Physicians' HEALTH Program
The Foundation of the Pennsylvania Medical Society

Physicians' Health Program

THERAPY REPORT FORM

Name of participant: _____

For the Month(s) of: _____

Therapy Attendance

Individual	☐ Good	☐ Intermittent	☐ Poor	☐ N/A
Group	☐ Good	☐ Intermittent	☐ Poor	☐ N/A
Medication Management	☐ Good	☐ Intermittent	☐ Poor	☐ N/A

(Please explain intermittent and poor ratings.)

Please provide brief statement on progress status: _____
_____
_____
_____
_____
_____

Any Changes in Medications:
_____
_____

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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