stepworks
recovery centers

Discharge Survey

Discharge date (month/year): _____

Programs completed (check all that apply):

Detox Residential IOP Partial Hospitalization Individual Therapy Aftercare

Please rate your satisfaction with the services provided to you:

(1=Strongly Disagree 2=Disagree 3=Agree 4=Strongly Agree)

I was satisfied with the admission process.	1 2 3 4
I was informed of costs and payment schedules at the time of admission.	1 2 3 4
I had an active part in developing my treatment plan.	1 2 3 4
I have a better understanding of the recovery process.	1 2 3 4
I made progress toward reaching my treatment goals.	1 2 3 4
I was satisfied with the materials presented by the clinical staff.	1 2 3 4
The therapists who treated me were skilled and knowledgeable.	1 2 3 4
The administrative staff members were professional and courteous.	1 2 3 4
I would recommend Stepworks to other people for treatment.	1 2 3 4

Please write any comments in the box below:

May we contact you at periodic times during the next year to see how you are doing? Yes / No
If yes, we will contact you 30, 90, 180, and 365 days after leaving Stepworks.

If yes, please PRINT your name and email address. (If you don't have an email address, we are happy to help you create one.)

Name: _____

Email: _____