an appropriate candidate for therapy?	1	2	3	4	5

	Excellent	Very Good	Good	Fair	Poor
Quality of information and education you received over the course of your care	1	2	3	4	5
Your overall quality of care	1	2	3	4	5

Comments:____
____

Front Desk Procedures

	Excellent	Very Good	Good	Fair	Poor
Ease of admission procedures and paperwork.	1	2	3	4	5
Simplicity of scheduling and time it took to get first appointment.	1	2	3	4	5
Courtesy and helpfulness of front desk staff.	1	2	3	4	5

Was this facility easy to access both by phone and physical location: YES NO

Would you recommend this facility to others? YES NO

Comments/Suggestions:
____
____