



# Somerset and Wessex Eating Disorders Association

## Service Questionnaire

As a charity SWEDA is reliant on fundraising to support its activities. Increasingly funding organisations are requiring more statistical information from us about the usage of our services. Please help us by filling out this questionnaire.

All the information you provide will be kept **strictly anonymous**.

### 1. About SWEDA Services you have used

How long have you been using SWEDA Services?

Under 6 months <input type="checkbox"/>	7 – 12 month <input type="checkbox"/>	1 -2 years <input type="checkbox"/>	2 – 5 years <input type="checkbox"/>	5 years + <input type="checkbox"/>
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Please tick the following services you have used

#### Frontline Services

Helpline <input type="checkbox"/>	Email <input type="checkbox"/>	Letter <input type="checkbox"/>	Website <input type="checkbox"/>	Messenger <input type="checkbox"/>
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#### Support Services

Counselling <input type="checkbox"/>	Life Skills <input type="checkbox"/>	Support Group <input type="checkbox"/>	Community Support <input type="checkbox"/>	Energise <input type="checkbox"/>	Penpals <input type="checkbox"/>
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If and when you contact SWEDA which method do you prefer to use?

Telephone <input type="checkbox"/>	Email <input type="checkbox"/>	In person <input type="checkbox"/>	Letter <input type="checkbox"/>
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Are there services that you would have liked but couldn't get from SWEDA? Yes  No

*If you answered Yes, please let us know what other services you would have liked.*

### 2. How would you rate your contact with SWEDA?

Very unhelpful  ————— Unhelpful  ————— Satisfactory  ————— Helpful  ————— Very Helpful

Is there anything that you think SWEDA could do better? Yes  No

*If you answered Yes, please let us know how we could improve things.*

### 3. In what ways has SWEDA helped/not helped you get better?

	<u>Much worse</u>	<u>Worse</u>	<u>No improvement</u>	<u>Improvements</u>	<u>Big improvement</u>
Knowledge of Eating Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insight into eating disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating Disorder Symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Underlying Issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emotional Wellbeing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-Esteem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Confidence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Healthy Eating Patterns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quality Of Life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**4. Are there issues that you feel remain unresolved despite your contact with SWEDA? Yes  No**

*If you answers Yes, Please explain what difficulties remain.*

**5. Has your contact with SWEDA Ended? Yes  No**  *(if Yes, please indicate the reasons below)*

- You felt better and no longer needed support.
- Contact with SWEDA wasn't helping you.
- You didn't get on with the person(s) supporting you.
- A service has altered or ended.
- You left the area or went to university
- You went, or were signposted, to a more appropriate service
- Other\*

\*Please Specify

**6. Would you recommend SWEDA to other people?**

Definitely Not  ————— Probably Not  ————— Neutral  ————— Yes  ————— Recommend Highly

**7. About you**

*(Please tick relevant boxes below)*

Are you? Male  Female  A sufferer?  A Carer  A Professional?

Which of the follow age groups do you fit?

13 yrs or under <input type="checkbox"/>	14-19 yrs old <input type="checkbox"/>	20-30 yrs old <input type="checkbox"/>	31-65 yrs old <input type="checkbox"/>	65+ yrs old <input type="checkbox"/>
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Are you registered disabled? Yes  No

Where do you live? *(First 3 or 4 digits of your postcode)* \_\_\_\_\_

How did you first hear about SWEDA?

Leaflet <input type="checkbox"/>	Website <input type="checkbox"/>	GP <input type="checkbox"/>	Friend <input type="checkbox"/>	Other* <input type="checkbox"/>	*Please State: _____
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**Please add any other comments you would like to make about any aspect of your involvement with SWEDA**

*If you are **not** happy for SWEDA to use your additional comments please tick this box*