

WEXFORD RAPE CRISIS - CLIENT SATISFACTION QUESTIONNAIRE

CLIENT NAME

(Optional)

COUNSELLOR NAME

LOCATION/TOWN:

COUNSELLING DAY & TIME:

DATE:

PLEASE RATE US ON THE FOLLOWING:

YOUR FIRST CONTACT WITH US/INTAKE/ASSESSMENT MEETING:

Excellent

Good

Fair

Poor

Very Poor

Comments:

YOUR COUNSELLOR'S UNDERSTANDING OF THE ISSUES YOU WERE DEALING WITH :

Excellent

Good

Fair

Poor

Very Poor

Comments:

HAS THE COUNSELLING YOU'VE RECEIVED HERE HELPED YOU?

Yes

No

If Yes, can you tell us how?

If No, can you tell us why?

IS THERE ANYTHING YOU WOULD LIKE TO SHARE WITH US ON HOW THE SERVICE COULD BE IMPROVED?

FINALLY, HAVE YOU ANY OTHER COMMENTS?

MANY THANKS FOR YOUR FEEDBACK