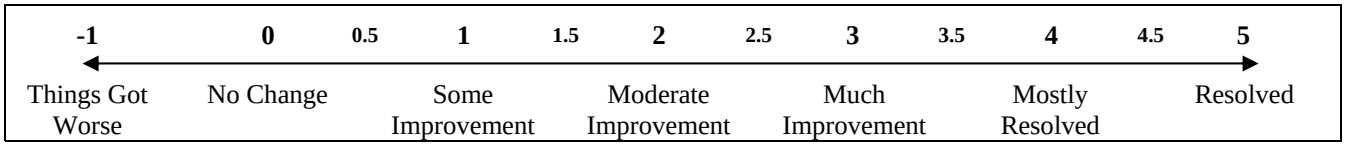
Identifier: _____ Gender: M F (circle one) Age: _____ Today's Date: _____
(Case ID or Date/Time of Last Session or Name)

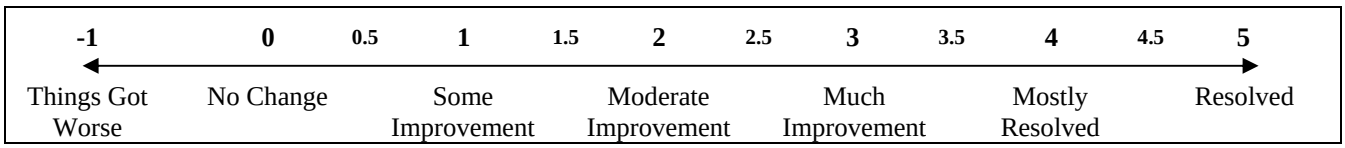
Symptom Follow-up and Client Satisfaction Survey

Thank-you for providing your feedback about the services you are receiving. Your responses will provide important information on how services can be improved in the future. As with all client information, your responses will be kept strictly confidential. Your survey will be identified based on your case number at the top of the page. After completing the survey, please return it to the address at the bottom of the page or return it by confidential fax to (403) 255-8570.

PART ONE. Think of the concerns you had when you first came to counselling. In the box below, please <u>circle the number</u> that best reflects how far you feel you *<u>have</u>*** come in resolving those concerns.**



In the next box, please <u>circle the number</u> that indicates how far you *<u>expected to have come</u>*** by now.**



PART TWO. Symptom Checklist Follow-Up

Please rate how much you have experienced each symptom over the ***past week*** (circle the number). Note: the first six symptoms (a-g) relate specifically to your relationship with your spouse or partner – if you are single, use the "0" rating. distant

	None or N/A	A Little	Moderate	A Lot	Extreme
a. Not talking to each other	0	1	2	3	4
b. Having bad arguments	0	1	2	3	4
c. Lack of trust between us	0	1	2	3	4
d. Feeling lonely in the relationship	0	1	2	3	4
e. Lack of affection and caring between us	0	1	2	3	4
f. Feeling unhappy about our relationship overall	0	1	2	3	4
g. Feeling sad, down or depressed	0	1	2	3	4
h. Avoiding certain people or places	0	1	2	3	4
i. Loss of interest in activities I normally enjoy	0	1	2	3	4
j. Low energy/feeling tired	0	1	2	3	4
k. Sleep problems (insomnia, not staying asleep, or early waking)	0	1	2	3	4
l. Eating too much or too little	0	1	2	3	4
m Not able to think clearly	0	1	2	3	4
n. Feeling no pleasure or joy in life	0	1	2	3	4
o. Anxiety attacks	0	1	2	3	4
p. Worrying about things	0	1	2	3	4
q. Angry outbursts	0	1	2	3	4
r. Low self-esteem or low self-confidence	0	1	2	3	4
s. Feeling guilty	0	1	2	3	4
t. Feeling too stressed	0	1	2	3	4
u. Thoughts of suicide	0	1	2	3	4
v. Drinking too much or abusing drugs (i.e. street drugs or prescribed medications)	0	1	2	3	4
w Acting out other compulsive behaviors (i.e. gambling, sex, porn, shopping, etc.)	0	1	2	3	4
x. Not getting my work done	0	1	2	3	4
y. Feeling unhappy with my workplace	0	1	2	3	4
				Symptoms Total:	**/ 100**

Over ➔

Please return by mail to 200C Haddon Road SW, Calgary, AB, T2V 2Y6 or by fax to (403) 255-8570
You can also complete this survey online if you prefer at www.nathancobb.com/clientsatisfactionsurvey.html

PART THREE. Client Satisfaction Survey

For each statement, please circle the number that indicates how much you agree or disagree with that statement.

	Strongly Disagree				Strongly Agree
1. I feel supported and understood by the therapist.	1	2	3	4	5
2. The therapist's approach or style is a good fit for me.	1	2	3	4	5
3. Things I am learning in counseling are helping me to make positive changes.	1	2	3	4	5
4. I have gained some new insights that have changed my views on my situation for the better.	1	2	3	4	5
5. I am trying out new patterns of behavior that are helping me.	1	2	3	4	5
6. In our sessions we are covering what is important to me.	1	2	3	4	5
7. I (or we) have clear goals for what I (or we) want to accomplish in counselling.	1	2	3	4	5
8. I/we are making progress toward reaching those goals.	1	2	3	4	5
9. Counselling is helping me improve the quality of my life. (For couples or family therapy, answer this statement instead): Counselling is helping us improve the quality of our lives *together*.	1	2	3	4	5
10. Overall, therapy has been very helpful so far.	1	2	3	4	5
TOTAL SCORE					

11. Please use this space to provide additional comments on any of your ratings above, particularly any ratings that may be low. For each comment, please mark the item number to which it corresponds.

Item # ___

Item # ___

12. So far, what has been most helpful or what have you liked the most about the counselling services you are receiving?

13. Is there anything that would make the process more helpful or useful to you?

15. Please add any other comments you wish to make in the space below.