

Continuing Care and Quarterly Monitoring Report

Name _____ Occupation/Profession _____ Specialty _____
 Street _____ City _____ State _____ Zip _____
 Home Phone _____ Daytime/Office phone _____
 Today's Date _____ TRC Discharge Date _____ Sobriety Date _____

Part I. Status Changes (Please circle YES or NO and write where needed.)

1. Has your sobriety date changed since your last treatment at TRC? YES NO
 a. If YES, did you seek help? YES NO
 b. If YES, are you back in recovery? YES NO
 Your new sobriety date, if applicable _____
2. Your marital status is (circle) Single Married Divorced Separated Widowed
 a. Changed since discharge? YES NO
 b. Have you ever been divorced? YES NO
3. Are you smoking now? YES NO
4. Is your life out of balance in any of these areas? YES NO
 a. If YES, (circle) Sex Food Gambling Spending Work Other _____
5. Are you taking any prescribed medications? YES NO
 a. IF YES, please list _____
6. Any trouble with your licensure status now? YES NO
 a. If YES, please explain _____
7. Any legal status troubles now (i.e., traffic, civil actions)? YES NO
 a. If YES, please explain _____
8. Any employment status or job location change? YES NO
 a. If YES, please explain _____

Part II. Recovery Activities

Please indicate how many **TIMES PER MONTH** you engage in the following activities. If the item does not apply, write "N/A" in the appropriate bracket. Please do not leave any blank spaces.

- | | |
|--|--|
| ____ 9. Attend 12 Step Group meetings | with family/spouse/other persons |
| ____ 10. Contact 12 Step sponsor | ____ 20. Spend an hour or more in recreational or social activities |
| ____ 11. Done 12 Step service work | ____ 21. Attend continuing medical education or other training |
| ____ 12. Attend professional group meeting | OTHER ACTIVITIES (note frequency change) |
| ____ 13. Contact professional monitor | ____ 22. How many hours working PER WEEK |
| ____ 14. Attend Continuing Care Group meeting | ____ 23. How many random urine/blood monitoring drug screenings THIS QUARTER. |
| ____ 15. Individual therapy or counseling sessions | |
| ____ 16. Exercise for 30-60 minute sessions | |
| ____ 17. Take time for regular meditation/reflection | |
| ____ 18. Contact your primary physician | |
| ____ 19. Attend therapy/counseling sessions | |

Please continue on other side...

Part III. Quality of Life

This section estimates the progress of your recovery by measuring levels of satisfaction with various aspects of your life, and the importance you assign to each. On a scale of 6 to 1, with 6 indicating “Very Satisfied” and 1 “Very Dissatisfied,” circle a number that best reflects your current level of satisfaction, as follows:

Very Satisfied Somewhat Satisfied Slightly Satisfied Slightly Dissatisfied Somewhat Dissatisfied Very Dissatisfied
 6 5 4 3 2 1

In the second column, using the same scheme, choose a number that best suggests the importance of each category in your life.

	How <i>satisfied</i> are you?						How <i>important</i> is it to you?					
	Hi		Lo				Hi		Lo			
Circle one Number: (EXAMPLE)	6	5	4	3	2	1	6	5	4	3	2	1
24-25 Your professional life	6	5	4	3	2	1	6	5	4	3	2	1
26-27 Your financial status	6	5	4	3	2	1	6	5	4	3	2	1
28-29 Your physical health	6	5	4	3	2	1	6	5	4	3	2	1
30-31 Your faith in a Higher Power	6	5	4	3	2	1	6	5	4	3	2	1
32-33 Your personal appearance	6	5	4	3	2	1	6	5	4	3	2	1
34-35 Achieving your goals	6	5	4	3	2	1	6	5	4	3	2	1
36-37 Support for recovery from others	6	5	4	3	2	1	6	5	4	3	2	1
38-39 Your peace of mind	6	5	4	3	2	1	6	5	4	3	2	1
40-41 Relationship with spouse/other	6	5	4	3	2	1	6	5	4	3	2	1
42-43 Your family	6	5	4	3	2	1	6	5	4	3	2	1
44 Overall satisfaction with life	6	5	4	3	2	1						

45. Your comments: _____

46. Monitoring Professional’s comments: _____

 (Patient’s signature) (Date) (Monitor/Group Leader Signature) (Date)

Thank you for completing this report.