

2016-2017 SBHC Student Satisfaction Survey

We need your help! To give you the best health care, we need your opinion.
Please **DO NOT** put your name on the survey so we can keep it private.

These are questions about YOU

1. What is today's date? _____ 2. Your Grade _____ 3. Your Age _____
4. Are you Male Female Other
5. In general, your **physical health** is:
 Excellent Very Good Good Fair Poor
6. In general, your **emotional and mental health** is:
 Excellent Very Good Good Fair Poor
7. Which statement best describes your visit to the Health Center?
 Today is the first time I've ever visited the Health Center. Today is the first time I've visited the Health Center this school year. I've already visited the Health Center at least once this school year.
8. How satisfied are you with the Health Center?
 Very satisfied Somewhat satisfied Not very satisfied Not at all satisfied

These are questions about how HEALTH CENTER STAFF talk to you

9. During your visit to the Health Center today , did the Health Center staff...	YES, definitely	YES, somewhat	NO
... explain things in a way that was easy to understand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
... give you easy-to-understand instructions about taking care of your health problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
... spend enough time with you	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
... treat you with courtesy and respect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. In the past 12 months, did a Health Center Staff talk to you about any of the following:	YES, and I got what I needed	YES, but I did not get what I need	YES, but I didn't need it	NO, but I need to talk about that	NO, I do not need to talk about that
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Healthy eating (breakfast, milk, fruits, veggies, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Screen time (TV, computer, tablet, smartphone, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



10. In the past 12 months, did a Health Center Staff talk to you about any of the following:	YES, and I got what I needed	YES, but I did not get what I need	YES, but I didn't need it	NO, but I need to talk about that	NO, I do not need to talk about that
Dental care, brushing & flossing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feelings (sad, angry, anxious, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Safety & injury prevention (seatbelts, helmets, life jackets, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye care, vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual health & puberty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise (sports, walking, dancing, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Healthy body weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Healthy relationships (dating, friends, family, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Immunizations/vaccines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your school performance, grades and attendance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

These are questions about TODAY

11. How many classes did you miss today to come to the Health Center?

- None or only part of a class
 1 -2 classes
 3 – 5 classes
 All Day
 I don't know

12. If your school did NOT have a Health Center, would you have another place to go for care today (like a doctor's office, emergency room, or another clinic)?

- Yes
 No
 I don't know

If you answered "Yes" above:

>> Would you have gone to the other clinic or doctor for care today?

- Yes
 No
 I don't know

>> How many classes would you have missed today if you had gone to the other clinic or doctor?

- None or only part of a class
 1 - 2 classes
 3 – 5 classes
 All Day
 I don't know



These are questions about the LAST 12 MONTHS
(this includes last school year and this school year)

13. In the past 12 months, how many days of school did you miss for **ANY** reason?

- None 1–5 days 6–10 days 11 or more days

14. During the past 12 months, how many days of school did you miss because of **physical health** reasons (for example, cough, cold, stomach problems, injury, headache, cramps, asthma, allergies, etc.)?

- None 1–5 days 6–10 days 11 or more days

15. During the past 12 months, how many days of school did you miss because of **emotional or mental health** reasons (for example, if you felt too sad or nervous to go to school)?

- None 1–5 days 6–10 days 11 or more days

16. In the past 12 months, have you visited an emergency room or urgent care clinic for a physical or mental health care need? **(Check ALL that apply)**

- No Yes – during school hours Yes – during the summer Yes – on the weekend Yes – before or after school Don't know/can't remember

17. During the past 12 months, have you had any **physical health** care needs that were **NOT** met? (Count any situation where you thought you should see a doctor, nurse, or other health professional, but couldn't or didn't.)

- Yes No

18. In the past 12 months, where did you usually go to get **physical health** care? **(Choose ONLY ONE)**

- School-Based Health Center Doctor's office Emergency room or urgent care clinic School nurse
 Some other place Other health clinic (not at school) Does not apply to me Don't know

19. During the past 12 months, have you had any **emotional or mental health** care needs that were **NOT** met? (Count any situation where you thought you should see a counselor, social worker, or other mental health professional, but couldn't or didn't.)

- Yes No

20. In the past 12 months, where did you usually go to get **emotional or mental health** care? **(Choose ONLY ONE)**

- School-Based Health Center Therapist or counselor Emergency room or urgent care clinic School nurse School Counselor
 Doctor's office Some other place Other health clinic (not at school) Does not apply to me Don't know

21. Where do you usually go during the summer to access **physical health** care? **(Choose ONLY ONE)**

- School-Based Health Center Doctor's office Emergency room or urgent care clinic Other health clinic
 Some other place I don't usually need care in the summer Don't know

22. Where do you usually go during the summer to access **emotional or mental health** care? **(Choose ONLY ONE)**

- School-Based Health Center Therapist or counselor Emergency room or urgent care clinic Other health clinic
 Doctor's office Some other place I don't usually need care in the summer Don't know



These are questions about the HEALTH CENTER

23. In the past 12 months, did the Health Center doctor or nurse send you to another place to get health care services, like mental health, dental, x-rays?

- Yes No Don't know

24. In the past 12 months, did the Health Center doctor or nurse order a blood test, x-ray, or other test for you?

- Yes No Don't know

25. In the past 12 months, when you called this Health Center to get an appointment for **care you needed right away**, how often did you get an appointment as soon as you thought you needed?

- Always Usually Sometimes Never Does not apply to me

26. In the past 12 months, when you made an appointment for a **check-up or physical exam** with this Health Center, how often did you get an appointment as soon as you thought you needed?

- Always Usually Sometimes Never Does not apply to me

27. In the past 12 months, when you made an appointment for a **mental health visit** (like therapy or counseling) with this Health Center, how often did you get an appointment as soon as you thought you needed?

- Always Usually Sometimes Never Does not apply to me

COMMENTS: Please write down anything you would like us to know about your health or the Health Center.

Thank you!