

# Patient Satisfaction Survey

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 our services. Your responses will be kept in confidence and only reviewed by our administrative staff.  
 Thank you for your time.

Your Age: \_\_\_\_\_ How far did you travel to get here today? \_\_\_\_\_

Gender:  Male  Female

I decline to complete survey  why? \_\_\_\_\_

How do you rate...? (Please circle the appropriate number)	Excellent	Very Good	Fair	Poor	Very Poor
1. The time it took us to answer your call or schedule your appointment	5	4	3	2	1
2. The manner of the person who scheduled your appointment	5	4	3	2	1
3. Your wait time to be screened after you checked in	5	4	3	2	1
4. Your screeners retrieval of vital signs	5	4	3	2	1
5. Your nurse's review of medications and Assessment	5	4	3	2	1
6. Your wait time in the room before the provider arrived	5	4	3	2	1
7. The amount of time spent with your provider.	5	4	3	2	1
8. The provider listening to you.	5	4	3	2	1
9. The provider's explanation of procedure, diagnosis, or treatment?	5	4	3	2	1
10. Overall quality of care and service provided by IHS.	5	4	3	2	1
11. I have a person who I think of as my personal doctor or nurse.	Strongly Agree <sup>5</sup>	Agree <sup>4</sup>	Neutral <sup>3</sup>	Disagree <sup>2</sup>	Strongly Disagree <sup>1</sup>
12. I am able to get the care I need and want - when I need and want it at the clinic.	Strongly Agree <sup>5</sup>	Agree <sup>4</sup>	Neutral <sup>3</sup>	Disagree <sup>2</sup>	Strongly Disagree <sup>1</sup>
13. I am sure that I can manage and control most of my health problems.	Very sure or No health problems <sup>5</sup>	Somewhat sure <sup>4</sup>	Neutral <sup>3</sup>	Not very sure <sup>2</sup>	Not at all <sup>1</sup>

**Do you have any suggestions or comments as to how we may better improve our services?**

---



---



---



---

**Thank you for taking the time to complete this survey. Your opinion means a lot to us.**

concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: U.S. Department of Health & Human Services, OS/OCIO/PRA, 200 Independence Ave., S.W., Suite 336E, Washington D.C. 20201, Attention: PRA Reports Clearance Officer.