Government of **Western Australia**
WA Country Health Service

Experience of Service Questionnaire (ESQ)

Community Adolescent Mental Health Service (9 - 11 years)

My Age: _____ My gender is: _____

I consider myself to be Aboriginal or Torres Strait Islander: ☐ Yes ☐ No

At home, the language I speak is: ☐ English ☐ A language other than English

For each item, please circle the answer that is closest to how you feel about coming here.

1. Did the people you meet today listen to you?

☺ Yes 😐 Only a little ☹ Not really ? Don't Know

2. Was it easy to talk to the people you met today?

☺ Yes 😐 Only a little ☹ Not really ? Don't Know

3. Did the people you saw today treat you well?

☺ Yes 😐 Only a little ☹ Not really ? Don't Know

4. Were your ideas and worries taken seriously?

☺ Yes 😐 Only a little ☹ Not really ? Don't Know

5. Do you feel that the people here know how to help you?

☺ Yes 😐 Only a little ☹ Not really ? Don't Know

6. Do you understand what people here can help you with?

☺ Yes 😐 Only a little ☹ Not really ? Don't Know

7. Do you feel that the people here are working together to help you?

☺ Yes 😐 Only a little ☹ Not really ? Don't Know

8. Do you remember where your appointment/s are?

☺ Yes 😐 Only a little ☹ Not really ? Don't Know

9. Do you remember the time of your appointment/s?

☺ Yes ☹ Only a little ☹ Not really ? Don't Know

10. If a friend needed this sort of help, do you think they should come here?

☺ Yes ☹ Only a little ☹ Not really ? Don't Know

11. Has the help here been good?

☺ Yes ☹ Only a little ☹ Not really ? Don't Know

13. What did you like about the service?

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14. Is there anything you didn't like or anything that needs improving? 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: ☐