Peer Assistance Services

# THERAPIST REPORT

Client Name: ______________________________ Contract Received? ❐ Yes ❐ No

State the number and frequency of visits: ______________________________

______________________________

Has the client complied with visits on dates scheduled? ❐ Yes ❐ No

If not, please explain in detail (i.e., was it a scheduling problem, what type, was it rescheduled):

______________________________

______________________________

Is the client engaged in treatment? ❐ Yes ❐ No

Progress: ______________________________

______________________________

Assessment of mental status: ______________________________

______________________________

*It is my opinion that the above named client does* ***not*** *have a mental or physical disability which renders him/her unstable to practice in the licensed profession with reasonable skill and safety.*

❐ Agree ❐ Disagree

If disagree, please explain: ______________________________

______________________________

Document any evidence of drug or other substance use: ______________________________

______________________________

Additional comments: ______________________________

______________________________

| ______________________ | ______________________ | ____________ |
|---|---|---|
| Signature | Title | Date |

| ______________________ | ______________________ |
|---|---|
| Name/Credentials (Please Print) | Facility/Agency |

Address: ______________________________

______________________________

Phone: ______________________________

Reports are due by the _____ of each month.
*See web site for due dates.*

**Mail Original To:** **Peer Assistance Services, Inc.**
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**Phone: 303.369.0039 or 866.369.0039**
**Fax: 720.213.1007**