

# EXPERIENCE OF SERVICE QUESTIONNAIRE



## Day services (9-11)

What do you think about coming to this service or clinic.

For each item, please circle the answer that is closest to what you think

Did the people who saw you listen to you?	Yes	Only a little	Not really	Don't Know	1
Was it easy to talk to the people who saw you?	Yes	Only a little	Not really	Don't Know	2
How were you treated by the people who saw you?	Very well	Ok	Not very well	Don't Know	3
Were your views and worries were taken seriously?	Yes	Only a little	Not really	Don't Know	4
Do you feel that the people here know how to help you?	Yes	A little	Not really	Don't Know	5
Were you given enough explanation about the help available here?	Yes	Only a little	Not really	Don't Know	6
Do you feel that the people here are working together to help you?	Yes	Only a little	Not really	Don't Know	7
The facilities here (like the waiting area) are	Comfortable	Ok	Uncomfortable	Don't Know	8
The time of my appointments was	Convenient	Ok	Not convenient	Don't Know	9
The place where I had my appointments was	Easy to get to	Ok to get to	Hard to get to	Don't Know	10
If a friend needed this sort of help, do you think they should come here?	Yes	Maybe	Not really	Don't Know	11
Has the help you got here been good?	Yes	Only a little	Not really	Don't Know	12

NOW TURN OVER...

What was really good about your care?

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Was there anything you didn't like or anything that needs improving?

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Is there anything else you want to tell us about the service you received?

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THANKS FOR HELPING US