CLIENT EXPERIENCE SURVEY
Your opinions are very important to us!

MARKING INSTRUCTIONS

- Use a No. 2 pencil or a blue or black ink pen only.
- Do not use pens with ink that soaks through the paper.
- Make solid marks that fill the response completely.
- Make no stray marks on this form.

CORRECT: ● **INCORRECT:** ✓ ✗ ◒ ◔

Office Use Only

Site Location				Provider			
0	0	0	0	0	0	0	0
1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2
3	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4
5	5	5	5	5	5	5	5
6	6	6	6	6	6	6	6
7	7	7	7	7	7	7	7
8	8	8	8	8	8	8	8
9	9	9	9	9	9	9	9

To Our Clients:
We want to know how you feel about the care you get at our health center. Please take a few minutes to complete this survey and then return it to us. Let us know your feelings about today's visit and any visits during the last year or so. Safe and effective care is our goal. Your answers are important to us.

PERSONAL INFORMATION

1. Age of client

- ○ Less than 5 years old
- ○ 5-9 years old
- ○ 10-13 years old
- ○ 14-19 years old
- ○ 20-29 years old
- ○ 30-39 years old
- ○ 40-49 years old
- ○ 50-64 years old
- ○ 65+ years old

2. Client Gender:

- ○ Male
- ○ Female
- ○ Transgender

3. Client Race/Ethnicity (mark one or more):

- ○ Asian
- ○ White
- ○ American Indian/Alaskan Native
- ○ Black/African American
- ○ Pacific Islander
- ○ Hispanic or Latino

4. Approximately how long have you been receiving services from this program?

○ 2 months or less ○ Less than 1 year ○ 1-2 years ○ 3-5 years ○ 6-10 years ○ 10 years or more

ACCESS TO CARE	Excellent	Good	Fair	Poor	N/A
Able to get an appointment	4	3	2	1	NA
Convenient hours of operation	4	3	2	1	NA
Easily accessible by telephone	4	3	2	1	NA
Calls quickly returned	4	3	2	1	NA
Explanation of fees	4	3	2	1	NA
FACILITY	**Excellent**	**Good**	**Fair**	**Poor**	**N/A**
Neat, clean and comfortable building	4	3	2	1	NA
Handicap accessibility	4	3	2	1	NA
Provides a safe environment	4	3	2	1	NA
RECEPTION	**Excellent**	**Good**	**Fair**	**Poor**	**N/A**
Respectful and helpful to you	4	3	2	1	NA
Amount of time spent in waiting room	4	3	2	1	NA
Time spent in checkout	4	3	2	1	NA
COUNSELOR/THERAPIST/CASE MANAGER	**Excellent**	**Good**	**Fair**	**Poor**	**N/A**
Listens to you	4	3	2	1	NA
Answers your questions	4	3	2	1	NA
Respectful to you	4	3	2	1	NA
Helps you meet your treatment goals	4	3	2	1	NA
Overall, how would you describe your relationship with your counselor/therapist/case manager?	4	3	2	1	NA

NURSES	Excellent	Good	Fair	Poor	N/A
Respectful to you	④	③	②	①	NA
Helpful to you	④	③	②	①	NA

NURSING AIDS/MEDICAL ASSISTANTS	Excellent	Good	Fair	Poor	N/A
Respectful to you	④	③	②	①	NA
Helpful to you	④	③	②	①	NA

MEDICAL PHYSICIANS	Excellent	Good	Fair	Poor	N/A
Respectful to you	④	③	②	①	NA
Answers your questions	④	③	②	①	NA
Helpful to you	④	③	②	①	NA
Understands your problem	④	③	②	①	NA
Education received on medical condition and medications prescribed (e.g. side effects or purpose)	④	③	②	①	NA

PSYCHIATRIST	Excellent	Good	Fair	Poor	N/A
Respectful to you	④	③	②	①	NA
Answers your questions	④	③	②	①	NA
Helpful to you	④	③	②	①	NA
Understands your problem	④	③	②	①	NA
Education received on medical condition and medications prescribed (e.g. side effects or purpose)	④	③	②	①	NA

GROUPS	Excellent	Good	Fair	Poor	N/A
Your participation has been helpful to your recovery	④	③	②	①	NA
Rate the skills taught and information presented to you	④	③	②	①	NA

DISCHARGE PLANNING	Yes	No	N/A
You have been involved in the planning of your transition from this program	Y	N	NA
Your discharge plan will support your recovery	Y	N	NA

GENERAL	Yes	No	N/A
Would you recommend our programs to your friends/relatives if they need our services?	Y	N	NA
Are you confident that personal information will be kept confidential by staff?	Y	N	NA
Are staff respectful of your cultural, ethnic, and spiritual needs?	Y	N	NA
Did you participate in planning your treatment?	Y	N	NA
Did staff meet your request for family involvement?	Y	N	NA
Did you have opportunities to learn daily living skills?	Y	N	NA
Have you used the health center website?	Y	N	NA
Do you have someone besides the agency staff to call during times when you are feeling helpless, hopeless, or sad?	Y	N	

How often do you socialize with your support network?

① Less than once a week ② At least one time a week ③ 2 to 4 times a week ④ More than 5 times a week

OVERALL	Excellent	Good	Fair	Poor	N/A
Overall, rate the progress you are making meeting your treatment goals.	④	③	②	①	NA