

# Quality Assurance Survey

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Please answer the following questions fully. This will help us to be sure you are achieving your treatment goals and that we are able to help you as much as possible.

1. What was the major problem you came here to resolve? Have you resolved it?

---

---

2. How would you describe the level of pain you had when you first came to the clinic?  
How would you describe it now?

---

---

3. With regard to the long-term, what is it that you still hope to accomplish in your treatment program with us?

---

---

4. Have you had difficulties at our Front Desk: scheduling, billing, etc? If yes, please describe.

---

---

5. Were you well cared for personally, or were you ever neglected, etc.?

---

---

6. Do you understand your condition and what caused you to have your problem well enough that you will not re-injure yourself and can maintain your improved condition?

---

---

7. Do you feel good enough about your experience with us that you would return in the future yourself and/or refer friend or relative?

---

---

8. Do you know anyone currently who would benefit from seeing us?

---

---

*Thank you. Please return this to the Front Office Receptionist.*