TREATMENT PROGRESS REPORT Check if applicable Consent/TRS-49 Forms completed ☐

Last Name, First Name	Admission Date	Date of Report	Report Period Covering (mm/dd/yy) to
DSM IV Diagnosis	Completion (est.)	(if applicable)DKT# IND/SCI # NYSID #	

Report Submitted to:(check all that apply)		
☐ DSS	☐ Domestic Violence Court	☐ DOCCS
☐ Drug Courts	☐ Family Treatment Court	☐ TASC
☐ Juvenile Court	☐ Child Protection Services	☐ Other (Please Specify):
	☐ Department of Probation	

COURT/SUPERVISION INFO (If n/a, check box) ☐

Agency	Case Manager/PO	Telephone	Fax

TREATMENT AGENCY

Treatment Agency Name	Type/Modality	Program Counselor
Program Contact	Contact Telephone	Preparer's Name

RECOMMENDATION

☐ Maintain Current Treatment Status
☐ Referral for Additional Services
☐ Consider for Completion
☐ Revise Treatment Plan
☐ Being Considered for Discharge

TREATMENT SCHEDULE

Month(s)	Sessions/Wk
Days/Week M T W TH F SA SU ☐ ☐ ☐ ☐ ☐ ☐ ☐	Hours/Wk

TREATMENT ATTENDANCE: Not required for Residential

1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**P-Present E-Excused A-Absent L-Late**
11	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	
21	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**

***TREATMENT AREAS** NA E G I NI

Attitude towards treatment	☐	☐	☐	☐	☐
Stability of mental/ psych health	☐	☐	☐	☐	☐
Status of Entitlements	☐	☐	☐	☐	☐
Family System Status	☐	☐	☐	☐	☐
Participates in all aspects of program	☐	☐	☐	☐	☐
Develop Social Support Network	☐	☐	☐	☐	☐
Edu/Vocational Employment	☐	☐	☐	☐	☐
Living Environment	☐	☐	☐	☐	☐

****TOXICOLOGY** P=Positive N=Negative L=Lab Pending [If not tested, check box] ☐

Date (mm/dd/yy)	ALC	AMP	BAR	BEZ	COC	HER	ME	OPI	PCP	RX	SUB	THC	Note

***Treatment Areas Key**: NA: Not Applicable; E: Excellent; G: Good; I: Improved; NI: Needs Improvement

****Toxicology Substances**: ALC: Alcohol; AMP: Meth/Amphetamine; BAR: Barbiturates; BEZ: Benzodiazepine; COC: Cocaine; HER: Heroin; ME: Methadone; OPI: Opiates; PCP: PCP; RX: Prescription Medication; SUB: Suboxone; THC: THC

EMPLOYABILITY STATUS

	Y	N
Based on progress in AOD treatment, is the client *able* to participate in employment-related activities?	☐	☐
Is the client *engaged* in employment related activities?	☐	☐
Has the client complied with agency financial obligations?	☐	☐

DISCHARGE STATUS if client has been discharged

☐	Completed Treatment: All Goals Met
☐	Completed Treatment: Half or More Goals Met
☐	Treatment Not Completed: Maximum Benefit
☐	Treatment Not Completed: Some Goals Met
☐	Treatment Not Completed: No Goals Met

TREATMENT PROGRESS REPORT

Last Name, First Name	Date of Report

TREATMENT SUMMARY/COMMENTS (This section must be completed)
Please be specific. Include recommendations, aftercare information, other relevant progress related to participation in parenting, community service, med/psych, compliance with parole/probation, support groups, etc. Include program's response to identified problems, changes in treatment plan, achievements and issues with which the court may be able to assist.

UPDATE ON CHILDREN (If not applicable, check box) ☐
Mandatory for Family Treatment Court Cases Include comments, concerns and issues regarding children where the court may be able to assist. Please include names of children and dates of occurrences if known, e.g., child visitation and child service issues, parent/child interaction, etc.

Client Self-Reported
Treatment Provider Observations
Family Services