Treatment Patient Experience Questionnaire: For Psychological Therapies

Please help us to improve our service by answering some questions about the service you have received. We are interested in your honest opinions, whether they are positive or negative. Please answer all of the questions. We also welcome your comments and suggestions.

Date & Time the Questionnaire was Completed:

Date:……../……. /………   Time: …………AM/PM (please delete appropriate option)

Friends and Family:

We would like you to think about your recent experiences of our service. How likely are you to recommend our service to friends and family if they need similar care or treatment

Assessment Tool:

Please tick one box for each question

1. Did staff listen to you and treat your concerns seriously?
2. Do you feel that the service has helped you to better understand and address your difficulties?
3. Did you feel involved in making choices about your treatment and care?
4. On reflection, did you get the help that mattered to you?
5. Did you have confidence in your therapist and his / her skills and techniques?

Please use the space below to tell us about your experience of our service:

Thank you very much. We appreciate your help.