St. Charles Family Care
Patient Satisfaction Survey

Your opnion matters. Please help us improve our patient care services

		Very Poor	Poor	Fair	Good	Excellent	N/A
1	How would you rate how well the medical provider listened to what you had to say?	O	O	O	O	O	O
2	How would you rate how well the medical provider answered your questions?	O	O	O	O	O	O
3	How would you rate how well the medical provider offered advice on ways you can avoid illness and stay healthy?	O	O	O	O	O	O
4	How would you rate how well the medical provider explained your diagnosis in a way you could understand?	O	O	O	O	O	O
5	How would you rate the follow-up on medical procedures or test results, if performed?	O	O	O	O	O	O
6	How would you rate the cleanliness and comfort of the clinic waiting room, reception area, and exam rooms?	O	O	O	O	O	O
7	How would you rate the level of respect you were treated with?	O	O	O	O	O	O
8	How would you rate the friendliness of the staff?	O	O	O	O	O	O
9	How would you rate the ease of registration?	O	O	O	O	O	O
10	How would you rate the care you received from the physician?	O	O	O	O	O	O
11	How would you rate the overall quality of care you received at the clinic?	O	O	O	O	O	O
12	Would you recommend this clinic to others?	Yes	O		No	O	

Please tell us if there is anything we can do to better serve you

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Name of the patient _____ (*optional*)

Name of the physician _____ Visit date _____

Please return completed survey to any staff member or mail it back to us in the prepaid envelope provided