Missouri Delta
Physician Services

PATIENT SATISFACTION SURVEY

Name:(optional)
Date of Service:
Name of Doctor/Nurse Practitioner:

Your opinion is very important to us. Help us to improve our services by completing this survey. Circle the number that corresponds to your answer for each question. Your comments will remain confidential. Thank you for allowing us to care for you and your family.

Please read the following statements and score them according to the scale on the right.

1. Please rate your provider on a scale of 0 – 10 0= worst provider possible 10= best provider possible	0	1	2	3	4	5	6	7	8	9	10
2. In general, how would you rate your overall health?	VERY POOR 1		POOR 2		GOOD 3		VERY GOOD 4		EXCELLENT 5		
Please respond to the following statements about your visit today using a scale of 1-5.	STRONGLY DISAGREE		SOMEWHAT DISAGREE		AGREE		SOMEWHAT AGREE		STRONGLY AGREE		
3a) It was very easy to schedule my appointment.	1		2		3		4		5		
b) My provider explained things to me in a way that was easy to understand.	1		2		3		4		5		
c) My provider listened carefully to me and respected the decisions I made.	1		2		3		4		5		
d) My provider explained the reason behind the recommendations that he/she made.	1		2		3		4		5		
e) My provider discussed ways to improve my health with me, like healthy eating and exercising.	1		2		3		4		5		
f) My provider talked to me about the cost of my healthcare.	1		2		3		4		5		
g) I am typically able to make a convenient appointment with a specialist, when needed.	1		2		3		4		5		
h) The office staff was friendly and courteous.	1		2		3		4		5		
i) I am likely to recommend my provider's office to friends or family members.	1		2		3		4		5		

SUGGESTIONS: _____

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