# Treatment Perceptions Survey (Adult)

**Print PDF as needed.**
***Do not photocopy!***

*County / Provider Use Only*

CalOMS Provider ID (required) | | | | | | |

Program Reporting Unit (if required by your county): | | | | | | | | | | |

**Treatment Setting (required):** ○ **OP/IOP** ○ **Residential** ○ **OTP/NTP** ○ **Detox/WM (standalone)** ○ **Partial hospitalization**

- **Please answer these questions about your experience at this program.**
- If the question is about something you have not experienced, fill in the circle for "Not Applicable."
- **DO NOT WRITE YOUR NAME ON THIS FORM.**
- Your answers must be able to be read by a computer. Therefore, please use a pen, fill in the circle completely, and choose only one answer for each question.

| | Strongly Agree | Agree | I am Neutral | Disagree | Strongly Disagree | Not Applicable |
|---|---|---|---|---|---|---|
| 1. The location was convenient (public transportation, distance, parking, etc.). | ○ | ○ | ○ | ○ | ○ | ○ |
| 2. Services were available when I needed them. | ○ | ○ | ○ | ○ | ○ | ○ |
| 3. I chose the treatment goals with my provider's help. | ○ | ○ | ○ | ○ | ○ | ○ |
| 4. Staff gave me enough time in my treatment sessions. | ○ | ○ | ○ | ○ | ○ | ○ |
| 5. Staff treated me with respect. | ○ | ○ | ○ | ○ | ○ | ○ |
| 6. Staff spoke to me in a way I understood. | ○ | ○ | ○ | ○ | ○ | ○ |
| 7. Staff were sensitive to my cultural background (race/ethnicity, religion, language, etc.). | ○ | ○ | ○ | ○ | ○ | ○ |
| 8. Staff here work with my physical health care providers to support my wellness. | ○ | ○ | ○ | ○ | ○ | ○ |
| 9. Staff here work with my mental health care providers to support my wellness. | ○ | ○ | ○ | ○ | ○ | ○ |
| 10. As a direct result of the services I am receiving, I am better able to do things that I want to do. | ○ | ○ | ○ | ○ | ○ | ○ |
| 11. I felt welcomed here. | ○ | ○ | ○ | ○ | ○ | ○ |
| 12. Overall, I am satisfied with the services I received. | ○ | ○ | ○ | ○ | ○ | ○ |
| 13. I was able to get all the help/services that I needed. | ○ | ○ | ○ | ○ | ○ | ○ |
| 14. I would recommend this agency to a friend or family member. | ○ | ○ | ○ | ○ | ○ | ○ |

**Comments**

*Please do not write any information that may identify you, including but not limited to your name and/or phone number.*

**Please answer the following questions.**

1. How long have you have received services here?

○ First visit/day ○ 2 weeks or less ○ More than 2 weeks

2. Gender Identity (Please mark all that apply):

○ Female ○ Male ○ Transgender ○ Other gender identity ○ Decline to answer

3. Race/Ethnicity (Please mark all that apply):

○ American Indian/Alaskan Native ○ Latino ○ Other
○ Asian ○ Native Hawaiian/Pacific Islander
○ Black/African American ○ White/Caucasian ○ Unknown

4. Age Range: ○ 18-25 ○ 26-35 ○ 36-45 ○ 46-55 ○ 56+

55484

**Thank you for taking the time to answer these questions!**