

Patient ID:	Date:	Session No:	Therapist ID:
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TO BE USED AT FIRST 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.

CHOICE
1. Were you given information about options for choosing a treatment that is appropriate for your problems?
2. Do you have a preference for any of the treatments among the options available?
3. Have you been offered your preference?

SATISFACTION
4. How satisfied were you with your assessment?
Please use this space to tell us about your experience of our service