Riverside Health Clinic

Clinic patient feedback form

Date of visit: _____

Your experience

How long did you wait past your appointment time?: _____

How was the clinician’s manner? (1–5): _____

Was everything explained clearly? (1–5): _____

Was the clinic clean? (1–5): _____

Did you feel your privacy was respected? (1–5): _____

How would you rate the overall experience? (1–5): _____

Would you recommend us to others? _____

Comments Anything else you would like to tell us

Contact (optional)

Phone: _____

Email: _____