

**ALCOHOLISM AND SUBSTANCE ABUSE TREATMENT PROGRAM  
PROGRESS REPORT**

PLEASE PRINT

**I. Client Identification**

Client Name: \_\_\_\_\_ Address: \_\_\_\_\_

SSN: \_\_\_\_\_ Case #: \_\_\_\_\_ CIN: \_\_\_\_\_ DOB: \_\_\_\_\_

Date of Admission: \_\_\_\_\_ Project Discharge Date (for Residential Program Only): \_\_\_\_\_

**II. Time Frame of Progress Report (Check appropriate box)**

Post-Admission (indicate which one applies)  Discharge/Transfer  
 3 months  6 months  9 months  12 months  Other : \_\_\_\_\_  
(specify)

**III. Treatment Program Information**

Name: \_\_\_\_\_ Address of Client's Treatment Site: \_\_\_\_\_  
\_\_\_\_\_

Mailing Address (if different from above): \_\_\_\_\_

Treatment Program Contact Person: \_\_\_\_\_ Telephone #: ( ) \_\_\_\_\_ Fax #: ( ) \_\_\_\_\_

Type of Treatment (check ONLY one)

Residential ( Congregate Care)  Drug Outpatient  Methadone  
 Inpatient Rehabilitation (Medical)  Alcohol Outpatient

**IV. Client Schedule (for Outpatients ONLY)**

Current Treatment Schedule : \_\_\_\_\_ Days per week \_\_\_\_\_ Hours per day

Has this schedule changed since the last progress report?  Yes  No

Reason for Change (such as improvement, relapse episode, etc) :  
\_\_\_\_\_  
\_\_\_\_\_

**V. Client Attendance (for Outpatients ONLY)**

Specify how many treatment sessions the client missed, since the last progress report was completed: \_\_\_\_\_

Based on the established attendance guidelines, rate the client's attendance: (check one)  
 Satisfactory  Not satisfactory

**VI. For All Clients (Outpatients and Residential)**

Has the client complied with the treatment plan?  Yes  No

If no, explain:  
\_\_\_\_\_  
\_\_\_\_\_

If the client has been discharged, transferred or referred :  
Specify Reasons: \_\_\_\_\_  
Date: \_\_\_\_\_

If referred or transferred to a different treatment program or site, specify below:

Name of Treatment program: \_\_\_\_\_

Address of Treatment Site: \_\_\_\_\_

Type of Treatment: \_\_\_\_\_

**A. Limitation(s)- Degree of Impairment/Progress**

Please indicate any limitations on this client's activities. Specify your assessment of the degree of impairment and progress made since the Examination for Employability Assessment Disability Screening and Alcoholism/Drug Addiction Determination or the last Progress Report, whichever is applicable.

LIMITATION(S)	CURRENT DEGREE OF IMPAIRMENT			CLIENT PROGRESS				
	Severe	Moderate	Slight	1	2	3	4	5
Physical: (Specify from list below.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1	2	3	4	5
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1	2	3	4	5
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1	2	3	4	5
Mental: (Specify from list below.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1	2	3	4	5
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1	2	3	4	5
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1	2	3	4	5
Addiction: (Specify from list below.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1	2	3	4	5
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1	2	3	4	5
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1	2	3	4	5
				<b>Legend:</b> 1 - No Improvement 2 - Slight Improvement 3 - Fair Improvement 4 - Average Improvement 5 - Significant Improvement				

**FUNCTIONAL LIMITATIONS**

PHYSICAL	MENTAL
1. Walking	1. Understands and remembers instructions
2. Standing	2. Carries out instructions
3. Sitting	3. Maintains attention/concentration
4. Lifting, Carrying	4. Makes simple decisions
5. Pushing, Pulling, Bending	5. Interacts appropriately with others
6. Seeing, Hearing, Speaking	6. Maintains socially appropriate behavior without exhibiting behavior extremes
7. Using Hands	7. Maintains basic standards of personal hygiene and grooming
8. Stairs or other climbing	8. Appears able to function in a work setting at a consistent pace
9. Other	9. Other

**ADDICTION**

1. Medical hospitalizations or emergency room visits due to addiction
2. Acute psychiatric hospitalization due to addiction
3. Hospitalization for alcohol/drug detoxification
4. Prior attempts at alcohol/drug abstinence
5. Passing out or black-out episodes
6. Repetitive violent actions towards self or others while drunk or high
7. Loss of housing due to addiction
8. Loss of job or failure to complete an education or training program due to an addiction
9. Pattern of addiction interferes with activities of daily living
10. Actual suicide attempt
11. Other

**B. Employment Related Functioning**

1. Employment:

Is the client employed?  Yes  No

Name of Employer: \_\_\_\_\_ Employer Address: \_\_\_\_\_

Employment Start Date: \_\_\_\_\_ Hours worked per week: \_\_\_\_\_ Position: \_\_\_\_\_

Salary: \$ \_\_\_\_\_ Per: (circle one) Hours Week Month Year

2. Education and Training

Is the client enrolled in an education or skills training program?  Yes  No

Name of Program: \_\_\_\_\_ Program Address: \_\_\_\_\_

Start date: \_\_\_\_\_ Anticipated Completion Date: \_\_\_\_\_ Type of Training/Education: \_\_\_\_\_

Training Schedule (circle days): M TU W TH F S Hours per day: \_\_\_\_\_

Based on the established guidelines, rate the client's attendance: (check one)  Satisfactory  Not satisfactory

Is the client's education or training program sponsored by VESID?  Yes  No

Name of Counselor: \_\_\_\_\_ Telephone #: ( ) \_\_\_\_\_ Fax #: ( ) \_\_\_\_\_

3. Pre-Employment Activities:

a. Describe other current employment related activities client is participating in (such as formalized vocational assessment process, employability skills training, or vocational groups):

\_\_\_\_\_

b. Has the client successfully engaged in trial employment related activities?  Yes  No

Specify activities: \_\_\_\_\_

c. Are there any issues e.g. (medical, legal or housing issues) which prevent the client from being able to participate in work activities at this time?  Yes  No

Explain issues and how they are being addressed: \_\_\_\_\_

Based on the client's progress treatment, is he/she able to participate in a work Experience Program?  Yes  No  
If not, estimate when client will be able to participate in a Work Experience Program: \_\_\_\_\_  
Project Employment Readiness Date: \_\_\_\_\_

**I certify that all the information is true and complete to the best of my knowledge.**

Report completed by: Counselor's Name (PRINT) \_\_\_\_\_ Title: \_\_\_\_\_

( ) \_\_\_\_\_ **X** \_\_\_\_\_  
Telephone # Ext. Signature Date of Report

Social Services Contact \_\_\_\_\_  
Date of Request \_\_\_\_\_ Please forward this completed report to: \_\_\_\_\_  
Address : \_\_\_\_\_ Telephone #: ( ) \_\_\_\_\_  
Fax #: ( ) \_\_\_\_\_

