Mental Health Services Patient Feedback Questionnaire

Your feedback is highly valuable to us. Please take a few moments to complete this questionnaire to help us improve our services. Since this is a printed form, please write your answers clearly in the spaces provided.

General Information

Date of Visit: _____

Service or Clinic Visited: _____

Name of Practitioner (Optional): _____

Service Evaluation

Please rate the following aspects of your visit (please write a number from 1 to 5, where 1 = Poor and 5 = Excellent):

1. Ease of scheduling appointments: _____

2. Friendliness and helpfulness of administrative staff: _____

3. Cleanliness, comfort, and safety of the environment: _____

4. Respect shown for your privacy and confidentiality: _____

Your Care Experience

Please answer the following questions regarding your therapy or consultation session:

5. Did you feel listened to and understood by your practitioner? (Write Yes, No, or Somewhat): _____

6. Were the treatment goals and plans explained clearly to you? (Write Yes, No, or Somewhat): _____

7. How involved did you feel in decisions about your care? (Rate from 1 = Not involved to 5 = Fully involved): _____

Overall Feedback and Comments

8. Overall satisfaction with the mental health service received (Rate from 1 = Dissatisfied to 5 = Highly Satisfied): _____

9. What did we do well during your visit? _____

10. What can we do to improve our services? _____

11. Would you recommend our services to others in need of support? (Write Yes or No): _____