

County: \_\_\_\_\_ Site: \_\_\_\_\_ Today's Date: \_\_\_\_\_

### Client Survey

**Instructions:** In order to better serve you, we want to know what you think about the care you are receiving. Please complete this survey, place it in the envelope provided, and give to the clerk before you leave today. Remember to answer the questions on the back side of this sheet. **THANK YOU!!**

What is the main purpose of *today's visit*? \_\_\_\_\_

Was *today's visit* scheduled (Check one box)

Less than one week in advance?

More than one week, but less than a month in advance?

A month or more in advance?

A walk-in visit with no advance scheduling?

What are the best day(s) for you to come to the clinic (check all that apply)?

Monday    Tuesday    Wednesday    Thursday    Friday    Saturday

On the days selected above, which times are the best for you?

Morning    Lunch    Afternoon    Evening

How much time did you spend in the waiting room before being seen for your visit?

15 minutes or less    16-30 minutes    31-45 minutes    46 minutes-1 hour    Over 1 hour

During your visit today did you:

Have someone offer to help you apply for SoonerCare (Oklahoma's Medicaid Program)?    Yes    No

Receive counseling on BMI (Body Mass Index) or healthy weight?    Yes    No

Receive counseling on the harmful effects of tobacco use?    Yes    No

If yes, did you receive a referral to the Oklahoma Tobacco Helpline?    Yes    No

Is there any health information that you did not receive today that you would want to receive?    Yes    No

If yes, please list \_\_\_\_\_

**PLEASE COMPLETE THE QUESTIONS ON THE BACK SIDE OF THIS PAGE**

Please rate *this clinic* for the following:

| <b>Check one box for each item:</b>              | <b>Excellent</b> | <b>Good</b> | <b>Fair</b> | <b>Poor</b> | <b>N/A</b> |
|--|------------------|-------------|-------------|-------------|------------|
| Hours of operation                               |                  |             |             |             |            |
| The cleanliness of the building                  |                  |             |             |             |            |
| The ease of getting in and out of the building   |                  |             |             |             |            |
| The ease of moving around inside of the building |                  |             |             |             |            |
| Check in & out system                            |                  |             |             |             |            |
| Other (specify: _____)                           |                  |             |             |             |            |

Please rate the following staff for customer service:

| <b>Check one box for each item:</b>          | <b>Excellent</b> | <b>Good</b> | <b>Fair</b> | <b>Poor</b> | <b>N/A</b> |
|--|------------------|-------------|-------------|-------------|------------|
| Staff who answered the phone                 |                  |             |             |             |            |
| Clerk/person at the front desk today         |                  |             |             |             |            |
| Medical practitioner/person who did the exam |                  |             |             |             |            |
| Nursing staff                                |                  |             |             |             |            |
| Other (specify: _____)                       |                  |             |             |             |            |

Thinking about this *visit today*, please rate your satisfaction of the following:

| <b>Check one box for each item:</b>                              | <b>Excellent</b> | <b>Good</b> | <b>Fair</b> | <b>Poor</b> | <b>N/A</b> |
|--|------------------|-------------|-------------|-------------|------------|
| Total length of time spent in the clinic today                   |                  |             |             |             |            |
| Amount of time staff spent with you during this visit            |                  |             |             |             |            |
| Staff explained services   |                  |             |             |             |            |
| Staff answered your questions in a way that you could understand |                  |             |             |             |            |
| Explanation of possible side effects of medication               |                  |             |             |             |            |
| Privacy was protected  |                  |             |             |             |            |
| Overall staff conduct  |                  |             |             |             |            |
| Other staff (specify: _____)                                     |                  |             |             |             |            |
| The visit overall  |                  |             |             |             |            |

If you rated any item as "Fair" or "Poor", please explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

How can we improve your experience at the Health Department? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Any additional comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**THANK YOU FOR YOUR FEEDBACK!**