RED ROCK
PHYSICAL THERAPY AND WELLNESS

Specializing in Myofascial Release & Manual Therapeutic Techniques

Date: _____

PATIENT/CLIENT SATISFACTION SURVEY

Your satisfaction of the care you have received at Red Rock Physical Therapy & Wellness is our highest priority. Your comments are appreciated and help us continue to improve our service. This survey can also be completed online at www.redrocktherapy.com.

Check service provided: ☐ Physical Therapy ☐ Massage Therapy ☐ Pilates ☐ Wellness Care

	Very Satisfied	Satisfied	Neutral	Dissatisfied	Very Dissatisfied
Did you feel your privacy was respected?	5	4	3	2	1
You feel you were educated about your examination and your questions were answered by the clinician?	5	4	3	2	1
You feel your clinician was knowledgeable about your consistency of service?	5	4	3	2	1
Your appointments were conveniently scheduled?	5	4	3	2	1
You feel your time was respected?	5	4	3	2	1
Atmosphere?	5	4	3	2	1
Cleanliness of clinic?	5	4	3	2	1
Your overall impression of Red Rock Therapy & Wellness?	5	4	3	2	1

We appreciate additional constructive criticism to help improve our services: ☐ Yes, ☐ No

If no, why? _____

Would you refer someone to Red Rock Physical Therapy & Wellness? ☐ Yes, ☐ No

If no, why? _____

Would you tell your physician about the services provided at this clinic? ☐ Yes, ☐ No

If no, why? _____

Name (optional): _____

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