

Continuing Professional Development Program

Multi Source Feedback: Patient Questionnaire Template



The Royal
Australian &
New Zealand
College of
Psychiatrists



Name of Psychiatrist	
Date of Completion	

The doctor is reliable with appointment times				
Strongly Disagree <input type="checkbox"/>	Disagree <input type="checkbox"/>	Neither agree nor disagree <input type="checkbox"/>	Agree <input type="checkbox"/>	Strongly Agree <input type="checkbox"/>

The doctor has professional communication skills				
Strongly Disagree <input type="checkbox"/>	Disagree <input type="checkbox"/>	Neither agree nor disagree <input type="checkbox"/>	Agree <input type="checkbox"/>	Strongly Agree <input type="checkbox"/>

The doctor makes eye contact and uses appropriate body language				
Strongly Disagree <input type="checkbox"/>	Disagree <input type="checkbox"/>	Neither agree nor disagree <input type="checkbox"/>	Agree <input type="checkbox"/>	Strongly Agree <input type="checkbox"/>

The doctor listens attentively				
Strongly Disagree <input type="checkbox"/>	Disagree <input type="checkbox"/>	Neither agree nor disagree <input type="checkbox"/>	Agree <input type="checkbox"/>	Strongly Agree <input type="checkbox"/>

The doctor explains things in a manner which I am able to understand clearly				
Strongly Disagree <input type="checkbox"/>	Disagree <input type="checkbox"/>	Neither agree nor disagree <input type="checkbox"/>	Agree <input type="checkbox"/>	Strongly Agree <input type="checkbox"/>

The doctor respects my privacy and does not act improperly towards me				
Strongly Disagree <input type="checkbox"/>	Disagree <input type="checkbox"/>	Neither agree nor disagree <input type="checkbox"/>	Agree <input type="checkbox"/>	Strongly Agree <input type="checkbox"/>

The doctor explains the procedures and follow up for my treatment				
Strongly Disagree <input type="checkbox"/>	Disagree <input type="checkbox"/>	Neither agree nor disagree <input type="checkbox"/>	Agree <input type="checkbox"/>	Strongly Agree <input type="checkbox"/>

The doctor reviews the effectiveness of my treatment regularly with me

Strongly Disagree <input type="checkbox"/>	Disagree <input type="checkbox"/>	Neither agree nor disagree <input type="checkbox"/>	Agree <input type="checkbox"/>	Strongly Agree <input type="checkbox"/>
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The doctor explains any side effects of my medication to me

Strongly Disagree <input type="checkbox"/>	Disagree <input type="checkbox"/>	Neither agree nor disagree <input type="checkbox"/>	Agree <input type="checkbox"/>	Strongly Agree <input type="checkbox"/>
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The doctor shows concerns regarding my ongoing care

Strongly Disagree <input type="checkbox"/>	Disagree <input type="checkbox"/>	Neither agree nor disagree <input type="checkbox"/>	Agree <input type="checkbox"/>	Strongly Agree <input type="checkbox"/>
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I feel comfortable to contact this doctor if I require additional assistance

Strongly Disagree <input type="checkbox"/>	Disagree <input type="checkbox"/>	Neither agree nor disagree <input type="checkbox"/>	Agree <input type="checkbox"/>	Strongly Agree <input type="checkbox"/>
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The doctor explains to me what is discussed with my family or carer

Strongly Disagree <input type="checkbox"/>	Disagree <input type="checkbox"/>	Neither agree nor disagree <input type="checkbox"/>	Agree <input type="checkbox"/>	Strongly Agree <input type="checkbox"/>
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I feel the doctor understands me

Strongly Disagree <input type="checkbox"/>	Disagree <input type="checkbox"/>	Neither agree nor disagree <input type="checkbox"/>	Agree <input type="checkbox"/>	Strongly Agree <input type="checkbox"/>
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I feel the doctor works in my best interests

Strongly Disagree <input type="checkbox"/>	Disagree <input type="checkbox"/>	Neither agree nor disagree <input type="checkbox"/>	Agree <input type="checkbox"/>	Strongly Agree <input type="checkbox"/>
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Additional Comments

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