



# Lake Cities Chiropractic Center

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DATE: \_\_\_\_\_

**INSTRUCTIONS:** Please fill out the enclosed form by circling your answer. Add any comments in the space provided. These forms are used to help us better serve you and other patients.

**In terms of your satisfaction, how would you rate each of the following?** (Circle one number on each line.)

	VERY POOR	POOR	FAIR	GOOD	VERY GOOD	EXCELLENT
1. The amount of privacy you were given.	1	2	3	4	5	6
2. Interest shown in you as a person.	1	2	3	4	5	6
3. Friendliness of the doctor who treated you.	1	2	3	4	5	6
4. Friendliness of the office staff.	1	2	3	4	5	6
5. Willingness to listen to what you had to say.	1	2	3	4	5	6
6. Your understanding of your health problem.	1	2	3	4	5	6
7. Explanation of your treatment.	1	2	3	4	5	6
8. Clinic driver and transportation service (if used).	1	2	3	4	5	6
9. Amount of time spent with you.	1	2	3	4	5	6
10. Skill and ability of your doctor.	1	2	3	4	5	6
11. Skill and ability of the doctor's assistants.	1	2	3	4	5	6
12. Assistance with your insurance or bills.	1	2	3	4	5	6
13. Seen by the doctor at your scheduled time.	1	2	3	4	5	6
14. Care received overall.	1	2	3	4	5	6
15. Recommendation of this office to your friends.	1	2	3	4	5	6

Would you like someone at the office to contact you about this survey? \_\_\_\_\_ Yes \_\_\_\_\_ No

Please use back of page for additional comments.

**THANK YOU FOR YOUR HELP!!!**

**Name (Optional)** \_\_\_\_\_