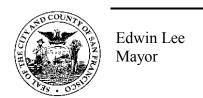
SAN FRANCISCO MENTAL HEALTH BOARD



1380 Howard Street, 2nd Floor San Francisco, CA 94103 (415) 255-3474 fax: 255-3760 mhb@mhbsf.org www.mhbsf.org www.sfgov.org/mental_health

CHILD AND YOUTH SATISFACTION SURVEY

1.	ıe	Il me a few things about this program or	service	e that you like the best?					
2.	Do	you know why you are here?							
3.	Do	you have anyone you take care of (elde	erly par	ents, sibling, child)					
4.	Do	es the staff ask you for your ideas about	servic	es you might need?					
Ye Co		nent:	No						
Ye	S	you feel the staff listens to or uses your nent:	ideas No	about services you might need? □					
Ye	S	you feel the staff respects you?	No						
\sim 0	omment:								

Revised 2015 1 of 5

7. Do you feel safe in this program?							
Yes □	No						
Comment:							
8. How do you get to and from this program? where you live? Do you feel safe in this program?		• •					
Yes □	No						
Comment:							
9. How long have you been getting these ser program?	vices?	How long do you expect to be in this					
10. Do you feel this program is the right one for	or you?						
Yes □	No						
Comment:							
11. Does the staff recognize your individual st your leadership abilities, compassion for otherYes □Comment:	_						
12. Does the staff help you use these strength	ns in yo	ur recovery?					
Yes □ Comment:	No						
13.Does the staff help you connect with other resources? (for example, programs in your school and neighborhood, medical needs, vision, dental, legal, housing, male/female issues, etc) Yes □ No □							

Comment:									
14.W	hat	could be	added to t	his prograr	m or service	to make it v	vork better fo	or you?	
15. l s	the	staff will	ing to make	e appointm	ents that are	e convenient	t for you?		
Yes					No				
Com	men	t:							
16.Ar Yes	e yo	ou taking	medication	ns? If <u>Yes</u> ,	ask questic	ons a to I,.If	<u>No,</u> go to que	estion 17.	
a. Did a doctor or staff person talk to you about what the medications were for?									
		Yes		No					
	b.	Did a d	octor talk to	you abou	t the side eff	fects of the r	medications?	•	
		Yes		No					
	C.			off talk to you		ernatives to i	medication, s	such as other	
		Yes		No					
	d.	Did the	doctor or s	staff answe	r all of your	questions al	bout your me	dications?	
		Yes		No					
e. <u>For female clients</u> : Did a doctor talk to you ab hormones, menstrual cycle, pregnancy or sex								edication on your	
		Yes		No					
	f.		For male clients: Did a doctor talk to you about the impact of medication on your hormones, or sexual function?						
		Yes		No					
	g.			<u>lients</u> : Did a , or sexual		to you abou	ut the impact	of medication	
		Yes		No					

	h.	Do you	feel the me	edications y	you are	e takin	g are h	elping	you?		
		Yes		No							
	i.			em with you id they do					tor or staf	f listen to y	our
		Yes		No							
Com	men	t:									
17.H	as th	ne staff sl	hared with	you the do	cumen	nts you	ır pareı	nts sign	ed?:		
	j.	Did you	have the o	chance to lo	ook the	m ove	er?	Yes		No	
	k.	Did you	read them	?				Yes		No	
	l.	Could ye	ou read the	em? (for e	хр. Са	n't rea	ıd)	Yes		No	
	m.	. Do you	understand	d what they	/ signe	d?		Yes		No	
Comi	men	it:									
18. Do	you	feel that	staff keeps	s your treat	tment r	ecord	s confi	dential?			
Yes						No					
Com	men	t:									
19	Do	you kno	w what WI	RAP is? (W	/ellnes	s and	Recov	ery Acti	on Plan)*		
Yes						No					
20.	Do	you hav	e a WRAP	plan?							
Yes						No					
21.	ls	there any	thing else	you would	like to	tell m	e abou	t?			

*WRAP is a self-designed plan to help people with mental health conditions stay well and to help individuals to feel better when not feeling well, increase personal responsibility, and improve quality of life. WRAP consists of the following: Wellness Toolbox, Daily Maintenance Plan, Identifying Triggers and an Action Plan, Identifying Early Warning Signs and an Action Plan, Identifying When Things Are Breaking Down and an Action Plan, and Crisis Planning and Post Crisis Planning.