

# Clinical Outcomes Questionnaire

Name *\*(Optional)\**: \_\_\_\_\_

Therapist: \_\_\_\_\_ Date: \_\_\_\_\_

No. of sessions attended: \_\_\_\_ Purpose of counseling (eg: depression, anxiety): \_\_\_\_\_

Type(s) of counseling: \_\_ Individual, \_\_ Group, \_\_ Family, \_\_ Marriage, Other \_\_\_\_\_

*Please circle the response under each statement which most closely indicated your level of agreement or disagreement:*

<b>Highly Disagree</b>	<b>Moderately Disagree</b>	<b>Slightly Disagree</b>	<b>Neutral</b>	<b>Slightly Agree</b>	<b>Moderately Agree</b>	<b>Highly Agree</b>
<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>

“I was given choices about my treatment.”

1	2	3	4	5	6	7
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“The therapist explained the benefits and risks of therapy to me.”

1	2	3	4	5	6	7
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“I was treated with respect and dignity by the therapist.”

1	2	3	4	5	6	7
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“The therapist listened to my concerns.”

1	2	3	4	5	6	7
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“The treatment plan was clearly explained to me.”

1	2	3	4	5	6	7
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“Services were performed in a time-efficient manner.”

1	2	3	4	5	6	7
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“The clinic’s policies were clearly explained to me.”

1	2	3	4	5	6	7
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“The counseling was directed toward helping my problem areas.”

1	2	3	4	5	6	7
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“I was satisfied with the counseling I received.”

1	2	3	4	5	6	7
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“The services I received were helpful.”

1	2	3	4	5	6	7
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“I would return to the therapist for services in the future if needed.”

1	2	3	4	5	6	7
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Comments: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Client Satisfaction Survey

*In order to help us provide quality services to our clients, we regularly conduct the Client Satisfaction Survey. The information is used to increase our strengths and learn what needs improvement. Your cooperation is extremely helpful and appreciated. You do not have to identify yourself.*

Name *\*(Optional)\**: \_\_\_\_\_

### Primary type of services received:

*\*(check one only)*

Marriage/Family     Adult Mental Health     Child/Adolescent     Substance Abuse  
 Other (describe) \_\_\_\_\_

### Circle the most fitting response on a 1-5 scale:

*Implications of Response:*

*“1” is very positive, “2” is positive, “3” is neutral, “4” is negative, “5” is very negative.*

1. “I feel satisfied with the services I received” .....(Agree) 1 2 3 4 5 (Disagree)
2. “If later, there is a need, I would re-enter treatment” .....(Agree) 1 2 3 4 5 (Disagree)
3. “I have experienced a reduction in the problems that I was experiencing before treatment” .....(Agree) 1 2 3 4 5 (Disagree)
4. “The office location was convenient to me” .....(Agree) 1 2 3 4 5 (Disagree)
5. “The office staff was helpful” .....(Agree) 1 2 3 4 5 (Disagree)
6. The therapist(s) addressed issues related to my problems” .....(Agree) 1 2 3 4 5 (Disagree)
7. Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**STAFF USE:** Date information received \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_