THE SPINE WORX

The Spine Worx Patient Experience

☐ Compliment ☐ Complaint or Grievance

☐ Testimony ☐ Request

Is this your first visit? Y / N

Approximately how long have you been a patient at The Spine Worx________

What area of the office are your comments directed towards?

☐ Building ☐ Support Staff ☐ Programs offered ☐ Exercise ☐ Massage ☐ Chiropractor ☐ Management

.

Date of Visit: _____________________________________ Time _____________________

Staff name(s):____

____

Your Name: ____DOB________________

Address: ____

City: ____ State: _______________ Zip: ___________

Daytime phone: ____________________ Is it OK to leave a message for you at this number? ☐Yes ☐ No

Call Back Requested? ☐ Yes ☐ No

Tell us about your visit: Please be as specific as possible. Include dates, times, staff names, and locations. Use the other side of the form if needed.

____

____

____

____

____

____

____

____

THE SPINE WORX

____

____

____

____

____

____

____

What solution would you like?____

____

____

Thank you for your comments,

The Spine Worx Team

The Spine Worx | 14 Professional Court | Lafayette, IN 47905 | Fax 765-449-0804 | stp@thespineworx.com

---

This section to be used for internal use only:

Reviewed by (print name and title): _______________________________________Date _____________

Referred to: ____ Date: ______________

Resolution:

____

____

____

____

____

Variance Completed? ☐ Yes ☐ Not needed Patient Contacted? ☐ Yes ☐ No

Returned to Site Director: ____ Date: ______________