CACC PHYSICAL THERAPY

Batch: (internal use only) _____

Name: _____

Date: _____

Your Therapist: _____

Customer Care Questionnaire

Please help us continue to improve by taking the time to complete our questionnaire. As part of our ongoing effort to provide you with the highest quality care, we would greatly appreciate your valuable input.

1. Have you ever been a patient at this clinic or any other CACC facility prior to this course of treatment?..... **YES/NO**
2. Do you have a friend or relative that has been a patient at this clinic or any other CACC facility?..... **YES/NO**
3. Did your therapist give you his/her business card or phone number for easy access?..... **YES/NO**
4. Were you informed about our Patient Progress Assurance Program?... **YES/NO**
5. Do you feel comfortable calling us with questions or concerns?..... **YES/NO**
6. Do you have the tools recommended for your Home Therapy?..... **YES/NO** (*Handouts, Supplies,etc.*)
7. Were you consistently treated by the same therapy team?..... **YES/NO**
8. Will you recommend CACC to others?..... **YES/NO**

If you have family or friends that could benefit from our services we will be happy to send them a Free Appointment card

Name _____

Address _____

City _____

Zip _____

Please answer the following statements on a scale of 1-5

1. My appointment dates and times were convenient

1 (strongly disagree) 2 3 4 5 (strongly agree)

Comments: _____

2. I was given a clear explanation about location and directions

1 (strongly disagree) 2 3 4 5 (strongly agree)

Comments: _____

* ***Continued on back***

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3. The front desk staff was courteous/helpful

1 2 3 4 5
(strongly disagree) (strongly agree)

Comments: _____

4. The therapy team that I saw was courteous/caring/enthusiastic

1 2 3 4 5
(strongly disagree) (strongly agree)

Comments: _____

5. The therapy team was willing to listen to my questions

1 2 3 4 5
(strongly disagree) (strongly agree)

Comments: _____

6. I was given clear instructions for my home exercise program

1 2 3 4 5
(strongly disagree) (strongly agree)

Comments: _____

7. The treatment area and bathrooms were clean

1 2 3 4 5
(strongly disagree) (strongly agree)

Comments: _____

8. What is the most memorable experience that took place during your therapy at CACC?

_____

_____

9. What changes would you suggest to improve your experience at CACC?

_____

_____

Additional Comments:

_____

_____

☐ **I would like to share my experience with a CACC administrator. Please contact me.**

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