ALCOHOLISM AND SUBSTANCE ABUSE TREATMENT PROGRAM PROGRESS REPORT

PLEASE PRINT

I. Client Identification

Client Name: _____ Address: _____

SSN: _____ Case #: _____ CIN: _____ DOB: ____

Date of Admission: _____ Project Discharge Date *(for Residential Program Only)*: _____

II. Time Frame of Progress Report *(Check appropriate box)*

☐ Post-Admission (indicate which one applies) ☐ Discharge/Transfer

☐ 3 months ☐ 6 months ☐ 9 months ☐ 12 months ☐ Other : _____

(specify)

III. Treatment Program Information

Name: _____ Address of Client's Treatment Site: _____

_____

Mailing Address *(if different from above)*: _____

Treatment Program Contact Person: _____ Telephone # : ( ) _____ Fax # : ( ) _____

Type of Treatment *(check ONLY one)*

☐ Residential (Congregate Care) ☐ Drug Outpatient ☐ Methadone

☐ Inpatient Rehabilitation (Medical) ☐ Alcohol Outpatient

IV. Client Schedule *(for Outpatients ONLY)*

Current Treatment Schedule : _____ Days per week _____ Hours per day

Has this schedule changed since the last progress report? ☐ Yes ☐ No

Reason for Change *(such as improvement, relapse episode, etc)* :

V. Client Attendance *(for Outpatients ONLY)*

Specify how many treatment sessions the client missed, since the last progress report was completed: _____

Based on the established attendance guidelines, rate the client's attendance: *(check one)*

☐ Satisfactory ☐ Not satisfactory

VI. For All Clients *(Outpatients and Residential)*

Has the client complied with the treatment plan? ☐ Yes ☐ No

If no, explain:

If the client has been discharged, transferred or referred :

Specify Reasons: _____

Date: _____

If referred or transferred to a different treatment program or site, specify below:

Name of Treatment program: _____

Address of Treatment Site: _____

Type of Treatment: _____

A. Limitation(s)- Degree of Impairment/Progress

Please indicate any limitations on this client's activities. Specify your assessment of the degree of impairment and progress made since the Examination for Employability Assessment Disability Screening and Alcoholism/Drug Addiction Determination or the last Progress Report, whichever is applicable.

LIMITATION(S)	CURRENT DEGREE OF IMPAIRMENT			CLIENT PROGRESS				
	Severe	Moderate	Slight					
Physical: (Specify from list below.)								
	☐	☐	☐	1	2	3	4	5
	☐	☐	☐	1	2	3	4	5
	☐	☐	☐	1	2	3	4	5
Mental: (Specify from list below.)								
	☐	☐	☐	1	2	3	4	5
	☐	☐	☐	1	2	3	4	5
	☐	☐	☐	1	2	3	4	5
Addiction: (Specify from list below.)								
	☐	☐	☐	1	2	3	4	5
	☐	☐	☐	1	2	3	4	5
	☐	☐	☐	1	2	3	4	5
				Legend: 1 - No Improvement 2 - Slight Improvement 3 - Fair Improvement 4 - Average Improvement 5 - Significant Improvement				

FUNCTIONAL LIMITATIONS

PHYSICAL	MENTAL
1. Walking	1. Understands and remembers instructions
2. Standing	2. Carries out instructions
3. Sitting	3. Maintains attention/concentration
4. Lifting, Carrying	4. Makes simple decisions
5. Pushing, Pulling, Bending	5. Interacts appropriately with others
6. Seeing, Hearing, Speaking	6. Maintains socially appropriate behavior without exhibiting behavior extremes
7. Using Hands	7. Maintains basic standards of personal hygiene and grooming
8. Stairs or other climbing	8. Appears able to function in a work setting at a consistent pace
9. Other	9. Other

ADDICTION
1. Medical hospitalizations or emergency room visits due to addiction
2. Acute psychiatric hospitalization due to addiction
3. Hospitalization for alcohol/drug detoxification
4. Prior attempts at alcohol/drug abstinence
5. Passing out or black-out episodes
6. Repetitive violent actions towards self or others while drunk or high
7. Loss of housing due to addiction
8. Loss of job or failure to complete an education or training program due to an addiction
9. Pattern of addiction interferes with activities of daily living
10. Actual suicide attempt
11. Other

B. Employment Related Functioning

1. Employment:

Is the client employed? ☐ Yes ☐ No

Name of Employer: _____ Employer Address: _____

_____

Employment Start Date: _____ Hours worked per week: _____ Position: _____

Salary: $_____ Per: *(circle one)* Hours Week Month Year

2. Education and Training

Is the client enrolled in an education or skills training program? ☐ Yes ☐ No

Name of Program: _____ Program Address: _____

_____

Start date: _____ Anticipated Completion Date: _____ Type of Training/Education: _____

Training Schedule *(circle days)*: M TU W TH F S Hours per day: _____

Based on the established guidelines, rate the client's attendance: *(check one)* ☐ Satisfactory ☐ Not satisfactory

Is the client's education or training program sponsored by VESID? ☐ Yes ☐ No

Name of Counselor: _____ Telephone # : (___) _____ Fax # : (___) _____

3. Pre-Employment Activities:

a. Describe other current employment related activities client is participating in *(such as formalized vocational assessment process, employability skills training, or vocational groups):*

_____

_____

b. Has the client successfully engaged in trial employment related activities? ☐ Yes ☐ No

Specify activities: _____

c. Are there any issues e.g. *(medical, legal or housing issues)* which prevent the client from being able to participate in work activities at this time? ☐ Yes ☐ No

Explain issues and how they are being addressed: _____

_____

Based on the client's progress treatment, is he/she able to participate in a work Experience Program? ☐ Yes ☐ No

If not, estimate when client will be able to participate in a Work Experience Program: _____

Project Employment Readiness Date: _____

I certify that all the information is true and complete to the best of my knowledge.

Report completed by: Counselor's Name (PRINT) _____ Title: _____

_____

(___) _____ ____ **X** _____ _____

Telephone # Ext. Signature Date of Report

Social Services Contact _____

Date of Request _____ Please forward this completed report to: _____

Address : _____ Telephone # : ( ) _____

_____ Fax # : ( ) _____

Comments: