PATIENT SURVEY

Please help us serve you better. Fill out survey and leave at registration desk.

1. Are you taking any type of nutritional supplements (vitamins, minerals, herbs, amino acids, fish oils, etc)?

_____yes

_____no

2. List the supplements that you take:

3. Who recommended these supplements?

[Check all that apply]

_____family member or friend

_____advertisement

_____health professional

_____other [please describe]

4. Where did you purchase supplements?

[Check all that apply]

_____mail-order

_____nutrition or vitamin shop

_____pharmacy

_____healthcare provider

_____other [please describe]

5. If your doctor offered an advanced, high quality line of supplements, would you consider purchasing them?

______yes

______no

6. If your doctor offered a simple genetic test to determine the supplemental regimen best suited for you, based on your genetic variations, would you consider doing it?

______yes

______no

7. If this practice offered a comprehensive weight management program, would you consider participating?

By appointment with one of our staff?

______yes

______no

In a class exclusively for our patients?

______yes

______no

8. If this practice offered a nutrition education program to improve your dietary habits, would you consider participating?

By appointment with one of our staff?

______yes

______no

In a class exclusively for our patients?

______yes

______no

Thank you for helping us serve you!