

"THE TALK-IN CLINIC" CLIENT EVALUATION
Your feedback is very important to us. Please take a few minutes to complete this Evaluation.

Today's Date: ___/___/___
 YR MO DY

Date attended Clinic: ___/___/___
 YR MO DY

Please indicate if you are: Parent/Guardian Child over 12

1. Did the session assist you in dealing with the problem(s) you brought to the Clinic?

Not at all A little Somewhat Mostly Very much

2. Did the session help you to develop a plan to address the problem(s)?

Not at all A little Somewhat Mostly Very much

3. Do you believe that you are able to carry out the plan?

Not at all A little Somewhat Mostly Very much

4. Was the session helpful in any other way? YES NO
If yes, in what ways?

5. Was the service disappointing in any way? YES NO
If yes, in what way?

6. Have you sought or will you be seeking further service for the difficulties that brought you to Talk-In? YES NO

7. If yes, will you come back to Talk-In? YES NO

8. Do you have any suggestions that would help us to improve the Talk-In Clinic?

9. I would recommend the Talk-In service to a friend or relative

Definitely Mostly Somewhat Not Really Definitely Not

10. In general, my contacts with the Talk-In staff were respectful and courteous.

Definitely Mostly Somewhat Not Really Definitely Not

11. I feel that my own and/or my family's individuality (e.g. culture, beliefs, feelings, etc.) were recognized and respected during my involvement at the Talk-In.

Definitely Mostly Somewhat Not Really Definitely Not

Thank you for your feedback!!