DGV - Customer Feedback Form

St. Peter Family Practice
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Patient Name _____ DOB _____

PCP _____ Date _____

1. What is important to you? What do you want to learn more about? (Check those that apply)

- ❑ Planning meals
- ❑ Reading and understanding food labels
- ❑ Dining out or eating with friends
- ❑ Holiday and/or vacation eating
- ❑ Grocery shopping
- ❑ Encouraging family to make food changes also
- ❑ Understanding barriers to exercise
- ❑ Maintaining exercise routines
- ❑ Blood sugars - checking and understanding them
- ❑ Avoiding/preventing foot problems
- ❑ Realistic goal setting
- ❑ Coping with stress or depression
- ❑ Communicating with my doctors and nurses

2. How satisfied are you with:

	Excellent				*Poor*
The overall care you've received?	1	2	3	4	5
The answers to your questions about diabetes?	1	2	3	4	5
Access to care during emergencies?	1	2	3	4	5
The explanation of your lab results?	1	2	3	4	5
The way you're treated by SPFP staff, specifically:					
• our front office	1	2	3	4	5
• our nurses & medical assistants	1	2	3	4	5
• our doctors & other providers	1	2	3	4	5

3. Please note any other comments or input you'd like to share:

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Thanks! We appreciate your input.

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