

5	Please decide how strongly you agree or disagree with the following statements by ticking <u>one</u> box in each line.					
	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Does not apply
a	This doctor will keep information about me confidential	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b	This doctor is honest and trustworthy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	I am confident about this doctor's ability to provide care			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
7	I would be completely happy to see this doctor again			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
8	Was this visit with your usual doctor?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
9	Please add any other comments you want to make about this doctor. Please note: No patients will be identified when this information is given to the doctor.					

The next questions will provide the doctor with some basic information about who took part in the survey. If you are filling this in on behalf of a child or a patient with a disability, please provide details about the patient.

10	Are you:	<input type="checkbox"/> Female	<input type="checkbox"/> Male			
11	Age:	<input type="checkbox"/> Under 15	<input type="checkbox"/> 15–20	<input type="checkbox"/> 21–40	<input type="checkbox"/> 40–60	<input type="checkbox"/> 60 or over
12	What is your ethnic group? Please choose one section from A to E, and then tick the appropriate box to indicate your cultural background.					
A White	B Mixed	C Asian or Asian British	D Black or Black British	E Chinese or other ethnic group		
<input type="checkbox"/> British	<input type="checkbox"/> White and Black Caribbean	<input type="checkbox"/> Indian	<input type="checkbox"/> Caribbean	<input type="checkbox"/> Chinese		
<input type="checkbox"/> Irish	<input type="checkbox"/> White and Black African	<input type="checkbox"/> Pakistani	<input type="checkbox"/> African	<input type="checkbox"/> Any other		
<input type="checkbox"/> Any other white background	<input type="checkbox"/> White and Asian	<input type="checkbox"/> Bangladeshi	<input type="checkbox"/> Any other Black background			
	<input type="checkbox"/> Any other Mixed background	<input type="checkbox"/> Any other Asian background				
Please write in	Please write in	Please write in	Please write in	Please write in		
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		