GOREWAY PHYSIOTHERAPY & REHABILITATION CENTRE

PATIENT NAME (Optional): **DATE:**

TREATING THERAPIST:

Please answer the following questions fully. This will help us to be sure you are achieving your treatment goals and to improve our service.

1. Did you have any difficulties with our therapist? If yes, Please describe:

2. Did you receive education about your condition and what caused you to have your problems & how to prevent/ maintain your condition?

3. Were you well cared for personally at all times? If not, please describe:

4. Have you had any difficulties at our front desk: scheduling, billing, etc? If yes, please describe:

5. Did you resolve the problem or condition that you came to Goreway Physio for?

6. Do you feel good enough about your experience with us that you would return in the future yourself or refer a friend / relative?

7. We welcome your additional comments to improve our services:

Thank you for your business, please return this form to the front desk.