



KRISTINA KOSMAC

**STICKSNSTONES**

**Counseling Evaluation Form**

*Please complete and return via email*

Please use the following scale to rate each statement according to how it best describes what you believe. Write the number in the box to the right.

Never Sometimes Always  
 1      2      3      4      5      6      7      8      9      10

Feel free to make comments on the bottom of this form. Thank you.

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

Client Name (optional): \_\_\_\_\_

1. My therapist me to go at their own pace	
2. I found the office atmosphere pleasant and comfortable.	
3. I practiced the skills between sessions, and I found these useful	
4. I reached many of the goals.	
5. I felt like our confidentiality was respected	
6. I felt comfortable enough to question, clarify, and disagree with my therapist when appropriate.	
	

1. I felt safe with my therapist	
2. My therapist and I worked well together.	
3. My therapist respected me.	
4. My therapist understood me and our problem(s).	
5. My therapist helped me explore our options and solutions.	
6. My therapist supported me to support my child	
7. My therapist gave us new information and taught me new skills related to my goals.	
8. My therapist provided me with various ways to express myself i.e.: art, music etc.	

Comments: