

Client Ref No:

Counsellor:

Date:

Client Experience Evaluation

Please help us improve the Simeon Centre by answering these questions about the therapeutic service you have received. We welcome all comments and suggestions and appreciate your contribution in helping us continually develop effective services to meet the needs of the community.

Please circle or underline **one** answer per question.

1. How satisfied were you with the wait for your first appointment?

Very Dissatisfied Dissatisfied Unsure Satisfied Very Satisfied

2. How satisfied were you with the choice of therapies available to you?

Very Dissatisfied Dissatisfied Unsure Satisfied Very Satisfied

3. How satisfied were you with the counselling you received?

Very Dissatisfied Dissatisfied Unsure Satisfied Very Satisfied

4. How satisfied were you with the counsellor/therapist you worked with?

Very Dissatisfied Dissatisfied Unsure Satisfied Very Satisfied

5. How satisfied were you with the total amount of time allocated to you?

Very Dissatisfied Dissatisfied Unsure Satisfied Very Satisfied

6. How satisfied were you with the accommodation/venue where your counselling took place?

Very Dissatisfied Dissatisfied Unsure Satisfied Very Satisfied

7. How satisfied were you with the administration staff supporting this service?

Very Dissatisfied Dissatisfied Unsure Satisfied Very Satisfied

8. Overall, how satisfied were you with the Simeon Centre's service?

Very Dissatisfied Dissatisfied Unsure Satisfied Very Satisfied

9. Were you provided with information about any alternative forms of therapy available to you – before, during or after your therapy sessions?

Yes No

10. Were you offered a choice of counsellor/therapist? (e.g. gender)

Yes No

11. Would you consider counselling/psychotherapy in the future?

Yes No

12. What has changed for you as a result of your counselling session?

(please tick all that apply)

- | | |
|---|---|
| <input type="checkbox"/> I am able to cope with day to day living | <input type="checkbox"/> Nothing has changed |
| <input type="checkbox"/> I feel more confident | <input type="checkbox"/> Things seem to be worse for me now |
| <input type="checkbox"/> I'm less anxious / worried | <input type="checkbox"/> I'm returning to work / returned to work |
| <input type="checkbox"/> I'm more optimistic about the future | <input type="checkbox"/> I can accept the way I am / who I am |
| <input type="checkbox"/> I no longer need medication / less dependant on medication | |
| <input type="checkbox"/> Other changes not mentioned above (please state) | |

13. Think back to the time when you FIRST MET YOUR COUNSELLOR. Please circle a number that represents how you felt at the time (0 = worst you could possibly feel, 10 = best you could possibly feel).

0 1 2 3 4 5 6 7 8 9 10

14. Now circle a number representing how you feel NOW YOUR COUNSELLING HAS FINISHED.

0 1 2 3 4 5 6 7 8 9 10

15. Please use the space below to provide additional comments including anything you think would improve this service for yourself and others.