


  
**Client Care Questionnaire**

Please check as many responses as apply to your experience. We want your honest opinions and suggestions. All replies are anonymous. Thank you.

1. How did you choose us for your rehab or massage therapy services?  
 I was referred by a relative or friend.  I was referred by my physician  
 I saw it listed in the yellow pages.  I saw the office and decided to try it.  
 Advertisement.  Other(please specify)\_\_\_\_\_
2. How long was your rehabilitation treatment here at TherapyWorks?  1 time visit  
 3 weeks or less  4 to 8 weeks  3 to 5 months  6 months or more
3. When I telephoned the office:  
 There was a busy signal.  The phone was answered promptly.  Put on hold.  
 Long wait before answering.  Had to try several times before I got an answer.
4. The person who answered the phone:  
 Seemed rushed.  Was rude.  Acted bored.  
 Didn't know what to do.  Was professional, yet pleasant and helpful.
5. Appointment scheduling:  
 I was able to make an appointment easily.  
 I was able to make appointments at a convenient time.  
 I had to wait too long to get an appointment.  
 I was forced to accept an inconvenient time.  
 I was able to make an appointment quickly when I had an emergency need
6. When I came to the office:  
 It was easy to find.  Parking was a problem.  
 I was greeted pleasantly and promptly.  I felt no one was interested in me.
7. The reception area was:  
 Pleasant  Comfortable  Crowded  Noisy  Clean and well kept
8. The waiting time before I was escorted into the treatment area:  
 I was seen on time.  I had to wait a "reasonable" length of time.  I had to wait too long.  
 I was kept informed as to how long I'd have to wait.
9. Please tell us about how many minutes you actually had to wait. \_\_\_\_\_
10. How many minutes do you consider a "reasonable" length of time to be asked to wait in a medical office? \_\_\_\_\_
11. The reading material:  
 Was interesting.  Was not of interest to me.  Was dated.  Was current. I would like to see \_\_\_\_\_ newspaper/magazine in the waiting area.

**Treatment**

1. The treatment room:  
 Was neat and clean when I entered.  Was dirty and messy.  
 Was well equipped.  Equipment seemed worn and dated.  
 Temperature was comfortable.

2. Please rate your satisfaction with the therapist who treated you.

	Poor	Fair	Good	Very Good	Excellent
<b>Therapist's concern for me as a person.</b>	1	2	3	4	5
<b>Courtesy of therapist.</b>	1	2	3	4	5

<b>Professionalism of therapist</b>	1	2	3	4	5
<b>Explanation of treatment plan and goals.</b>	1	2	3	4	5
<b>Communication during therapy</b>	1	2	3	4	5
<b>Took time to listen and answer my questions.</b>	1	2	3	4	5
<b>Explanation of treatment</b>	1	2	3	4	5
<b>Overall Quality of Care.</b>	1	2	3	4	5

3. How would you describe the improvement in you condition at the completion of your rehabilitation program?

- Returned to same condition prior to injury/ illness.
- Some improvement.
- Achieved a higher level of function than prior to injury/illness.
- At the maximum level of functioning possible within my condition
- No improvement.
- Loss of function.

4. Are you satisfied with the improvement in your condition?  Yes  No

**Office Staff**

1. About payment plans and financial arrangements:

- They were explained and questions answered.
- They were not explained clearly.
- They seemed fair to me.
- Definite arrangements were made.
- I did not like the way this was handled. If so, why?

2. Overall I rate the therapist, practice and staff as a \_\_\_(10 being high 1 low)

3. One of the things I particularly like about the practice is \_\_\_\_\_.

4. One of the things I would like to see changed \_\_\_\_\_.

**Please tell us something about yourself**

1. I:  Am a new patient.  Am a returning patient.

Came for 1 treatment only.

2. My age group is:

- 0 to 5 yrs.  6 to 10 yrs.  11 to 15 yrs.  16 to 20 yrs.
- 21 to 30 yrs.  31 to 41 yrs.  41 to 60 yrs.  61 or older.

3. What is your occupation? \_\_\_\_\_

4. Your zip code: \_\_\_\_\_ Home \_\_\_\_\_ Work \_\_\_\_\_

5. How long have you lived in this area? \_\_\_\_\_

6. Who made the decision to seek treatment in this practice?

- Self  Spouse  Parent  Referring Doctor  Other (please specify) \_\_\_\_\_

7. Have you recommended us to others?  Yes  No

8. Have you attended another massage/rehab facility? If so, how did our services compare to theirs? \_\_\_\_\_

9. How can we better serve you? \_\_\_\_\_

***We sincerely thank you for taking the time to complete this survey!***

Please mail the survey to: Therapyworks 917 Dante Place, Jacksonville, FL 32207

Email to: info@therapyworksinc.com

(Optional)Signature: \_\_\_\_\_

Date: \_\_\_\_\_

On the next page, if you wish, please give your testimonial about your experience with us so we can list it on our website. We will keep you name anonymous.

