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**

777 East Park Drive ⁂ P.O. Box 8820 ⁂ Harrisburg, PA 17105-8820
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