

# PATIENT SATISFACTION QUESTIONNAIRE

My goal as your Chiropractic doctor is to help you understand your health problem. It is important to me that we explore our findings of your condition and that you are treated with respect and that you feel my staff and I are fulfilling our goals. Please read the questions below and mark the appropriate box.

- | YES                   | NO                    |   |
|-----------------------|-----------------------|---|
| <input type="radio"/> | <input type="radio"/> | Were you treated professionally on the telephone (or the office) when you scheduled your initial appointment? |
| <input type="radio"/> | <input type="radio"/> | Did you have any problem filling out our office forms?  |
| <input type="radio"/> | <input type="radio"/> | Do you feel your health history and consultation with the doctor was thorough?                                |
| <input type="radio"/> | <input type="radio"/> | Do you feel your examination was thorough?  |
| <input type="radio"/> | <input type="radio"/> | Did you understand the result of your x-rays and examinations?  |
| <input type="radio"/> | <input type="radio"/> | Did you have any questions about your recommended schedule of care that were not answered?                    |
| <input type="radio"/> | <input type="radio"/> | Is there any reason you cannot follow the recommended schedule?   |
| <input type="radio"/> | <input type="radio"/> | Is there anything about your health condition that this office should know?                                   |
| <input type="radio"/> | <input type="radio"/> | Do you feel the need to discuss anything with the doctor?   |

Your comments are welcome \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If you have any questions or concerns regarding your chiropractic health care services provided by this office we welcome the opportunity to discuss them with you. Thank you for your time and input.

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE