# Guidance Foundation Inc.

# Step-by-Step intensive outpatient client satisfaction survey

We would like to know how you feel about the services that are provided to you by our:

Step-By-step Intensive Outpatient Dual Diagnosis treatment Program.

Please complete the questionnaire and return it to us at your earliest convenience.

Name :\_( Optional) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_ Length of Treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | ***Instructions:*** Please read each statement and **mark** your response in the column to the right as to how much you agree with each statement. | Strongly Agree  4 | Slightly Agree  3 | Slightly Disagree  2 | Strongly Disagree  1 |
| 1. | All of my needs are being met |  |  |  |  |
| 2. | The staff are knowledgeable and courteous |  |  |  |  |
| 3. | I am able to get in touch with the agency by phone on any day during the week |  |  |  |  |
| 4. | My concerns and problems were addressed in a timely manner |  |  |  |  |
| 5. | Questions about my condition and care were adequately explained to me |  |  |  |  |
| 6. | After services were completed I felt I could manage my own care. |  |  |  |  |
| 7. | I would recommend these services to a friend or family member. |  |  |  |  |
| 8. | Additional Comments: |  |  |  |  |
| 9. | How could we have served you better if you felt your needs have not been met? |  |  |  |  |