MONTHLY TREATMENT LOG

Complete one form per person per month. Include all scheduled contacts. In the event the person does not attend a scheduled service, indicate "no show" in the signature column. In the event the person does not attend any services within the month, include a comment noting this.

Vendor: Defendant/Person Under Supervision: Month/Year: Supervising Officer:		PAC Req	Agreement #: PACTS #: Required monthly co-payment: Date monthly staffing with office			Therapist: Date of Last Treatment Plan:	
•		vices are co			, ,		items to document the person's treatment progress.
Steps ta Need for Client be Overall p	Int goals:	□Negative nend □No nent: □Pos ceptable C lient encour	Commert Recomment Recomments: Comments:	ended egative month:	Comments Comments stment over t	::	n:
Date	Defendant/Person under Supervision signature	Project Code	Time In	Time Out	Vendor Initials	Co-pay Received	Comments

Additional Page

Defendant/Person Under Supervision Name:

Date	Defendant/Person under Supervision Supervision signature	Project Code	Time In	Time Out	Vendor Initials	Co-pay Received	Comments