Wisconsin Department of Safety and Professional Services

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PROFESSIONAL ASSISTANCE PROCEDURE

THERAPY REPORT

Complete this form and submit it to PAP to the address listed above on or before each quarterly due date. You may copy this blank form so you have forms for future reports. It is recommended you keep a copy of each completed form for your files.

Client Name: _____
Last First Middle

Report Due Date: _____
Month / Day / Year

Dates of therapy contact during the last quarter:

_____ Month / Day / Year	_____ Month / Day / Year	_____ Month / Day / Year	_____ Month / Day / Year
_____ Month / Day / Year	_____ Month / Day / Year	_____ Month / Day / Year	_____ Month / Day / Year
_____ Month / Day / Year	_____ Month / Day / Year	_____ Month / Day / Year	_____ Month / Day / Year

1. What progress has the client made within the last quarter?

2. Do you have any concerns regarding this client's recovery? ☐ Yes ☐ No
   If so, explain further.

3. Do you believe this client attends 12 step meetings? ☐ Yes ☐ No
   How many/wk? _____

4. Is this client working the 12 steps? ☐ Yes ☐ No
   If so, which step? _____

5. Does this client have and properly utilize a sponsor? ☐ Yes ☐ No

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6. Describe the client's acceptance of addictive disease and his/her willingness to acknowledge and accept the consequences of the disease.

7. To the best of your knowledge, is this client remaining abstinent? ☐ Yes ☐ No

8. Is the client having difficulty doing so? ☐ Yes ☐ No
Report slips/relapses immediately.

9. Does the client participate in individual sessions? ☐ Yes ☐ No
Does the client participate in group sessions? ☐ Yes ☐ No
Facilitator: _____

10. Discuss difficulties you have encountered providing services for this client to meet the requirements of the Professional Assistance Procedure.

11. Do you recommend modifications in this client's treatment plan? ☐ Yes ☐ No
If yes, provide clinical justification. **Modifications may not be implemented until approved by PAP.**

12. Do you feel this client is able to safely practice his/her profession? ☐ Yes ☐ No
If no, explain further.

13. Prognosis: _____

14. Additional comments (attach additional sheets if necessary)

_____ _____
Signature and Title of Therapist Date (month/day/year)

_____
Print Name of Therapist

_____ _____
Address (city / state / zip code) Phone number