Client Evaluation of Service

**Would you say that your therapy has helped:** *Please Tick*

Not at all: \_\_\_\_\_\_\_\_\_\_\_\_ A little bit: \_\_\_\_\_\_\_\_\_\_ moderately: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Quite a bit: \_\_\_\_\_\_\_\_\_\_\_\_\_ Extremely: \_\_\_\_\_\_\_\_\_\_\_\_

**Could you please describe what you feel has been positive about your therapy? This might be an outcome, insight or experience.**

**How helpful do you feel the experience, outcome or insight will be to you in the future. (Tick one)**

Slightly helpful: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Moderately helpful: \_\_\_\_\_\_\_\_\_\_

Extremely helpful: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Looking back over your therapy, do you feel that there is anything which remains unresolved or that you still feel uncomfortable about? (Tick one)**

Yes : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No: \_\_\_\_\_\_\_\_\_\_

If yes, please tick how hindering you feel this may be in the future (Tick one)

Slightly hindering: \_\_\_\_\_\_\_\_\_\_ Moderately hindering: \_\_\_\_\_\_\_\_\_\_\_ Extremely hindering: \_\_\_\_\_\_\_\_\_\_

**Have you any additional comments you wish o make about the service you have received?**

**On the basis of your experience, would you recommend this service to a friend? (Tick one)**

NO: definitely not: \_\_\_\_\_\_\_ YES: I think so: \_\_\_\_\_\_\_\_\_

NO:I don’t think so: \_\_\_\_\_\_\_ YES: definitely: \_\_\_\_\_\_\_\_\_

**Overall, how satisfied are you with the service you have received? (Tick one)**

Very satisfied: \_\_\_\_\_\_\_ Dissatisfied: \_\_\_\_\_\_\_\_\_ Satisfied: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Very dissatisfied: \_\_\_\_\_\_\_\_ Mixed feelings: \_\_\_\_\_\_\_\_\_\_\_

**Thank you!**

**Your feedback will help us improve our service for others!**