

## 2015-2016 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 or  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 TODAY

---

9. 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
10. 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
11. Was your visit today to the SBHC a walk-in or a scheduled appointment?  
 Walk-in appointment  Scheduled appointment

---

### These are questions about the LAST 12 MONTHS

---

12. 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
13. 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



14. 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
15. 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
16. 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
17. 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
18. 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
19. 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
20. 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
21. 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**

22. 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



23. 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

24. 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

25. 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

26. 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

**These are questions about how HEALTH CENTER STAFF talk to you**

27. 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"/>

28. 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"/>
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"/>

Turn to page 4



28. Continued:

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
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"/>

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

**Thank you!**