Therapist ID: __________ Today's Date: __________________ Client ID: __________

CLIENT SATISFACTION QUESTIONNAIRE

Caregiver Version

Please rate the accuracy of these statements by selecting VERY MUCH FALSE (1), MOSTLY TRUE (2), BOTH TRUE AND FALSE (3), MOSTLY TRUE (4), or VERY MUCH TRUE (5) about your child's treatment.

	Very Much False	**Mostly False**	**Both True & False**	**Mostly True**	**Very Much True**
1. The MAIN problems that I wanted my child treated for have improved.	☐	☐	☐	☐	☐
2. OTHER problems that my child had before coming here for therapy have improved.	☐	☐	☐	☐	☐
3. I am happy with my child's progress in therapy.	☐	☐	☐	☐	☐
4. My child's treatment has improved other parts of my life (e.g. family relationships, my own mood).	☐	☐	☐	☐	☐
5. I know what to do if my child's problems get worse or come back.	☐	☐	☐	☐	☐
6. My child's therapist has explained Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) to me.	☐	☐	☐	☐	☐
7. I understand how Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) works.	☐	☐	☐	☐	☐
8. I have felt included in my child's treatment.	☐	☐	☐	☐	☐
9. My child's therapist has listened to my thoughts, worries, and concerns about my child.	☐	☐	☐	☐	☐
10. My child's therapist knows how to help my child.	☐	☐	☐	☐	☐
11. I would recommend this treatment to a friend who had a child in the same situation.	☐	☐	☐	☐	☐
12. Overall, I am happy with my child's treatment.	☐	☐	☐	☐	☐

13. What were the MOST HELPFUL parts of your child's treatment?

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14. What were the LEAST HELPFUL parts of your child's treatment?

____

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15. Do you have any suggestions about improving this treatment? If so, please describe:

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