

**<<Your Clinic Name Here>>  
Client Satisfaction Survey**

We would like to know how you feel about the services we provide. Please take a few minutes to complete this survey so we can make sure we are meeting your needs. Your responses are directly responsible for improving these services. All responses will be kept confidential and anonymous.

Today's Date: \_\_\_\_\_

Your age: \_\_\_\_\_

Your sex: Male \_\_\_\_\_ Female \_\_\_\_\_

How did you hear about us?

\_\_\_ Website

\_\_\_ Advertisement (Where?) \_\_\_\_\_

\_\_\_ Friend/Family

\_\_\_ Referred by another agency/clinic

\_\_\_ Other \_\_\_\_\_

<b>Please circle how well you think we are doing in the following areas:</b>	<b>Great 5</b>	<b>Good 4</b>	<b>OK 3</b>	<b>Fair 2</b>	<b>Poor 1</b>	<b>Not Applicable</b>
<b>Appointments:</b>						
Ease of making appointment	5	4	3	2	1	NA
Amount of time you had to wait for an appointment	5	4	3	2	1	NA
Hours clinic are open	5	4	3	2	1	NA
Convenience of clinic location	5	4	3	2	1	NA
Waiting time in the reception area	5	4	3	2	1	NA
Waiting time in the exam room	5	4	3	2	1	NA
Waiting for test results	5	4	3	2	1	NA
Prompt return of phone calls	5	4	3	2	1	NA
						NA
<b>Staff:</b>						
Listens to you	5	4	3	2	1	NA
Spends enough time with you	5	4	3	2	1	NA
Explains what you want to know	5	4	3	2	1	NA
Friendly and helpful	5	4	3	2	1	NA
Answers your questions	5	4	3	2	1	NA
						NA
<b>Payment:</b>						
What you pay	5	4	3	2	1	NA
Explanation of charges	5	4	3	2	1	NA
						NA
<b>Facility:</b>						
Neat and clean building	5	4	3	2	1	NA
Comfort and safety while waiting	5	4	3	2	1	NA
Privacy	5	4	3	2	1	NA
						NA
<b>Confidentiality:</b>						
Keeping my personal information private	5	4	3	2	1	NA

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1. Did you receive the birth control method you wanted?
  - Yes
  - No
  - If no, why not? \_\_\_\_\_
  - Not Applicable
  
2. Were you told how to use the birth control method provided?
  - Yes
  - No
  - Not Applicable
  
3. Were you told about the benefits and possible side effects of the birth control method?
  - Yes
  - No
  - Not Applicable
  
4. Did you receive written material about the birth control method's use, benefits, and possible side effects?
  - Yes
  - No
  - Not Applicable
  
5. Did someone speak to you about STD's/HIV/AIDS during your visit?
  - Yes
  - No
  
6. Would you recommend this clinic to others?
  - I would highly recommend
  - I would somewhat recommend
  - I am not sure
  - I would not recommend

Comments/Suggestions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Thank You for completing our Survey!**