

Name: \_\_\_\_\_

Clinic: \_\_\_\_\_

Therapist: \_\_\_\_\_

# Carlson Therapy Network, PC



## Patient Satisfaction Survey

1. Was the Front desk helpful to you booking appointments, or assisting with insurance issues if there was one?

**Circle:**            **Absolutely**    **Very much so**    **Not**  
**Really**

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

2. Were you happy with the services that your Physical Therapist provided to you? *Example:* Informative, attentive, knowledgeable, good listener

**Circle:**    **Very Happy**    **Satisfied**    **Not**  
**Happy**

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

3. Were you given a home exercise program? If yes, was the program explained in detail and were you comfortable with it?

**Circle:**    **Yes, I was**    **Yes, but felt confused**    **No, I did not get**  
**one**

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

4. If you had to change something about your service at Carlson Therapy Network what would it be and how do you suggest we make it better?

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5. Would you recommend Carlson Therapy Network to a relative and or friend?

**Circle:**      **Absolutely**      **Probably**      **No, I would not**

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

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6. If you are interested in the services listed and would like to see them offered by Carlson Therapy Network please circle, and provide your e-mail address:

***Phase IV  
Personal  
Training***

***Yoga  
Nutrition***

***Pilates  
Massage  
Therapy***

**E-Mail Address:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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~For In Office Use ~

**Reviewed by:** \_\_\_\_\_ **Date:** \_\_\_\_\_