The Center *for* Loss and Bereavement

Follow Up Client Survey Date_____

In order to assess the benefit of our services and programs here at the **The Center for Loss and Bereavement** we are hoping that you would be willing to take a few moments to fill out the questions below concerning our counseling services. This information will be used to help us improve and strengthen our clinical counseling program. No identifying information about you or your situation is necessary, though you are welcome to share anything personal that you wish. We appreciate hearing any thoughts you have about your experience at the Center.

Please circle 1 (strongly disagree) to 5 (strongly agree) regarding your feelings for each statement below. Please use 3 to indicate a neutral opinion.

1. The counseling program was beneficial for me/my family.	1 2 3 4 5
2. I feel my counselor was professional and conscientious of my needs.	1 2 3 4 5
3. I felt heard, understood, and respected by my therapist.	1 2 3 4 5
4. My time in therapy was spent working on what I wanted to work on and talk about.	1 2 3 4 5
5. My therapist's approach was a good fit for me/my family and I would return if ever a need presented.	1 2 3 4 5
6. I feel that my counselor was competent in the knowledge and understanding of my grief process and needs.	1 2 3 4 5
7. I gained insight about my grief process through the counseling at the Center.	1 2 3 4 5
8. I feel that the facility, offices, and scheduling process are professionally managed and easily accessible.	1 2 3 4 5
9. I would recommend the Center to others.	1 2 3 4 5
10. I would recommend my therapist to others.	1 2 3 4 5

Name (optional): _____ Therapist:_____

(*over*)

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I have not returned to the Center because: *(Please check all that apply)*

__ I am coping without the need for therapy currently.

__ I have transitioned to peer-level support groups rather than individual therapy needs.

__ I had difficulty making appointments due to my schedule or transportation difficulties.

__ I have moved from the area.

__ I am receiving services elsewhere. (*Circle*: referred by therapist / self-elected change)

__ I had difficulty with the cost of sessions.

__ I was dissatisfied with the service at the Center.

__ Other (please use comments section below).

Comments: *We welcome all thoughts and constructive feedback.*

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If you give us permission to use this feedback in any of our Center literature or on our website, please sign below, and indicate if you would prefer to be anonymous or named:

☐ You may reprint my comments. ☐ Anonymous ☐ Named

Signature: _____ Date: _____

☐ I would be interested in being highlighted to tell my story as a client of the Center.
(The Clinical Director will follow up with you about this if you are interested.)

☐ I do NOT want any of my comments reprinted.

If you would benefit from a call from the Clinical or Executive Director regarding any of your feedback, comments, or concerns, please let us know.

Name: _____ Phone:_____

☐ I would like to speak with the Clinical Director (oversees all therapist and counseling services).

☐ I would like to speak with the Executive Director (oversees all Center programs and staff).

Your feedback is very important to us. Thank you!