Date of last session: Month recorded:	Phone #:	Date/Time called:	
, HELLO,			
of our program. We would	l like to ask you to take a opinions are important to	re continually interested in evaluating the diff couple of minutes to evaluate the counseling FCS and can help us identify potential difficatial.	g you have
Counselor: 1 Were you satisfied with the	Number of Number of the overall appearance of the	sessions:No	٠
2. Were you treated with re			
3. Did your counselor seem	concerned about you and	d your problems?No	
4. Overall, how did you/do y	you feel about your counsiled		*
6. Overall do you feel you be	enefited from your counse		
7. If client attended only 1 se	ession ask: Was there a sp	pecific reason why you only attended 1 session	<u>n</u> ?
8. Was there anything you pa	articularly liked/disliked a	bout your counseling experience?	
8. While you were in treatment Yes		attempts by anyone in your party receiving tr	eatment?
Yes N	IO ind out who, their age and	any suicide attempts by anyone involved in tre	eatment?
	reatment were any new is	ncidents of child abuse reported to DCFS or t	to the
10. Since you final counseling police?Yes		cidents of child abuse be reported to DCFS or	r to the
11. While you were in treatme	ent were any new incident	ts of domestic violence τεροτted to the police	?
12. Since your last treatment spolice?Yes	-	dents of domestic violence been reported to t	<u>h</u> e
13. Do you have any suggestion	ons on how we can impro	ve the counseling experience for clients?	