Appendix 4 Client Satisfaction Survey (Example 2)

CLIENT SATISFACTION SURVEY
XXX HEALTH SERVICE DISTRICT

Please help us to improve our service by completing this survey. We value your comments.

PLACE IN BOX PROVIDED OR MAIL IN ENVELOPE ATTACHED BY: _____

REFERRAL PROCESS

1 Did you consider your referral to this service was: ☐ Too early ☐ Just right ☐ Too late

2 Were you informed of how to make another appointment (if required) with this service? Yes ☐ No ☐

3 (a) How long after seeing your doctor did you have your first full treatment session?

☐ Less than a week ☐ 1-2 weeks ☐ 2-4 weeks ☐ greater than 4 weeks

(b) Was this adequate? Yes ☐ No ☐

4 (a) Did any of the following make attending this service difficult?

Public transport	Yes ☐	No ☐
Parking	Yes ☐	No ☐
Finding us	Yes ☐	No ☐
Hours of opening	Yes ☐	No ☐
Stairs/hills etc	Yes ☐	No ☐
Waiting room	Yes ☐	No ☐

(b) If yes, how could this be improved? _____

5 (a) Did you miss any appointments during your course of treatment? Yes ☐ No ☐

(b) If yes, what caused you to miss the appointments? (Please tick as appropriate)

Forgot	☐	Didn't want to come	☐
Sick	☐	Work commitments	☐
Transport problem	☐	Other	☐

Comments: _____

_____

VIEWS ON SPEECH PATHOLOGY

6 Prior to treatment, how important did you feel speech pathology would be to helping your condition?

Very important	Important	Unsure	Not important	Very unimportant
1	2	3	4	5

7 Following treatment, how important did you feel speech pathology was in helping your condition?

Very important	Important	Unsure	Not important	Very unimportant
1	2	3	4	5

Comments: _____

_____

DEPARTMENT AND STAFF

8 How well did your therapist communicate with you?

Very well	Well	Average	Poor	Very poor
1	2	3	4	5

Comments: _____

_____

9 How well were you informed about your condition?

Very well	Well	Average	Poor	Very poor
1	2	3	4	5

Comments: _____

_____

10 How well were you informed about your treatment?

Very well	Well	Average	Poor	Very poor
1	2	3	4	5

Comments: _____

_____

11 Was your home program:

Too large	Right size	Too small	Not applicable
1	2	3	N/A

Comments: _____

_____

12 How confident were you in the skills of your therapist?

Very confident	Confident	Unsure	Not confident	Very unconfident
1	2	3	4	5

Comments: _____

_____

13 (a) On average, how many treatments per week did you have?

3 or more	Two	One	Less than one
1	2	3	4

(b) Was this adequate? Yes ☐ No ☐

Comments: _____

_____

14 How many therapists did you have? _____

15 Were you satisfied with the consistency of your treatment? Yes ☐ No ☐

Comments: _____

_____

16 Were you satisfied with the amount of time your therapist spent with you during treatment sessions? Yes ☐ No ☐

Comments: _____

_____

17 Compared to your first treatment, how much have you improved?

100%	50-99%	1-49%	Not at all
1	2	3	4

18 (a) Did you feel your discharge was appropriate? Yes ☐ No ☐

(b) If not, what could be improved? _____

_____

19 (a) Is our waiting area comfortable? Yes ☐ No ☐

(b) If not, how can it be improved? _____

_____

20 (a) Were our reception staff helpful? Yes ☐ No ☐

(b) If not, how can this be improved? _____

_____

21 (a) Were our Assistants helpful? Yes ☐ No ☐

(b) If not, how could this be improved? _____

_____

22 What can we do better to help you? _____

_____

23 What do we do well? _____

_____

PERSONAL DETAILS

1 What is your age Group? (Please tick one) Under 18 ☐ 18-29 ☐ 30-44 ☐ 45-59 ☐ 60+ ☐

2 Male ☐ Female ☐

3 (a) Are you employed? Yes ☐ No ☐

(b) If yes, is your employment: Full time ☐ Part time ☐ Shift work ☐

4 Are you a pensioner? Yes ☐ No ☐

5 How long have you had this condition?
0-3 weeks ☐ 3 weeks - 3 months ☐ greater than 3 months ☐

6 Have you attended this department before:
(a) for this condition? Yes ☐ No ☐

(b) for another condition? Yes ☐ No ☐

Thank you very much for completing this survey.