Therapist Report Form

A. Participant: ______________________________________________________

B. Treating Physician: _________________________________________________
    a. Address: _________________________________________________________
    b. Phone: (    ) _______________ Fax: (    ) __________________

C. Reporting Period: __________________________________________________
    (Indicate month or months client was seen)

D. Treatment issues addressed (as identified in Participation Agreement):
    ________________________________________________________________

E. Provide a brief comment regarding the progress made in treatment (or the lack thereof):
    ________________________________________________________________
    ________________________________________________________________
    ________________________________________________________________
    ________________________________________________________________

F. Frequency of sessions: ___________________(weekly, monthly, quarterly, etc)
    Next scheduled session: ____________________________________________

G. Number of sessions scheduled: ______ Number of sessions attended: ______

H. Reason(s) for missed sessions: _______________________________________

I. Provided copy of Consent Order and/or Participation Agreement?   Y   N

J. Provided copy of Evaluation/Discharge Summary from primary provider?   Y   N

K. AA/NA attendance reported:   Y   N   N/A

L. Any known alcohol or drug use:   Y   N   N/A

M. Compliant with treatment:     Y   N

N. Anticipated date of completion of treatment: ____________________________

_________________________________                ________________________
Signature                                                                                     Date

PLEASE MAIL; DO NOT FAX AS FAXED COPIES WILL NOT BE ACCEPTED.