

# 1<sup>ST</sup> CHOICE PHYSICAL THERAPY Patient Satisfaction Survey

You recently received Physical Therapy services from 1<sup>st</sup> Choice Physical Therapy, a member of the **Ohio Physical Therapy Network, Inc.** To improve our quality of care, we need to hear from you. Your participation is appreciated. Please complete this form on your discharge visit. **THANK-YOU!**

Directions: Please circle the number that best describes your experience with the care you received.  
Strongly Disagree=1 Disagree=2 Neither Agree nor Disagree=3 Agree=4 Strongly Agree=5 No Opinion=6

**Circling #1 indicates a negative response <> Circling #5 indicates a positive response**

- |  | Strongly Disagree  | ----- | Strongly Agree |
|--|--|-------|----------------|
| 1. My privacy was respected during my physical therapy care.....1                                      | 2  | 3     | 4 5            |
| 2. My physical therapist was courteous.....1   | 2  | 3     | 4 5            |
| 3. All other staff members were courteous.....1  | 2  | 3     | 4 5            |
| 4. The clinic scheduled appointments at convenient times.....1   | 2  | 3     | 4 5            |
| 5. I was satisfied with the treatment provided by my physical therapist.....1                          | 2  | 3     | 4 5            |
| 6. My first visit for physical therapy was scheduled quickly.....1                                     | 2  | 3     | 4 5            |
| 7. It was easy to schedule visits after my first appointment.....1                                     | 2  | 3     | 4 5            |
| 8. I was seen promptly when I arrived for treatment.....1  | 2  | 3     | 4 5            |
| 9. The location of the facility was convenient for me.....1  | 2  | 3     | 4 5            |
| 10. Parking was available for me.....1   | 2  | 3     | 4 5            |
| 11. My physical therapist understood my problem or condition.....1                                     | 2  | 3     | 4 5            |
| 12. The instructions my physical therapist gave me were helpful.....1                                  | 2  | 3     | 4 5            |
| 13. I was satisfied with the overall quality of my physical therapy care.....1                         | 2  | 3     | 4 5            |
| 14. I would recommend this facility to family or friends.....1   | 2  | 3     | 4 5            |
| 15. I would return to this facility if I required physical therapy care in the future..1               | 2  | 3     | 4 5            |
| 16. Do you feel that your treatment was terminated because of a limitation in your insurance coverage? | <input type="checkbox"/> Yes <input type="checkbox"/> No |       |                |

Name: (Optional) \_\_\_\_\_ Date: \_\_\_\_\_ Office: (Clinic Number)

Payer Code: \_\_\_\_\_ Employer Code: \_\_\_\_\_