PROB 46
TX/E (REV. 08/14)

MONTHLY TREATMENT REPORT

This form must be completed and submitted with each monthly billing.

1. PROVIDER NAME:	2. OFFICER NAME:	3. DATE OF CURRENT PLAN:

4. CLIENT NAME:	4a. PACTS NO.	5. FOR PERIOD COVERING:	6. PRETRIAL CLIENT: ☐ Yes ☐ No

7. CONTACTS SINCE LAST REPORT

a. Date	b. Service/Project Code	c. Length of Session	d. Comments: (No Shows, Tardiness , Issues Addressed)

8.COMMENTS REGARDING CLIENT'S TREATMENT PROGRESS

a. Describe the treatment goals addressed this month (☐ Met ☐ Not Met):

b. Describe any steps taken by the client this month toward these goals (☐ Positive ☐ Negative):

c. Describe any obstacles or setbacks the client encountered this month:

d. Describe one unique way the PO/PSO can assist/support the client in treatment over the next month:

e. If continued treatment is recommended, discuss the plan for next month (☐ Recommended ☐ Not Recommended):

f. Discuss your observations of the client's behavior and commitment to treatment (☐ Positive ☐ Negative):

g. Comments:

h. Overall Progress: ☐ Acceptable ☐ Unacceptable

SIGNATURE OF COUNSELOR	DATE