Survey 2: Survey of clients of mental health services

**Client demographics**

1. Client’s Gender:
   - □ Male
   - □ Female
   - □ Transgender

2. Client’s Age: ___________________

3. Including today’s session, how many sessions have you had with this client? ___________

4. How many more sessions do you anticipate providing to this client? ___________

5. Is the client:
   - □ White
   - □ Chinese
   - □ South Asian (e.g. East Indian, Pakistan, Sri Lankan, etc.)
   - □ Black
   - □ Filipino
   - □ Latin American
   - □ Southeast Asian (e.g. Cambodian, Indonesian, Laotian, Vietnamese, etc.)
   - □ Arab
   - □ West Asian (e.g., Afghan, Iranian, etc.)
   - □ Japanese
   - □ Korean
   - □ Aboriginal Peoples of North America (North American Indian, Métis, Inuit)
   - □ Other (please specify)______________________________
6. Client’s language spoken at home:

- [ ] English
- [ ] French
- [ ] Other (please specify) _________________________________

7. Was the client born in Canada or did the client move to Canada?

- [ ] Born in Canada
- [ ] Not born in Canada, and has lived here for __________ years

7.2 Under what status did the client move to Canada?

- [ ] Immigrant
- [ ] Refugee
- [ ] Unknown

8. Marital Status:

- [ ] Married
- [ ] Common Law
- [ ] Widow
- [ ] Separated
- [ ] Divorced
- [ ] Single and never married
- [ ] Unknown

9. Sexual orientation as reported by the client:

- [ ] Heterosexual
- [ ] Gay/lesbian
- [ ] Bisexual
- [ ] Unknown
10. Client’s living arrangements:

- □ Private residence
- □ Residential care
- □ Institutional setting
- □ Homeless or shelter
- □ Other (please specify) ________________________

11. For clients 17 years of age or older, please indicate their educational attainment:

- □ Grade 8 or lower
- □ Some high school
- □ High school diploma
- □ College certificate or diploma
- □ Trades certificate or diploma
- □ Some undergraduate
- □ Undergraduate degree
- □ Graduate or professional degree
- □ Unknown
- □ Not applicable

12. If your client is over the age of 16, are they a student?

- □ Full-time
- □ Part-time
- □ No
- □ Not applicable
13.1 Is the client employed?

☐ Full-time
☐ Part-time
☐ No
☐ No, but on disability
☐ Unknown
☐ Not applicable

13.2 What is your client’s occupation?

☐ Management
☐ Professional (e.g. lawyer, accountant, physician, nurse, psychologist)
☐ Technologist, technician or technical occupation
☐ Administrative, financial or clerical
☐ Sales or service
☐ Trades, transport or equipment operator
☐ Occupation in farming, forestry, fishing or mining
☐ Occupation in processing, manufacturing or utilities
☐ Other (please specify) ________________________________
Client service characteristics

14. Language in which service is provided to client:

☐ English
☐ French
☐ Other (please specify) ________________________________

15.1 Is this client receiving another health service for the same presenting problem?

☐ Yes
☐ No

15.2 From whom are they receiving these services?

☐ Psychiatrist
☐ Family practitioner or general physician
☐ Nurse practitioner
☐ Psychologist
☐ Counsellor
☐ Educational professional
☐ Other (please specify) ________________________________

16. In what type of setting or organization did you provide the service to this client?

☐ Private practice setting – group practice
☐ Private practice setting – individual practice
☐ Public health care organization (e.g. hospital, clinic)
☐ Correctional facility
☐ Community or street outreach program
☐ School
☐ University or college
17. How did the client or the client’s caretaker pay for the service? The service was:

- □ Paid for services directly, with no extended health insurance reimbursement
- □ Pay for services directly, all or most of which is reimbursed by extended health insurance
- □ Paid for directly by workers’ compensation board (e.g., WSIB)
- □ Paid for directly by other insurer or program (e.g., motor vehicle accident insurance)
- □ Paid for directly by employer through an employee assistance programme
- □ Received services within a publicly funded institution (e.g., hospital, school, correctional facility)
- □ Received pro-bono services
- □ Other (please specify):__________________________

18. What service(s) did you provide to the client during this session? (check all that apply)

- □ Assessment which includes psychometric testing of mood, behaviour, or personality
- □ Assessment which includes psychometric testing of intellectual functioning
- □ Neuropsychological assessment
- □ Vocational assessment
- □ Cognitive behavioural therapy
- □ Interpersonal therapy
- □ Psychodynamic therapy
- □ Humanistic/experiential therapy
- □ Family systems therapy
- □ Other (please specify)_____________________________
19. In this session, who was included in the delivery of the service?

