



**Client Questionnaire Following Treatment**

Treatment received

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Were the following items provided to a satisfactory standard:

- Approximate cost quoted? Yes / No
- Treatment fact sheet provided? Yes / No
- Understood potential risks? Yes / No
- Were there any treatment complications? Yes / No
- Did you need to be referred to another specialist? Yes / No

Please provide a rating on how you perceive our services (1 = Poor, 2 = Adequate, 3 = Average, 4 = Very good, 5 = Excellent):

Our services	1	2	3	4	5	N/A	Comments
<b>Efficiency with enquiries</b>							
<b>Treatment information</b>							
<b>Consultation</b>							
<b>Staff Professionalism</b>							
<b>Treatment comfort</b>							
<b>Treatment outcome</b>							
<b>Overall Facilities</b>							
<b>Complaints handling</b>							

If there were any treatment complications what were they? \_\_\_\_\_

How were they resolved? \_\_\_\_\_

Would you consider any other treatments? Yes / No (please specify): \_\_\_\_\_

If you needed a referral, please circle to whom. Doctor / Nurse / Beautician / Other

Please add any further comments here:

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Thank you for your time.

**Name:** \_\_\_\_\_ **Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_