



Therapy Report – Quarterly

Patient's Name: \_\_\_\_\_ License No(s): \_\_\_\_\_

Therapist's Name: \_\_\_\_\_ License No(s): \_\_\_\_\_

Therapist's Address: \_\_\_\_\_

Therapist's Office Ph. #: \_\_\_\_\_

**Period covered under this report (complete year and check appropriate quarter):**

Year: \_\_\_\_\_ Quarter:  Jan-Mar  Apr-Jun  Jul-Sep  Oct-Dec

*This report must be received from 5 days before until 5 days after the end of the current quarter (e.g., if due 3/31, send between 3/26 and 4/5)*

During this quarter:

No. of therapy sessions scheduled this quarter: \_\_\_\_\_ # attended: \_\_\_\_\_

Dates of treatment this quarter: \_\_\_\_\_

Current diagnosis: \_\_\_\_\_

Any changes in medication noted?  yes  no

If yes, list changes: \_\_\_\_\_

List the treatment goals (also include any changes in recommended frequency of treatment):

Is the patient in compliance with the treatment plans?  yes  no

Please comment in detail on how the patient is doing with regard to relevant issues. Include at least the following: recognition and insight into problems, interaction during sessions, ability to solve problems, and compliance with recommendations.

Describe your assessment of the patient's progress in treatment since the last report:

Much improved  Somewhat Improved  Same  Somewhat worse  Much worse

To your knowledge, is the patient currently practicing in their capacity as a mental health provider?  yes  no

In your opinion, is the patient safe to practice in their capacity as a mental health provider?  yes  no

\_\_\_\_\_  
 Signature of Therapist

\_\_\_\_\_  
 Date