

Patient ID:	Date:	Session No:	Therapist ID:
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TO BE USED AT LAST SESSION ONLY

Please help us to improve our service by answering some questions about the service you have so far received. We are interested in your honest opinions, whether they are positive or negative.

Please answer all of the questions. We also welcome your comments and suggestions.

1. Did staff listen to you and treat your concerns seriously?
2. Do you feel that the service has helped you to better understand and address your difficulties?
3. Did you feel involved in making choices about your treatment and care?
4. On reflection, did you get the help that mattered to you?
5. Did you have confidence in your therapist and his/her skills and techniques?
Please use this space to tell us about your experience of our service