Client Name:__________________________

Today's Date:_________________________

Living Well Christian Family Clinic, LLC

Prior to each therapy session, please take a few moments to fill out a survey updating your provider on your progress and satisfaction with the services you are receiving. This helps us to more effectively serve you.

UPDATES SINCE LAST SESSION:

Is the problem/issue you sought counseling for:
1 2 3 4 5 6 7 8 9 10
Worse Stable Improved

If you were given homework or recommendations, did you attempt the homework? Yes No

How helpful was the homework? N/A
1 2 3 4 5 6 7 8 9 10
Very unhelpful Neutral Very Helpful

Have you had any change in stressors (life events) since you were last seen? Please describe.
____
____
____
____

Have you had any medication changes since you were last seen? Please list. Yes No
____
____

Have you had any thoughts of suicide since your last session? Yes No

Have you had any incidents of self-injurious behavior since your last session? Yes No

Have you had any thoughts of harming others since your last session? Yes No

CURRENT LEVEL OF FUNCTIONING/TODAY'S FOCUS:

What is your present level of distress?
1 2 3 4 5 6 7 8 9 10
None Little Moderate Significant Severe

What would you like to focus on in today's session? Do you have any new goals for therapy?
____
____
____
____

THERAPEUTIC RELATIONSHIP:

How comfortable are you with your therapist/counselor?
1 2 3 4 5 6 7 8 9 10
Very Uncomfortable Neutral Very comfortable

Are you satisfied with the degree that faith/biblical principles are part of therapy/counseling? N/A
1 2 3 4 5 6 7 8 9 10
Very Unsatisfied Neutral Very Satisfied

Are there any changes you would recommend your therapist/counselor make in order to better meet your needs?
____
____
____
____

How close do you feel you are to completing your therapy/counseling?
1 2 3 4 5 6 7 8 9 10
Not at all Completed

Client Signature: _________________________________