- [ ] Client alone
- [ ] Client with significant other (e.g., partner, spouse, roommate)
- [ ] Client with family member(s)
- [ ] Client with other caregiver(s)
- [ ] Client with other service provider(s)
- [ ] Client with other (please specify)_________________________

20. Service setting is in:

- [ ] Major urban centre
- [ ] Suburb of major urban centre
- [ ] Smaller city or town
- [ ] Rural setting

21. How was the client referred to you?

- [ ] Self
- [ ] Other client
- [ ] Legal system
- [ ] Family member
- [ ] School system
- [ ] Psychologist
- [ ] Psychiatrist
- [ ] Physician
- [ ] Other health care professional
- [ ] Insurance system
22. Have you made any referrals for this client for: (check all that apply)

- [ ] Substance abuse treatment
- [ ] Other mental health treatment
- [ ] Psychological assessment (neuropsychological, educational, vocational)
- [ ] Child and family services
- [ ] Social services other than child and family services
- [ ] Medication evaluation
- [ ] Other health
- [ ] Support or self help
- [ ] No referrals made

**Client psychosocial functioning**

23. Does the client have any early or identifiable risk factors for mental health problems? (Check all that apply)

- [ ] Parental mental disorder and/or family history of mental health problem
- [ ] Marital problems
- [ ] Bereavement during childhood
- [ ] Mobility (e.g. frequent moves)
- [ ] Failure to graduate from high school
- [ ] Physical and/or sexual abuse as a child
- [ ] Removal from family by child welfare authorities
- [ ] Unknown
- [ ] No risk factors
- [ ] Other (please specify) ________________________________
24. Which best describes your client’s presenting problem (check as many that apply):

- Mood disorders
- Anxiety disorders
- Personality disorders
- Intrapersonal issues (e.g. Self-esteem, self-confidence, anger, conduct)
- Interpersonal issues / Relationship conflicts
- Vocational issues
- Learning problems
- Cognitive functioning problems of adulthood (other than learning)
- Cognitive functioning problems of childhood (other than learning)
- Psychological and psychosocial problems of childhood
- Psychosis
- Managing health, injury, and illness
- Adjustment to life stressors (work problem, marital problem, bereavement)
- Eating disorders
- Sleep disorders
- Somatoform disorders (e.g., chronic pain)
- Sexual abuse and trauma
- Sexual disorders
- Substance use and/or abuse disorders
- Other (please specify)__________________________

25. Please rate the extent to which you believe, prior to starting treatment with you, the client’s daily functioning was negatively affected by his or her presenting problem(s):

- None
- Little
- Moderately
- Severely
- Unknown
26. Thus far in your services to this client how much change is there in his or her presenting problem(s)?

□ Recovered
□ Greatly improved
□ Improved
□ No change
□ Deterioration

27. Does the client report problems related to a chronic disease, disorder or condition? (check all that apply)

□ Neurological functions
□ Mental functions
□ Gross and fine motor functions
□ Visual functions
□ Auditory functions
□ Speech and language functions
□ Gastrointestinal functions
□ Endocrinological functions
□ Cardiological functions
□ Respiratory functions
□ Immunological functions
□ Other (please specify) __________________________________________
□ Unknown
□ No Chronic Disorder

28. Please rate the extent to which you believe the client’s daily functioning is restricted by his or her chronic disease(s), disorder(s) or conditions:

□ None
□ Little
□ Moderate
□ Severe
□ Unknown
29. Client’s appraisal of own health status (if the client is under 14, please enter the caregiver’s appraisal of health status):

- [ ] Excellent
- [ ] Very Good
- [ ] Good
- [ ] Fair
- [ ] Poor
- [ ] Unknown

30.1 Does your client have any DSM-IV diagnoses?

- [ ] Yes
- [ ] No
- [ ] Diagnostic evaluation not yet completed
- [ ] Unknown

30.2 Enter the names of diagnoses for this client: (Click here for DSM-IV Diagnostic Names)

Primary Diagnosis:__________________________________________

Additional Diagnosis:__________________________________________

Additional Diagnosis:__________________________________________

Additional Diagnosis:__________________________________________

31. Does your client have a substance use problem or disorder which is not the presenting problem but is concomitant with it?

- [ ] Yes
- [ ] No
- [ ] Unknown

32. Is the client receiving psychotropic medication?

- [ ] Yes
- [ ] No
- [ ] Unknown
32.2 If yes, what medication(s)? (check all that apply)

- Antidepressant
- Anxiolytic
- Antipsychotic
- Stimulant
- Hypnotic
- Mood Stabilizer
- Unknown

32.3 If yes, this medication is prescribed to the client by:

- Family physician or general practitioner
- Psychiatrist
- Nurse-practitioner
- Other health specialist

33. Does your client take medication for a health problem which is related to the presenting problem? (e.g., seeing you for help in managing chronic pain and patient takes pain medication)

- Yes
- No
- Unknown

34. Does your client take medication for another health problem unrelated to the presenting problem? (e.g., seeing you for depression and takes antihypertensive medication)

- Yes
- No
- Unknown