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Quality Assurance Check

Patient Name: _____ Date: _____

Physician: _____

Please answer the following questions fully in order for us to be certain that you are receiving the highest quality care that we can provide.

1. What was the major problem that you came here to resolve? _____

2. Are you making progress towards resolving your problem? _____
3. How would you describe your symptoms when you came to our facility? How would you describe them now? _____

4. With regard to the long-term, what is it that you still hope to accomplish in your treatment program with us? _____

5. Do you understand your condition well enough and what caused you to have your problem that you will not re-injure yourself or can maintain you improved condition? _____
6. Have you had any difficulties with our front desk, scheduling or billing personnel? _____

7. Do you feel good enough about your experience at Rehab Connection that you would return or would recommend us to a friend or relative? _____
8. Do you know anyone who could currently benefit from seeing us? _____

Thank you for your time. Please return this to your therapist.

Patient's Initials: _____
Therapist's Initials: _____