

## Consumer Feedback Form

Date Client Completes Survey:  Completed with Staff Assistance: Yes:  No:

Site ID:  Provider ID:  Client ID:  Refused Form:

<b>Survey</b>	<b>Program/Clinic:</b> <input type="checkbox"/>	<b>Community:</b> <input type="checkbox"/>	<b>Hospital:</b> <input type="checkbox"/>	<b>Residential:</b> <input type="checkbox"/>
<b>Setting:</b>	<b>Corrections:</b> <input type="checkbox"/>	<b>Telephone:</b> <input type="checkbox"/>	<b>Other:</b> <input type="checkbox"/>	

Read each statement below and think about how things are going in your life. Fill in the box that best describes how you felt over the <u>past two weeks</u> . “Does Not Apply” can be used if you did not experience the circumstance.		Usually or Always	Sometimes	Rarely or Never	Does Not Apply
1.	I am able to cope if things go wrong.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2.	I have little interest in doing things.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3.	I feel comfortable raising issues about or asking for changes in my services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4.	I am satisfied with the amount of physical activity that I get.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5.	I am doing well in work/school/my preferred activities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6.	My providers are sensitive to my cultural background (race, religion, sexual orientation, etc.).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7.	I am able to accomplish most of the things I want to do.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8.	I am making progress in my wellness/recovery goals.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	I have family or friends with whom I can have fun.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10.	The wellness/recovery tools and skills that I use are effective for me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
11.	I have trouble with daily activities because of drinking or using drugs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
12.	I have <u>recently</u> thought about ending my life.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
13.	I participate in self help groups for alcohol or drug use on a regular basis.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14.	When I need help right away, I am able to see someone as soon as I need to.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
15.	I am bothered that I have no family or friends to talk to when I am troubled.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
16.	My physical health is a concern.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
17.	I feel down, depressed, that there is no hope of things getting better.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18.	I have trouble concentrating.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19.	I am able to manage my symptoms.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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20.	I have a good working relationship with my current:				
	peer supporter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	primary counselor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	psychiatrist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	nurse practitioner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21.	I use alcohol or drugs in my life to help get through the day.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22.	I feel like I am losing control over my life.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
23.	I am getting care for any physical health concerns I have.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
24.	I feel welcomed and respected by staff.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
25.	I am actively working to make positive changes in my life.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
26.	I have a responsibility to choose opportunities that improve my life.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
27.	I have opportunities to join social, spiritual and/or recreational activities in my life.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
28.	Feeling anxious keeps me from doing things I would like to do.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
29.	I feel my sexual needs are being met.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30.	I have the opportunity to involve family or other natural supports in my services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31.	My provider knows about my strengths and weaknesses.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
32.	When I explain my life to my provider, I feel that I am understood.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
33.	My counselor and I agree on the goals and objectives of my service plan.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
34.	My service provider shares with me the results of my assessments and other tests.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35.	I am satisfied with my role in making decisions about my care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

**36. In the past month, have you been (check all that apply)**

- employed full time
- employed part time
- involved in unpaid or volunteer work
- enrolled in job training
- enrolled in school
- involved in other meaningful activities \_\_\_\_\_ specify
- None of the above

**37. Please check all of the places where you have lived in the past month**

- I lived in my own place (house, apartment, etc.)
- I lived with my family

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- I lived with roommates
- I lived at someone else's place
- I lived in a residential treatment center (board and care facility, nursing home, detox, group home, sober living homes, etc.)
- I lived in a hospital
- I lived in lots of places
- I was homeless
- I was in jail
- Other: \_\_\_\_\_

**38. Please check all the statements below which describe how you may feel about your medications.**

- I no longer feel I need my medications
- I would like to change my medications and/or dose
- My medications aren't working for me the way I expected they would.
- I use vitamins, herbs or food supplements
- My medications make me too tired
- My medications make me anxious
- My medications interfere with my sexuality
- My medications make me gain weight
- I cannot afford my medications
- My medications are working fine
- Does not apply. No medications were prescribed for me.

**39. If your doctor prescribed medications as part of your mental health treatment, please check the one statement that best describes the way you take your medications. (check only one response)**

- I always remember to take my medications the way my doctor prescribed.
- I take my medications most of the time, but occasionally I forget
- I take my medications until I start to feel better then I stop
- I seldom take my medications
- I never take my medications
- Does not apply. No medications were prescribed for me.
- I am not currently taking medications but would like to discuss it.

**Please tell us anything you think is important for us to know about you or the services you receive.**

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**Are there services you would like in addition to what you currently receive, or are there services you no longer would like?**

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