CLIENT SATISFACTION SURVEY

Leaders in Community Health Solutions

Our organization wants to provide you and your family with the highest quality care possible. To help us evaluate and improve our services, we would like your opinion about us. The information you provide is confidential. Thinking about the services you receive, **please rate the following by circling the option that best represents your opinion**. If you have not experienced the specific item asked in a question, please select the "N/A" option.

	N/A	Poor	Fair	Good	Very Good	Excellent
1. Overall Experience						
Overall, how would you evaluate the quality of service you received?	0	1	2	3	4	5
2. Interaction						
Helpfulness of staff	0	1	2	3	4	5
Courtesy shown to you by staff	0	1	2	3	4	5
Concern of staff	0	1	2	3	4	5
Attention to privacy	0	1	2	3	4	5
Degree of confidentiality	0	1	2	3	4	5
Professionalism of staff	0	1	2	3	4	5
3. Clinical Program						
Opportunity to participate in decisions about your treatment	0	1	2	3	4	5
Extent to which your individual needs were addressed	0	1	2	3	4	5
Organization of weekday program schedule	0	1	2	3	4	5
Organization of weekend/holiday program schedule	0	1	2	3	4	5
Appropriate therapies and interventions offered	0	1	2	3	4	5
Ability of services to meet your needs	0	1	2	3	4	5
Availability of staff to talk with you	0	1	2	3	4	5
Ease of completing paperwork	0	1	2	3	4	5
4. Access						
Convenience of location of facility	0	1	2	3	4	5
Signs and directions to treatment areas	0	1	2	3	4	5
Ability to reach desired department or person by phone	0	1	2	3	4	5
Hours appointments are available	0	1	2	3	4	5
Length of time between making appointment and seeing the psychiatrist	0	1	2	3	4	5
Length of time between making appointment and seeing the therapist/counselor	0	1	2	3	4	5

	N/A	Poor	Fair	Good	Very Good	Excellent
Time spent in waiting area for your scheduled appointment	0	1	2	3	4	5
5. Environment						
Safety of the environment	0	1	2	3	4	5
Comfortable feeling	0	1	2	3	4	5
Noise level	0	1	2	3	4	5
Attractiveness of the facility	0	1	2	3	4	5
Cleanliness of the facility	0	1	2	3	4	5
Provision of necessary convenience items	0	1	2	3	4	5
Desirability of food	0	1	2	3	4	5
Availability of refreshments or snacks	0	1	2	3	4	5
6. Finance/Business office						
Arrangements for you to pay bill without unnecessary hardship	0	1	2	3	4	5
Reasonableness of fees	0	1	2	3	4	5
7. Outcome and Reputation						
Degree to which treatment helped you deal with your problem/complaint	0	1	2	3	4	5
Willingness to return for treatment	0	1	2	3	4	5
Reputation of our organization	0	1	2	3	4	5
Overall quality of care and services	0	1	2	3	4	5

The following questions are asked for the purpose of demographic or statistical information. Your responses cannot be identified.

	Yes	No	I do not wish to answer this question
8. Would you recommend our organization to others?	1	2	0
9. Have you completed treatment?	1	2	0

	Worse	Somewhat Worse	No Change	Somewhat Better	A Great Deal Better	I do not wish to answer this question
10. You came to our program with certain problems. How are those problems now?	1	2	3	4	5	0

	0-5	6-12	13-17	18-44	45-64	65+
11. Age	1	2	3	4	5	6

	Male	Female	I do not wish to answer this question
12. Are you:	1	2	0

	White	Asian	Black/African American	Mexican	Hispanic	Other	I do not wish to answer this question
13. Which best describes your ethnic background?	1	2	3	4	5	6	0

	Less than 8th grade	Some high school	High school graduate	Some college	College graduate	I do not wish to answer this question
14. What was the last grade you completed in school?	1	2	3	4	5	0

	Never married	Married	Divorced	Widowed	Separated	I do not wish to answer this question
15. Current marital status	1	2	3	4	5	0

	Employed full-time	Employed part-time	Unemployed	Retired	Other (specify)	I do not wish to answer this question
16. Employment status	1	2	3	4	5	0
If other selected, please specify:						

	Health insurance	Health Maintenance Organization (HMO)	Medicaid	Medicare	Self-pay	Other (specify)
17. How do you pay for services?	0	1	2	3	4	5
If other selected, please specify:						

	Client	Family member of client	Staff person	Other (specify)
18. Person filling out this questionnaire	1	2	3	4
If other selected, please specify:				

	Yes	No
19. Was your treatment voluntary?	1	2

20. Comments:

Thank You!

Thank you for taking our survey. Your response is very important to us.