



# KC Pain

A service of Pain Management

## Patient Satisfaction Survey

Your complete satisfaction is our goal. We strive to continually improve our patient services, and your honest opinions help us to do so. We appreciate your thoughts on what we do well and what we might do better. Please complete this short survey and return it to us in the enclosed self-addressed, postage-paid envelope.

Name (optional) \_\_\_\_\_ Date of Service \_\_\_\_\_

Phone Number (optional) \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_

Physician Seen \_\_\_\_\_ Referring Physician \_\_\_\_\_

Please circle one:    New Patient    Repeat Patient    Clinic Location \_\_\_\_\_

	<b>Poor</b>	<b>Fair</b>	<b>Satisfactory</b>	<b>Good</b>	<b>Excellent</b>
1. If scheduled by phone, was your service prompt and courteous?	1	2	3	4	5
2. Was your appointment time convenient?	1	2	3	4	5
3. Was the clinic location (parking and accessibility) convenient?	1	2	3	4	5
4. Was the registration and waiting time reasonable?	1	2	3	4	5
5. Once in the treatment room, were you cared for promptly?	1	2	3	4	5
6. Did the staff treat you with courtesy and respect for your privacy?	1	2	3	4	5
7. Did the doctor spend adequate time assessing and treating you?	1	2	3	4	5
8. Was your treatment clearly explained to you?	1	2	3	4	5
9. Were you given clear post-treatment care instructions?	1	2	3	4	5
10. Did you experience any post-treatment complications?	Yes _____			No _____	
11. If you answered "yes" to # 10, did you know whom to contact?	Yes _____			No _____	
12. How would you rate your overall clinic experience?	1	2	3	4	5

**Comments** \_\_\_\_\_  
\_\_\_\_\_

**THANK YOU!**