

CRF30i: CSQ-8 16wk

Site ID
PID
Patient Initials
Patient DOB | |
Date of visit | |

Please answer some questions about the help that you have received. We are interested in your honest opinions, whether they are positive or negative. Please **CIRCLE** your answers and please answer all of the questions.

1. How would you rate the quality of treatment you received?	4 Excellent	3 Good	2 Fair	1 Poor
2. Did you get the kind of treatment you wanted?	1 No, definitely not	2 No, not really	3 Yes, generally	4 Yes, definitely
3. To what extent has our treatment met your needs?	4 Almost all of my needs have been met	3 Most of my needs have been met	2 Only a few of my needs have been met	1 None of my needs have been met
4. If a friend were in need of similar help, would you recommend the treatment to him or her?	1 No, definitely not	2 No, I don't think so	3 Yes, I think so	4 Yes, definitely
5. How satisfied are you with the amount of help you received?	1 Quite dissatisfied	2 Indifferent or mildly dissatisfied	3 Mostly satisfied	4 Very satisfied
6. Has the treatment you received helped you to deal more effectively with your problems?	4 Yes, it helped a great deal	3 Yes, it helped somewhat	2 No, it really didn't help	1 No, it seemed to make things worse
7. In an overall, general sense, how satisfied are you with the treatment you received?	4 Very satisfied	3 Mostly satisfied	2 Indifferent or mildly satisfied	1 Quite dissatisfied
8. If you were to seek help again, would you come back to receive the treatment?	1 No, definitely not	2 No, I don't think so	3 Yes, I think so	4 Yes, definitely

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Completed by: Name: Date completed: | |

 Signature:

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Once completed this form should be sent to: **RAPID, Centre for Trials Research, 4th Floor Neuadd Meirionnydd, Cardiff University, Heath Park, Cardiff, CF14 4YS**