



**Physicians' Health Programs
THERAPY REPORT FORM**

Name of participant: _____

For the Month(s) of: _____

Therapy Attendance

Individual	<input type="checkbox"/> Good	<input type="checkbox"/> Intermittent	<input type="checkbox"/> Poor	<input type="checkbox"/> N/A
Group	<input type="checkbox"/> Good	<input type="checkbox"/> Intermittent	<input type="checkbox"/> Poor	<input type="checkbox"/> N/A

(Please explain intermittent and poor ratings.)

Please provide brief statement on progress status: _____

Therapist Information -- Please Print:

*** Items do not need to be completed after the initial report unless there is a change.**

Therapist Name _____

*Organization _____

*Address: _____

*County: _____

Telephone Number: _____

Date

Therapist Signature

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