NEW MEXICO HEALTH PROFESSIONAL WELLNESS PROGRAM

MENTAL HEALTH PROVIDER REPORT: (Therapist) To be submitted to HPWP ***by participant or therapist*** each month by the 10th of the month for the preceding month.

Participant Name:_____ReportingPeriod_____

Provider_____Phone_____
_

Attendance: ( )Weekly ( )Twice a month ( ) Monthly
( ) Satisfactory
( ) Unsatisfactory (please explain)

# of sessions scheduled _____ #of sessions attended _____

Reason for missing (no show, excused, etc) _____

Participation:
( ) Satisfactory
( ) Unsatisfactory (please explain)

What are the client's treatment goals?
_____
_____
_____

Is participant making satisfactory progress toward achievement of treatment goals?
( ) Yes
( ) No (please explain)

Treatment Plan: Have there been any changes in the treatment plan since your last report? (i.e. frequency of therapy, change in goals, new treatment modalities, etc.)
( ) No
( ) Yes (please explain)

Is there any indication of behavioral or chemical relapse?
( ) No
( ) Yes (please explain)

Does the individual appear to be benefiting from participation in individual psychotherapy?
( ) Yes
( ) No (please explain)

Additional Comments:

_____ _____
Signature of Provider Date

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