

Feedback Form

Your feedback is important for us to improve our service. All information you provide will be treated confidentially and will help to improve our services. We appreciate your honesty in your responses.

Name (Optional):	
Service received	Doctor/nurse Mental health support/counselling Culture in Mind PM + Allied health: physiotherapy, dietetics Acupuncture/massage/homeopathy Group program
Name of the staff member who helped you	
Did we see you at the Stones Corner clinic or somewhere else	Stones Corner clinic Somewhere else: (address) _____ _____

(Please ✓ where appropriate)

Please evaluate the following statements	Not at all	A little	Moderately	A lot
1. Did we help you with your health concern?				
2. Since receiving the service, my overall wellbeing has improved				
3. Since receiving the service, I feel more hopeful about the future				
4. I felt respected and able to make decisions about my health				
5. Since receiving the service, I have more skills and strategies to assist with looking after my health and wellbeing				

6. What type of language/cultural support did you receive? (Please where appropriate)				
I did not need language/cultural support	WWG staff spoke my language	Interpreter	Multicultural Peer Support Worker	Other support- Please explain:

7. Would you recommend this service to a friend or family member?	NO	UNSURE	YES

8. Overall, how satisfied with the service you received	Not happy	A little happy	Moderately	Very happy

9. Other comments (Optional)

Date:

Signature: