

# EXPERIENCE OF SERVICE QUESTIONNAIRE



Day services (Parent or Carer)

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

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

	Certainly True	Partly True	Not True	Don't know	
I feel that the people who have seen my child listened to me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?	1
It was easy to talk to the people who have seen my child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?	2
I was treated well by the people who have seen my child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?	3
My views and worries were taken seriously	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?	4
I feel the people here know how to help with the problem I came for	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?	5
I have been given enough explanation about the help available here	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?	6
I feel that the people who have seen my child are working together to help with the problem(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?	7
The facilities here are comfortable (e.g. waiting area)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?	8
The appointments are usually at a convenient time (e.g. don't interfere with work, school)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?	9
It is quite easy to get to the place where the appointments are	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?	10
If a friend needed similar help, I would recommend that he or she come here	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?	11
Overall, the help I have received here is good	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?	12

PLEASE TURN OVER...

What was really good about your care?

13

---

---

---

---

---

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

14

---

---

---

---

---

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

15

---

---

---

---

---

Child's age: _____	Child's gender: Female <input type="checkbox"/> Male <input type="checkbox"/>
Child's ethnicity: White <input type="checkbox"/> Black/Black British <input type="checkbox"/> Asian/Asian British <input type="checkbox"/>	Mixed <input type="checkbox"/> Other <input type="checkbox"/>
Is your child registered disabled (e.g. hearing-impaired)?	No <input type="checkbox"/> Yes <input type="checkbox"/>

If you don't want to take part, please tick this box  and return the blank questionnaire in the envelope provided.

### THANK YOU FOR YOUR HELP

Now place this form in the envelope provided and put it in the box marked CHI in the reception

For administration purposes	
Trust: _____	
Service: _____	Code: _____
Tier: _____	DB No: _____