



Patient Satisfaction Survey

Please return completed survey to: 615 S. Vandeventer Ave. St. Louis, MO 63110

Patient's name _____

Date _____

Please answer the following questions by checking "Yes" or "No".

- 1. Was our staff courteous and friendly? Yes No
2. Did your orthotist address all of your questions and concerns to your satisfaction? Yes No
3. Were you given sufficient information on how to wear, clean, and care for your brace? Yes No
4. Are you satisfied with the overall fit of your brace? Yes No
5. Are you satisfied with the overall quality of your brace? Yes No
6. Are you satisfied with the overall function of your brace (ie, how your brace works)? Yes No
7. Have you experienced any falls while wearing your brace that have resulted in an injury re-quiring medical attention? Yes No
8. Has your brace directly caused any skin breakdown? Yes No
9. Are you or a caregiver able to put your brace on and take it off? Yes No
10. Would you refer a family member or friend to us? Yes No
11. Please provide additional comments/feedback below:

May we use your comments, first name, and city for marketing purposes? If yes, please initial _____

For office use only: Invoice # _____ Practitioner/Tech: _____ Device(s): _____