**Counselling Feedback Form**

**It’s helpful to know if your life has changed or improved since you started counselling.**

When you started counselling, which of the following do you think applied to you? (Yes/No)

Then please rate on a scale of 0-5 how much these have improved, 0 = not at all, 5= much improved.

Yes/No 0-5

Low Mood/Depression…................................................................................................

Self-Esteem/Self-Worth issues........................................................................................

Confidence issues...........................................................................................................

Anxiety........................................................................................................................….

Stress.......................................................................................................................……

Relationship difficulties...........................................................................................…….

Communication Issues...........................................................................................…….

Isolation......................................................................................................................….

Mood changes/swings...............................................................................................….

Lack of direction.........................................................................................................….

Loss/ Bereavement..........................................................................................................

Self-Harm / Self destructive patterns...........................................................................…

Suicidal thoughts..........................................................................................................…

Loss of energy...............................................................................................................…

Sleep Disturbances........................................................................................................…

Addiction...............................................................................................................................

Life Transitions.............................................................................................................……..

Trauma...............................................................................................................................…

Cultural Difficulties..................................................................................................................

Physical Health Issues..................................................................................................................................…

Work/ Life Issues.................................................................................................................................….

Expressing yourself………………………………………………………………………………….

Understanding yourself……………………………………………………………………………..

**Please give any feedback about the counselling you received**

If you would like to write an anonymous testimonial for my website I would appreciate your comments but please don’t feel any pressure to do so.

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Thank You

Date ................