Patient Experience of Care Survey

Patient Name: _____

Treating Physician: _____

Date _____

We value our patients and your input is greatly appreciated.

Would you be available to provide further commentary to us if so requested? : ____ Yes ____ No

Our Question	*Your Response (please circle one)*
1. During my most recent visit, the doctor listened to me carefully.	Strongly Agree 10 9 8 7 6 5 4 3 2 1 Strongly Disagree
2. The doctor explained things in a way that was easy to understand.	Strongly Agree 10 9 8 7 6 5 4 3 2 1 Strongly Disagree
3. The doctor spent enough time with me.	Strongly Agree 10 9 8 7 6 5 4 3 2 1 Strongly Disagree
4. The doctor showed respect for what I had to say.	Strongly Agree 10 9 8 7 6 5 4 3 2 1 Strongly Disagree
5. I have experienced improvement as a result of my treatment plan.	Strongly Agree 10 9 8 7 6 5 4 3 2 1 Strongly Disagree

Please describe, if anything, how the care and services you received could be improved:

_____

_____

_____

_____

_____

_____

_____

_____