



WELLNESS RX CLIENT SATISFACTION SURVEY: IOP AND OP

1. DO WE PROVIDE A CLEAN SAFE SETTING?

- YES
- NO
- SOMETIMES

2. DO YOU RECEIVE THE SERVICES THAT YOU NEED AND WANT?

- YES
- NO
- SOMETIMES

3. ARE YOU TREATED WITH RESPECT?

- YES
- NO
- SOMETIMES

4. DO YOU TAKE PART IN PLANNING YOUR SERVICES?

- YES
- NO
- SOMETIMES

5. ARE YOU TOLD WHAT YOU NEED TO KNOW ABOUT YOUR SERVICES?

- YES
- NO
- SOMETIMES

6. ARE YOUR QUESTIONS ANSWERED IN A WAY THAT YOU UNDERSTAND?

- YES
- NO
- SOMETIMES

7. DO YOU KNOW WHERE TO GO WITH YOUR QUESTIONS AND CONCERNS?

- YES
- NO

8. ARE YOU WILLING TO PARTICIPATE ON A "CLIENT INPUT FEEDBACK COMMITTEE?"

- YES
- NO
- NEED MORE INFORMATION
- IF YES, PLEASE PROVIDE CONTACT INFORMATION (NAME, EMAIL, PHONE NUMBER)

9. WOULD YOU RECOMMEND TIME ORGANIZATION SERVICES TO OTHERS?

- YES
- NO
- MAYBE

10. What, if any, barriers are there to your participation in services?

- transportation
- not enough incentive
- hours of operation
- NONE
- Other

11. PLEASE PROVIDE ANY ADDITIONAL COMMENTS THAT YOU WOULD LIKE TO SHARE. THANK YOU FOR YOUR FEEDBACK!