Return to: ATTN: Rehab Director
17233 N. Holmes Blvd., Suite 1650, Phoenix, AZ 85053
Confidential Fax: (602) 547-0508

[Clinic Name Here]

STI CUSTOMER SERVICE SURVEY

Please give us your opinion of the therapy services that you have or are receiving by responding to the questions below. Your responses will be kept confidential. All information will be kept strictly confidential. Thank you for taking the time to help us improve the services we deliver.

YOUR NAME (optional): ________________________________ TODAY'S DATE: ______________________

PLEASE CIRCLE ONE RESPONSE

PLEASE RATE OUR DEPARTMENT	**5**	**4**	**3**	**2**	**1**
Your ability to schedule a convenient appointment time	Excellent	Very Good	Good	Fair	Poor
Ease of making appointment in a timely manner	Excellent	Very Good	Good	Fair	Poor
Overall cleanliness of our Clinic	Excellent	Very Good	Good	Fair	Poor

PLEASE RATE OUR FRONT OFFICE STAFF	**5**	**4**	**3**	**2**	**1**
Greeted you when you entered the department	Always	Usually	Sometimes	Rarely	Never
Scheduled convenient appointment times for you	Always	Usually	Sometimes	Rarely	Never
Staff were courteous and friendly	Always	Usually	Sometimes	Rarely	Never
Had a professional appearance	Always	Usually	Sometimes	Rarely	Never
Had friendly telephone manners	Always	Usually	Sometimes	Rarely	Never
Explained our paperwork and offered to help you fill it out	Always	Usually	Sometimes	Rarely	Never
Protected your personal information	Always	Usually	Sometimes	Rarely	Never

PLEASE RATE YOUR CLINICIAN – Name: ______________________________	**5**	**4**	**3**	**2**	**1**
The clinician was courteous and friendly	Always	Usually	Sometimes	Rarely	Never
Had a professional appearance	Always	Usually	Sometimes	Rarely	Never
Explained your therapy & answered your questions to your understanding	Always	Usually	Sometimes	Rarely	Never
Taught you how to follow-through on your therapy at home	Always	Usually	Sometimes	Rarely	Never
Worked on goals that were important to you	Always	Usually	Sometimes	Rarely	Never
Discussed your plan for discharge from therapy	Always	Usually	Sometimes	Rarely	Never
Provided effective therapy that helped you reach your goal	Always	Usually	Sometimes	Rarely	Never

PLEASE RATE YOUR CARE	**5**	**4**	**3**	**2**	**1**
Please rate the improvement of your condition due to therapy	Excellent	Very Good	Good	Fair	Poor
Please rate the overall quality of care and service that you received	Excellent	Very Good	Good	Fair	Poor

Would you return to this facility should you need services in the future? ❑Yes ❑No If no, why not?

Would you recommend our services to another person? ❑Yes ❑No If no, why not?

What can you do now that you could not do before your therapy?

Do you feel like your goals for therapy were addressed?

Was it met? ❑Yes ❑No

In what ways could we better service you? Please provide honest feedback on what that would look like.

IF PAIN WAS ONE OF YOUR PROBLEMS, PLEASE COMPLETE THE FOLLOWING SECTION

PLEASE CIRCLE THE NUMBER THAT BEST DESCRIBES YOUR PAIN LEVEL AT THE **BEGINNING** OF YOUR THERAPY PROGRAM

NO PAIN					DISTRESSING PAIN					UNBEARABLE PAIN
0	1	2	3	4	5	6	7	8	9	10

PLEASE CIRCLE THE NUMBER THAT BEST DESCRIBES YOUR PAIN LEVEL **NOW OR AT THE END** OF YOUR THERAPY PROGRAM

NO PAIN					DISTRESSING PAIN					UNBEARABLE PAIN
0	1	2	3	4	5	6	7	8	9	10

ADDITIONAL COMMENTS OR SUGGESTIONS: ____

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THANK YOU FOR HELPING US GET BETTER