



TURNING POINT FAMILY CARE
PO BOX 789, WASHINGTON, UT. 84780
VOX: 435.674.7421 FAX: 435.674.3175

Monthly Progress Report

Date: _____ Review Date: _____

Client: _____ Case Number: _____

Medicaid Number: _____ Case Manager: _____

Therapist: _____ Therapist signature: _____

Page # 1

I. Adjustment Behavior at Current Placement:

Rules: _____

Stabilizing: _____

Socializing: _____

Other: _____

II. Education:

School: _____

Grades: _____

Attendance: _____

Other: _____

III. Work/Job Experience:

Location: _____

Schedule: _____

Savings Plan: _____

Other: _____

IV. Restitution/Work Hours:

Total Hours Left: _____

Work Activity: _____

Hours Worked Off This Month: _____

Other: _____



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Page # 2

V. Treatment Goals:

Skill: (Goal One):

Client Progress or Failure:

Skill: (Goal Two):

Client Progress or Failure:

Skill: (Goal Three):

Client Progress or Failure:



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Page # 3 _____

THERAPY:

Number of **Individual Counseling** hours this month: _____

Number of **Family Counseling** hours this month: _____

Number of **Group Counseling** hours this month: _____

1. **Contact/Meetings with Family/Significant Others:**

(Attach: Phone Contact Log)

2. **Medical/Dental Contacts:**

(Health Visit Reports should already be turned in to Turning Point, please list all appointments below)

3. **Emergencies:**

(Incident Reports should already be turned in to Turning Point)

4. **Recommendations:** _____



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Page # 4

RECREATION ACTIVITY LOG

Once per week you are to have some type of Recreation Activity for the youth in your home. There are many activities that you already are doing that just need to be reported. This log will be completed by describing in detail what your once per week activity was while the youth was in your home. This log is to be turned in with your Monthly Report.

Week 1: _____

Week 2: _____

Week 3: _____



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Week 4: _____

