



Tennessee Professional Assistance Program
545 Mainstream Drive, Suite 414
Nashville, TN 37228

www.tnpap.org
Phone: 615-726-4001
Fax: 615-726-4003

Counseling/Therapist/Medication Management Report

Explanation: The Tennessee Professional Assistance Program (TnPAP) requires this evaluation of the participant's progress as a condition of compliance with the monitoring program. Please be specific in your answers. To be accepted, form must be legible.

Report due in TnPAP by the last day of the following months:
March, June, September and December

Participant Information

Reporting period:	From:	To:	Report Due:		
Name			Telephone		
Address		City	State	Zip	
Have you been given a copy of the evaluation/treatment discharge by the above named individual?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you understand the terms and conditions?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Treatment Plan (focus of work with this individual)					
How long have you been working with this individual?					
Type of therapy			<input type="checkbox"/> Individual	<input type="checkbox"/> Group	<input type="checkbox"/> Family
How often is individual required to attend sessions?			<input type="checkbox"/> Weekly	<input type="checkbox"/> Bi-weekly	<input type="checkbox"/> Monthly
Is individual attending regularly? If no, explain in other comments section.			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Therapy goals:					
Individual's progress toward goals to date:					
Prognosis of therapy:					
Estimated length of continued treatment?					
Other Comments:					

Assess the individual's ability to practice safely	Comments This section is mandatory
Stability in recovery	
Support systems	
Problem solving ability	
Cognitive functioning	
Judgment	
Ability to cope with stressful situations	
Decision making ability during a crisis	
Affect/mood	
Individual's understanding and integration of need for counseling and rehabilitation.	
Attendance at session.	
Compliance with recommended treatment regimen	
Progress in treatment	
Social skills/interactions	

Signature of Counselor/Therapist		Date	
Print Name			
Name of Agency		Telephone	
Address	City	State	Zip

Please provide the following information the first time you file this report.

Type of Degree	Length of Time in Practice	TN License #	
Certified/Qualified Chemical Dependence and/or Alcohol Counselor/Therapist		<input type="checkbox"/> Yes	<input type="checkbox"/> No