Sojourns COMMUNITY HEALTH CLINIC

Patient Satisfaction Survey

Please respond to the following questions about your experience at Sojourns. We would like to know how you feel about the services we provide so we can make sure we are meeting your needs. Your responses are directly responsible for improving these services. All responses will be kept confidential and anonymous. Thank you for your time.

Please check the number that best represents your response to each question

5 = Excellent 4 = Very Good 3 = Good 2 = Fair 1 = Poor n/a = Does Not Apply

Scheduling:	*5*	*4*	*3*	*2*	*1*	*n/a*
Ease of making appointments by phone						
Appointment available within a reasonable amount of time						
Courtesy of the person who scheduled you						
Knowledge / effectiveness of the person who scheduled you						
Speed in answering and simplicity of phone system						

Suggestions:_____

_____

Your Appointment:	*5*	*4*	*3*	*2*	*1*	*n/a*
Courtesy of the person who checked you in						
Comfort of waiting area						
Waiting time in the waiting room						
Keeping you informed if your appointment time was delayed						
Friendliness / courtesy of your practitioner						
Amount of time practitioner spent with you						
Practitioner's concern for your questions and worries						
Skill of physician						
Instructions regarding medication/follow-up care						
The thoroughness of the examination						

Suggestions:_____

_____

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Client Services/Communication:	*5*	*4*	*3*	*2*	*1*	*n/a*
Getting advice or help when needed during office hours						
The helpfulness of the people who assisted you with billing or insurance						
Your test results reported in a reasonable amount of time						
Effectiveness of our health information materials						

Suggestions:_____
_____

The Clinic / Our facility:	*5*	*4*	*3*	*2*	*1*	*n/a*
Hours of operation convenient for you						
Overall comfort						
Adequate parking						
Signage and directions easy to follow						

Suggestions:_____
_____

Your overall satisfaction with:	*5*	*4*	*3*	*2*	*1*	*n/a*
Our practice						
The quality of your medical care						
Overall rating of care from your practioner						

*Suggestions:*_____
_____

Would you recommend Sojourns Community Health Clinic to others? (please circle one) Yes No
If no, please tell us why:_____
_____
_____

If there is anyway we can improve our services to you, please tell us about it: _____
_____
_____
_____

Please share some information about yourself (*optional*):

Are you (please circle one): A returning patient A new patient

Gender (please circle one): Male Female Other:_____

Age (please circle one): Under 18 18-30 31-40 41-50 51-60 Over 60