Patient Satisfaction Questionnaire

Name:I				_ Date:	Date:				
Thank you for taking the time to complete this questionnaire. Your feedback is vital as we strive to provide the best possible care. Please indicate your level of satisfaction with the following aspects of your recent visit by checking the appropriate number:									
1 = Very	1 = Very Dissatisfied, 2 = Dissatisfied, 3 = Neutral, 4 = Satisfied, 5 = Very Satisfied								
Quality	of Care:								
Overall s	atisfaction v	vith the me	edical treati	ment recei	ved:				
	1		2		3		4		5
Satisfacti	on with the	effectivene	ess of the t	reatment:					
	1		2		3		4		5
Satisfacti	on with the	explanatio	n of your n	nedical cor	ndition and	treatment	plan:		
	1		2		3		4		5
Commu	unication	with Med	dical Stat	ff:					
Satisfacti	on with the	way the m	edical staf	communic	cated with	you:			
	1		2		3		4		5
Satisfacti	on with the	time the m	edical staf	f spent with	າ you:				
	1		2		3		4		5

Satisfac	tion with the	respect ar	nd empathy	shown by	the medic	al staff:		
	1		2		3		4	5
Faciliti								
Satisfac	tion with the	cleanlines	s and com	fort of the f	facility:			
	1		2		3		4	5
Satisfac	tion with the	accessibili	ty and con	venience d	of the facili	ty:		
	1		2		3		4	5
Waiting	g Times:							
Satisfac	tion with the	waiting tim	ne for your	appointme	ent:			
	1		2		3		4	5
Satisfac	tion with the	waiting tim	ne in the re	ception are	ea:			
	1		2		3		4	5
	I Experien		xperience :	at our heal	thcare faci	lity:		
	1		2		3		4	5

Please share any additional comments, concerns, or suggestions that might help us improve our services:

Optional: Comments or Suggestions

Thank you for your feedback! Your responses will help us to improve our services continually.