



treatment centers

Patient Satisfaction Survey

Please Complete the Following Information	
Date _____	
Doctor _____	
New Patient _____	Follow-Up Patient _____

Please rate the following questions on a scale of 1 to 5, with "5" being great, and "1" being needs improvement. Also, you may leave your individual comments in the space provided below. Please place your survey into the box located at check-out upon completion. *Thank You!*

How would you rate...

(Your Office Visit)

- 1) Friendliness / Helpfulness of the check-in personnel?
- 2) Waiting room comfort and cleanliness?
- 3) The wait time from initial check-in to the exam room?
- 4) The wait time while in the exam room?
- 5) Was the nursing staff knowledgeable and respectful?
- 6) Doctor, Physician Assistant or Nurse Practitioner professionalism, ability to provide care and inform you of your condition and available treatment options?
- 7) Procedure scheduling and/or check-out staff?

1 = Needs Improvement 5 = Great				
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5

(Outside of Your Office Visit)

- 8) Timeliness of office staff returning your phone messages?
- 9) Ability of the phone operator to route your call to the appropriate person?
- 10) The overall performance and professionalism of Pain Solutions Treatment Centers?

How did you find out about Pain Solutions Treatment Centers?

Primary Care Physician _____ Specialist _____ Friend/Family (Existing patient) _____
 Magazine/Newspaper Article _____ Television Ad _____ Website _____ Yellow Pages _____
 Other _____

Additional Comments: _____

Logged _____