



Monroe

Flat Rock

Livonia

Please check the location at which you were treated.

We want to know!

To better serve you, we would like to know your opinion of the quality of our services. Please indicate the extent to which you agree or disagree with the following statements regarding the service you received at Performax. Circle the appropriate number using the scale below.

1- I strongly disagree with the statement-(SD)

2- I disagree with the statement-(D)

3- I neither agree nor disagree with this statement (N)

4- I agree with this statement (A)

5- I strongly agree with this statement (SA)

	SD	D	N	A	SA
1- Your first impression of Performax was a pleasant one.	1	2	3	4	5
2- Appointment times were convenient for me.	1	2	3	4	5
3- I received treatment promptly upon my arrival.	1	2	3	4	5
4- The facilities fit my needs.	1	2	3	4	5
5- The insurance process and approval process was convenient.	1	2	3	4	5
6- The treatment staff was knowledgeable, professional, and personable.	1	2	3	4	5
7- I was completely satisfied with the treatment received.	1	2	3	4	5
8- I was completely satisfied with the education and information regarding my therapy.	1	2	3	4	5
9- I would happily return for treatment of a new diagnosis.	1	2	3	4	5
10- I would recommend Performax to anyone needing therapy.	1	2	3	4	5

Who significantly contributed to your care and treatment at Performax?

Please specify: _____

Comments: _____

Did you complete your scheduled visits? Yes No

If no because, Dr recommended Improved more quickly Illness Other _____

How would you like to see us improve? _____

How did you hear about us? _____

Name (optional) ? _____