Virginia Department of Health Professions
Board of Psychology

Compliance Monitoring
Boards of Counseling, Psychology, and Social Work
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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