

**THE CENTER FOR HEALTHY DEVELOPMENT (CHD)**  
**Parent Survey – End of Program**

*Dear Parents: The Center for Healthy Development needs your help to ensure that the best possible services are provided. Your responses to this survey will be confidential.*

**CASE #** \_\_\_\_\_ **FCS #** \_\_\_\_\_

**1. Which of the Center for Healthy Development’s services did you participate in?**

- |                                                      |                                                                |
|------------------------------------------------------|----------------------------------------------------------------|
| <input type="checkbox"/> Parents in Conflict Program | <input type="checkbox"/> Co/Parallel Parent Counseling         |
| <input type="checkbox"/> Safe Families               | <input type="checkbox"/> Therapeutic and Supportive Visitation |
| <input type="checkbox"/> Counseling Services         |                                                                |

**2. Please rate how strongly you agree or disagree with each of the following statements.**

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	N/A
I have very few disputes with the other parent.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Our conflict is harmful to our children.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Our family can learn new skills and choices.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am concerned that our children are not safe.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Both parents want to reduce conflict.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Our family situation is not stable for the children.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am concerned about my child’s behavior.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My child is doing well in school / day care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staff of this program were respectful of my family’s culture.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
This program has helped me learn how to deal with conflicts within my family.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
This program has taught me new parenting skills.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I plan to use some of the things I have learned from this program in my own life.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have learned about services and resources that can help me and my family.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Overall, I am satisfied with this program.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**3. Please rate your experiences with each of the following.**

	Poor	Fair	Good	Very Good	Excellent	N/A
Timeliness of CHD staff in answering your calls	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Courtesy shown to you by CHD staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Knowledge and helpfulness of CHD staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**4. IF YOU HAD A COUNSELOR, please rate your experiences with each of the following.**

	Poor	Fair	Good	Very Good	Excellent	N/A
Ease with which you were able to reach a counselor by phone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Convenience of your counselor's location from your home or workplace	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Convenience of your counselor's office hours	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How well your counselor listened to and understood your concerns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Amount of time you had to wait to see a counselor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**5 What is your race / ethnicity? (Please mark one only)**

- |                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>a. American Indian</li> <li>b. Alaska Indian</li> <li>Asian</li> <li>c. Asian Indian</li> <li>d. Chinese</li> <li>e. Filipino</li> <li>f. Japanese</li> <li>g. Korean</li> <li>h. Vietnamese</li> <li>i. Other _____</li> <li><input type="checkbox"/> Hispanic/Latino</li> </ul> | <ul style="list-style-type: none"> <li>Pacific Islander</li> <li><input type="checkbox"/> Native Hawaiian</li> <li><input type="checkbox"/> Samoan</li> <li><input type="checkbox"/> Guamanian or Chamorro</li> <li><input type="checkbox"/> Other Pacific Islander</li> <li><input type="checkbox"/> Black/African-American</li> <li><input type="checkbox"/> White</li> <li><input type="checkbox"/> Multiracial / multiethnic</li> <li><input type="checkbox"/> Unknown / Declined</li> <li><input type="checkbox"/> Other → Specify: _____</li> </ul> |
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**6. What is your gender?**     Male     Female

**7. How many children do you have? #** \_\_\_\_\_

**8. What are their ages? (Please indicate the # of children you have for each age group.)**  
 \_\_\_\_\_ 0 to 2 year olds    \_\_\_\_\_ 3 to 5 year olds    \_\_\_\_\_ 6 to 9 year olds  
 \_\_\_\_\_ 10 to 13 year olds    \_\_\_\_\_ 14 to 18 year olds

**9. Are you the primary caretaker of your children?**     Yes     No     Shared

**10. Are you on speaking terms with the other parent?**     Yes     No

**11. Have you been receiving services from a Family Partner?**     Yes     No

**12. Do you have any recommendations for how we can improve this program?**

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