



Experience of Service Questionnaire (ESQ)

Community Adolescent Mental Health Service (Parent/Carer)

Child's Age: _____ Child's gender is: _____

I consider my child to be Aboriginal or Torres Strait Islander: Yes No

At home, the language my child speaks is: English A language other than English

Please think about the contact you, your child and family have had with our service. For each item below, rate how true it has been for you.

- The people who have seen my child listened to me.
 True Partly True Not True Don't Know
- It was easy to talk to the people who have seen my child.
 True Partly True Not True Don't Know
- I was treated well by the people who saw my child.
 True Partly True Not True Don't Know
- My views and worries were taken seriously.
 True Partly True Not True Don't Know
- The people here know how to help with the problem I came for.
 True Partly True Not True Don't Know
- I have been given enough explanation about the help available here.
 True Partly True Not True Don't Know
- The people who have seen my child are working together to help with the problem/s?
 True Partly True Not True Don't Know
- The facilities here are comfortable (e.g. waiting area, toilets, offices).
 True Partly True Not True Don't Know
- The appointments are usually at a convenient time (e.g. don't interfere with work or school).
 True Partly True Not True Don't Know

10. It is quite easy to get to the place where the appointments are.
 True Partly True Not True Don't Know

11. If a friend needed this sort of help, I would recommend that he or she come here.
 True Partly True Not True Don't Know

12. Overall, the assistance I have received here has been good.
 True Partly True Not True Don't Know

13. What did you like about the service?
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14. Was there anything you didn't like or anything that needs improving? If so, what could we do better?
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15. Is there anything else you want to tell us about the service you received?
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Thank you for taking the time to complete this questionnaire, your feedback is important to us.

Please place your completed questionnaire in the ESQ Return Box located in the Child & Adolescent reception area.

OFFICE USE ONLY
Date: __/__/__ MH CADS
Point of Service:
 Choice Partnership Transfer of care
Appointment conducted at:
 Clinic School Home ED Other
Processed by Admin: