

Clinic Evaluation Survey

Dear Patient

Providing the highest quality chiropractic care is of vital importance to us. This quality includes trust and rapport with our patients. It would be of great value to us if you would take a moment and complete the areas below that apply and return this letter in the enclosed envelope.

I feel the doctor's communication skills are: Poor Fair Good Great Superb	I was given various treatment options? (pain relief, correction, other) Yes / No
I feel the doctor's sincerity and genuineness is: Poor Fair Good Great Superb	Were your finances clearly explained? Yes / No
I feel the doctor's honesty is: Poor Fair Good Great Superb	Were you comfortable on your first visit as a new patient? Yes / No
I feel the doctor's openness with me is: Poor Fair Good Great Superb	I feel the front desk assistant's scheduling / rescheduling of my appointments is: Poor Fair Good Great Superb
I feel the doctor's empathy is: Poor Fair Good Great Superb	I feel the payment procedure at the front desk is: Poor Fair Good Great Superb
I feel the doctor's "table side" manner is: Poor Fair Good Great Superb	Is there a conflict between what the doctor says and what he does? Yes / No
Waiting time for adjustments is: Poor Fair Good Great Superb	When you show progress during treatment, does the doctor encourage you? Yes / No
How are you treated by the front desk assistant? Poor Fair Good Great Superb	Are you aware that most of our new patients come from referrals from our existing patients? Yes / No
When calling on the phone, how are you treated by the assistant? Poor Fair Good Great Superb	I would feel comfortable returning to the office for care in the future? Yes / No
Does the doctor seem rushed during treatment? Poor Fair Good Great Superb	I would feel comfortable referring my friends/family to the office for care? Yes / No
How would you rate the doctor's ability to answer questions? Poor Fair Good Great Superb	Would like to be kept on our mailing / e-mail list (re: upcoming events, birthday cards, etc.) Yes / No Email: _____
Is the doctor clear about his treatment recommendations? Do you feel well informed? Yes / No	Would like to be removed from our mailing / e-mail / phone list? Yes Name: _____ (* To remove you from our mail list, please provide your name or to keep your survey anonymous you may drop us a note in the mail or call 480-940-4880.)

Please complete the following questions to the best of your feeling. Be specific!

- What do you see as the doctor's greatest weakness as he relates to you? _____
- What do you see as the doctor's greatest strength as he relates to you? _____
- My personal recommendation to the doctor is? _____
- What changes would you like to see regarding: the office:

Check all that are applicable:

Some of the reasons I dropped out / discontinued care are: N/A

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Couldn't afford treatment | <input type="checkbox"/> Didn't like the doctor | <input type="checkbox"/> Transportation problems | <input type="checkbox"/> Inconvenient hours |
| <input type="checkbox"/> Moved away from the office | <input type="checkbox"/> Spouse urged me to stop | <input type="checkbox"/> Treatments didn't help | <input type="checkbox"/> Got the results I wanted |
| <input type="checkbox"/> Other: _____ | | | |

**Thank you for taking the time to help us serve you better.
Our purpose is to create quality family spinal wellness for you for a lifetime.**