Today's Date:_____

Patient Satisfaction Survey

We hope that you will help us improve our services by taking this survey. Your answers matter to us so please spend a few minutes taking this survey and answer honestly. Your answers will be kept confidential and anonymous.

What is your age?_____

What is your sex? (circle one) M / F / T

What is your race? (check one or more)

__ Black/African American __White __Asian American __Indian/Alaskan Native
__Native Hawaiian __Other Pacific Islander __ Rather not say

Are you Hispanic/Latino? (circle one) Y / N

Did you have an appointment or did you walk in? (circle one) Appointment / Walk-in
If you had an appointment, what time was your appointment? _____
If you had an appointment, at what time were you called? _____
If you were a walk-in, for how long did you wait? _____

Please circle how we are doing in these areas:	Great (5)	Good (4)	Okay (3)	Fair (2)	Poor (1)
Do we work with you so that you can get in and be seen for appointments?	Great	Good	Okay	Fair	Poor
Do the hours we are open work for you?	Great	Good	Okay	Fair	Poor
Do you find it easy to reach us by phone?	Great	Good	Okay	Fair	Poor
Are you comfortable in the waiting room?	Great	Good	Okay	Fair	Poor
Are you comfortable in the exam room?	Great	Good	Okay	Fair	Poor
Do you generally find the facility comfortable and clean?	Great	Good	Okay	Fair	Poor
Do you find the front desk staff friendly and helpful?	Great	Good	Okay	Fair	Poor
Does the staff listen to you?	Great	Good	Okay	Fair	Poor
Is the staff friendly and helpful to you?	Great	Good	Okay	Fair	Poor
Does the staff answer your questions?	Great	Good	Okay	Fair	Poor
Does your doctor listen to you?	Great	Good	Okay	Fair	Poor
Is your doctor friendly and helpful?	Great	Good	Okay	Fair	Poor
Does your doctor spend enough time with you?	Great	Good	Okay	Fair	Poor
Does your doctor answer your questions?	Great	Good	Okay	Fair	Poor
Does your doctor make sure you can understand him/her?	Great	Good	Okay	Fair	Poor
Does your doctor give you good advice and treatment?	Great	Good	Okay	Fair	Poor

OVER

Please circle an answer to tell us about your care:	Yes	No	Does Not Apply to You
Did anyone talk to you about your medications today?	Yes	No	Does Not Apply to You
Do you have any difficulty getting your medications?	Yes	No	Does Not Apply to You
Did anyone talk to you about a plan or any goals for your health today?	Yes	No	Does Not Apply to You
Were you given any information about your health, like an educational brochure or care plan today?	Yes	No	Does Not Apply to You
Have we helped you find other services you need that we do not provide?	Yes	No	Does Not Apply to You
Were you asked today if you had seen any health care providers besides us since your last visit?	Yes	No	Does Not Apply to You
Do you think we help you lead a healthier life?	Yes	No	Does Not Apply to You

What do you like about us or our services?

_____
_____
_____
_____

What do you dislike about us or our services?

_____
_____
_____
_____

How can we improve?

_____
_____
_____
_____