

EXPERIENCE OF SERVICE QUESTIONNAIRE ADDENDUM

Day services (Parent or Carer)

Please think about the appointments you, your child and/or your family have had with this service or clinic.

For each item, please tick the box that best describes what you think or feel about the service.

| | Certainly True | Partly True | Not True | Don't Know |
|--|--------------------------|--------------------------|--------------------------|-------------------|
| I feel more able to think about the child and the challenge the child presents now | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ? |
| I feel more able to think about myself in relation to my role as a carer now | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ? |
| It was convenient to meet at my house | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ? |

THANK YOU FOR YOUR HELP