

### CLIENT SATISFACTION SURVEY

**Note to Clients:** This survey will help our Center improve the quality of its services. Your candid responses are *optional* and will be very much appreciated. Your answers will be kept confidential. Please answer all of the questions. Written comments are especially helpful. Thank you! Surveys can be returned to the Center in person, by mail or fax.

Instructions: Questions on this survey are followed by a 1 – 10 scale, **10 being “highly satisfied” and 1 being “not satisfied at all.”** Please circle the number that best expresses your opinion. There are also places for you to identify a response simply by checking a box. Your name on this survey instrument is not required.

Date Filled Out: \_\_\_\_\_

Number of Therapy Sessions:  1-5  6-10  11-20  21 or more

Type of Therapy:  Individual  Couple  Family  Group  Child (play)

Office Location:  Lemmon Ave.  Satellite Name: \_\_\_\_\_

#### First Contact, Location, and Facilities

1. *Arrangements in beginning therapy* (e.g., telephone contacts, office reception, referral, etc.):

1 2 3 4 5 6 7 8 9 10

Comments: \_\_\_\_\_

2. *The convenience of the location where therapy was received:* 1 2 3 4 5 6 7 8 9 10

Comments: \_\_\_\_\_

3. *Waiting room/reception area environment* (Lemm. Ave. office only): 1 2 3 4 5 6 7 8 9 10

Comments: \_\_\_\_\_

4. *The therapy room or satellite office as a place for therapy:* 1 2 3 4 5 6 7 8 9 10

Comments: \_\_\_\_\_

#### Your Therapy Experience

1. *Did you receive enough information when you came for therapy to make an informed decision about entering therapy here?* 1 2 3 4 5 6 7 8 9 10

Comments: \_\_\_\_\_

2. *Was the therapist’s and your assessment of the problem(s) that brought you to therapy thorough?*

1 2 3 4 5 6 7 8 9 10

Comments: \_\_\_\_\_

3. *Did the therapist assist you to identify the goal of your therapy?* 1 2 3 4 5 6 7 8 9 10

Comments: \_\_\_\_\_

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4. *Are you satisfied with the amount of progress you have made in your therapy?*

1 2 3 4 5 6 7 8 9 10 Comments: \_\_\_\_\_

5. *If the therapist has referred you to other specialists (e.g., psychiatrist, psychologist), are you satisfied with the treatment you received?* 1 2 3 4 5 6 7 8 9 10  Not applicable

Comments: \_\_\_\_\_

**Center Policies and Procedures**

1. *Are you satisfied with Center policies and procedures as they have applied to you, such as appointment times and payment procedures?* 1 2 3 4 5 6 7 8 9 10

Comments: \_\_\_\_\_

2. *Was the procedure used in filling out forms and sharing personal and medical information satisfactory to you?* 1 2 3 4 5 6 7 8 9 10

Comments: \_\_\_\_\_

3. *Are you satisfied with the way the Center or your therapist handled any emergency or crisis that occurred during the time you were here?* 1 2 3 4 5 6 7 8 9 10  Not applicable

Comments: \_\_\_\_\_

4. *Are you satisfied with the way your fee and therapy payments have been handled?*

1 2 3 4 5 6 7 8 9 10 Comments: \_\_\_\_\_

5. *Are you satisfied with our concern for your privacy?*

1 2 3 4 5 6 7 8 9 10 Comments: \_\_\_\_\_

6. *Are you satisfied with the Center as a place to refer a family member or friend for the help they need?*

1 2 3 4 5 6 7 8 9 10 Comments: \_\_\_\_\_

7. *Are you satisfied with the Center as a place you could return to if the need arose?*

1 2 3 4 5 6 7 8 9 10 Comments: \_\_\_\_\_

**Personal Information** (providing the following information is *optional*)

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone(s) \_\_\_\_\_ Gender: \_\_\_\_\_ Age: \_\_\_\_\_

**May we contact you regarding your responses on this survey?**  Yes  No