DESERET MUTUAL
BENEFIT ADMINISTRATORS
60 East South Temple • P.O. Box 45530
Salt Lake City, Utah 84145
Telephone (801) 578-5600 • Toll Free 1-800-777-3622
Fax Number (801) 578-5916

MENTAL HEALTH SATISFACTION SURVEY

To make sure that you are receiving quality services, please complete this questionnaire and return it to Deseret Healthcare.

Patient Name: ____________________

Member Social Security Number: ____________________

Therapist Name: ____________________

Date: ____________________

Please indicate the type of services you received from this therapist:

- ❑ Evaluation
- ❑ Testing
- ❑ Counseling
- ❑ Medication Management

Please answer the following questions about your experience:

To what extent did the therapist:

	Not At All		Neutral		Completely
• Help you achieve the purpose for which you sought counseling?	1	2	3	4	5
• Help you obtain skills that will help you handle future problems?	1	2	3	4	5
• Show interest in your needs?	1	2	3	4	5
• Understand your needs?	1	2	3	4	5
• Help you define your needs?	1	2	3	4	5
• Involve you in the treatment planning (such as treatment goals and frequency of appointments)?	1	2	3	4	5
• Respond to your requests for services?	1	2	3	4	5

Are you going to continue treatment with this therapist? ____________________

Do you have any specific concerns or complaints about your treatment? ____________________

____

____

____

Are there some things you feel were especially good or helpful about your treatment? ____________________

____

____

____

EI-04 1/01 2M