THCC Patient Re-exam Survey

Name_____**Date**_____

Date of Birth_____

1. How do you feel about your progress?_____

_____

2. What improvements have you noticed?_____

_____

3. What conditions still need attention? _____

_____

4. What changes would you make with your treatment? _____

_____

5. Please rate staff interactions with you (where applicable) from 0 to 10, with 10 being most favorable:
   Physical Therapy staff_____
   Chiropractic staff_____
   Medical staff_____

6. Were finances adequately explained to you and a payment arrangement made? _____

_____

7. Would you refer others to our practice? If not, why? _____

8. Would you be willing to do a brief video testimonial? YES_____ Not at this time_____

9. Would you be willing to do a Google online review? YES_____ Not at this time_____

If yes, scan the QR code
and tell us about your experience!

Thank you for your feedback!

Please fill out other side →

TEAM HEALTH CARE CLINIC

We are pleased to provide information and educational classes for many health conditions. Please circle any condition for which you would like to attend.

- ADD/ADHD
- Brain Fog
- Depression/Anxiety
- Dizziness/Vertigo
- Weight Loss
- Detoxification
- Sleep Difficulty
- Concussion
- Memory Decline
- Digestion Difficulty
- Fatigue
- Thyroid Imbalance
- Hormone Imbalance
- SIBO
- Cardiovascular Conditions
- Stem Cells/PRP for Joint Pain
- Lyme Disease
- Dry Eyes

Do you have a friend, family member, or co-worker that you would like to have information provided to?

Name:_____

Condition:_____

Would you like us to speak on wellness related topics at your place of employment, civic group, or church?

Contact Name:_____

Phone:_____