Family Service Association (FSA) of the Greater Elgin Area
Client Satisfaction Survey

In an effort to evaluate the effectiveness of the services we offer, we would appreciate your feedback through this brief survey. Your responses are very important, and they will not impact in any way the services you receive. Rather, they will be used to improve the quality of the services we provide and to determine additional training opportunities.

Date: ____________________ Your Name (Optional): _____________________

Your Therapist's Name: ____

Are you the client, or parent/guardian? € Client € Parent/Guardian

Please rate your therapist's ability to:

1. Understand your main concerns:
   € Excellent € Very Good € Good € Fair € Poor
2. Understand you, and your family?
   € Excellent € Very Good € Good € Fair € Poor
3. Help you make progress towards your goals?
   € Excellent € Very Good € Good € Fair € Poor
4. How often did you review your treatment plan with your provider?
   € Very Often € Occasionally € Sometimes € Rarely € Never
5. How often did your therapist include your family/supports in treatment?
   € Very Often € Occasionally € Sometimes € Never € N/A
6. How long did you wait to start services?
   € Less than a month € 3-4 months € 5-6 months € 6-8 months € 8+ months
7. How likely are you to recommend FSA to others?
   € Very Likely € Likely € Neutral € Not Likely € Not at all Likely
8. I am treated with respect on the phone and in person: € True € False
9. The building is neat and clean: € True € False
10. Please provide any additional suggestions or comments regarding your overall experience with FSA: