MISSOULA Bone & Joint Physical Therapy & Sports Medicine

PATIENT SURVEY

As part of Missoula Bone & Joint Physical Therapy & Sports Medicine's commitment to excellence, your opinion and satisfaction are very important to us. We need to know what we are doing right and in what areas we can improve. Your comments will be strictly confidential. Thank you for your help.

YOUR PROVIDER'S NAME: ☐ Bob Botkin, PT, LAT ☐ Marla Crago, PT ☐ LaRyn Martin, DPT ☐ Emily Pfeifer, PTA

TODAY'S DATE:_____

1. Is this your ☐ first therapy visit or ☐ a return therapy visit?

2. Was your appointment scheduled in a reasonable amount of time? ☐ Yes ☐ No

3. Was your therapy appointment scheduled at a convenient time of day? ☐ Yes ☐ No

4. Please rate our practice in terms of :

	Excellent	Very Good	Good	Fair	Poor	
• The person who answered your call *Name if Known:* _____	5	4	3	2	1	N/A
• How you were treated when you arrived at the front desk *Name if Known:* _____	5	4	3	2	1	N/A
• The amount of time the therapist spent with you	5	4	3	2	1	N/A
• The comfort of the waiting room	5	4	3	2	1	N/A
• Your check-out experience	5	4	3	2	1	N/A
• The therapist's interest in your problem	5	4	3	2	1	N/A
• The therapist's explanation of your treatment plan and/or exercise program	5	4	3	2	1	N/A
• The therapist's sensitivity to your pain or discomfort	5	4	3	2	1	N/A
• The satisfaction of the therapy treatment you received	5	4	3	2	1	N/A
• The patient education material provided	5	4	3	2	1	N/A
• The explanation of your options, cost, fitting of Durable Medical Equipment (such as braces or slings)	5	4	3	2	1	N/A
• The explanation of our billing and payment policies *Name if Known:* _____	5	4	3	2	1	N/A
• Notification from staff if the therapist was running behind	5	4	3	2	1	N/A
• What is your overall rating of our physical therapy department?	5	4	3	2	1	

5. The treatment I received has improved my condition/injury ☐ Agree ☐ Disagree
6. Overall the staff was professional and courteous ☐ Agree ☐ Disagree
7. I would refer a family member or friend to our office for therapy ☐ Agree ☐ Disagree

Name (*optional*): _____**Telephone Number (*optional*):** _____

☐ Feel free to contact me for permission to use my patient survey as a testimonial

Comments:_____**Thank You!**

Updated 12/1/11 kam