

Tennessee Professional Assistance Program

545 Mainstream Drive • Suite 414 • Nashville, TN 37228
Phone 615-726-4001 • Fax 615-726-4003
www.TnPAP.org

Self Report

Beginning report date _____ Ending report date: _____
TnPAP Case Manager _____

Instructions:

- To be completed by TnPAP participant.
- Complete both page 1 and page 2. As a convenience, our PDF form allows you to fill in the blanks online.
- Mail or fax to TnPAP on or before the 5th day of every month.

TnPAP participant's name: _____

Address: _____

Daytime area code and phone number _____

I have changed my address and/or phone number since my last report. Yes No

Report for (month/year): _____ Sobriety date: _____

1. Have you had any changes in employer, work site address, employment status, employment shift or hours of work, with site monitor, or work restrictions or responsibilities?
 Yes No If yes, please explain: _____

SUPPORT GROUP ATTENDANCE AND INVOLVEMENT

2. Name of facilitator: _____
3. Number of meeting required per week: _____ Number attended this month: _____
4. Progress in group: _____

12-STEP MEETING ATTENDANCE AND INVOLVEMENT

5. Do you have a sponsor? Yes No
6. Frequency of contact Face-to-face _____ Phone _____
7. What step are you on? : _____
8. Number of required meetings/week? _____ Number attended this month: _____
9. Type of meeting: _____
10. Service involvement/other progress: _____

THERAPY ATTENDANCE AND INVOLVEMENT (Required: Yes No)

11. Therapist's name and title: _____
12. How long have you been in counseling with this person? _____
13. Number of sessions scheduled this month? _____ Number attended this month: _____
14. Progress: _____

Complete page 2 →→

Participant's Name: _____

PSYCHIATRIC ATTENDANCE AND INVOLVEMENT (Required: Yes No)

15. Psychiatrist's name and title: _____
16. Frequency of visits: _____
17. Medications and Doses: _____ Required Yes No

TREATMENT/AFTERCARE

18. Program name: _____
19. Location: _____
20. Length of participation: _____ Type of Involvement: _____
21. Progress: _____

MEDICAL TREATMENT DURING THIS MONTH

22. Physician's Name: _____ ASAM Status: _____
23. Reason for Care: _____

24. Is the physician familiar with your recovery program? Yes No
25. Identify any prescription drugs or over-the-counter drugs taken this month
26. If any drugs were taken, given the reason for their use:
27. Has the physician sent any documentation to TNPAP? Yes No

SOCIAL/RECREATIONAL

28. Activities: _____

FINANCIAL/LEGAL

29. Status: _____

Comments: _____

Signature

Date

Complete page 1 →→