RISKINDOC CLIENT SATISFACTION SURVEY

Name (Optional):
Address:
City, State, Zip Code:
Email:

For each item identified below, please circle the number to the right that best fits your judgment of its quality.

Description/Identification of Survey Item	Scale			
	Poor	Good	Very Good	Excellent
1. The ease of making an appointment	1	2	3	4
2. Your reception upon arrival	1	2	3	4
3. Cleanliness of the reception area	1	2	3	4
4. Timeliness of your appointment	1	2	3	4
5. Appearance and cleanliness of the treatment room	1	2	3	4
6. Staff was polite, knowledgeable and helpful	1	2	3	4
7. Providers were knowledgeable and helpful	1	2	3	4
8. Likelihood of you referring a friend or family member	1	2	3	4
9. Availability of products	1	2	3	4
10. Price of service or treatment	1	2	3	4
11. Your overall satisfaction with this experience	1	2	3	4

1. ***Please list any products or services that you would like us to offer***

2. ***Please tell us about any problems that you had with your last visit***

Please enter your name above if you would like to be entered into a Monthly Gift Certificate Drawing.
Thank you for your time and for completing our survey.