KRISTINA KOSMAC
STICKSNSTONES

Counseling Evaluation Form Parent/Carer

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 allowed my child to go at their own pace	
2. I was able to make appointments at a time that worked for me.	
3. I found the office that my child used atmosphere pleasant and comfortable.	
4. My child practiced the skills between sessions, and I found these useful	
5. My child reached many of the goals.	
6. I felt like our confidentiality was respected	
7. I felt comfortable enough to question, clarify, and disagree with my child's therapist when appropriate.	
	

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

Comments: