COUNTY OF EL DORADO
HEALTH AND HUMAN SERVICES AGENCY

Child Welfare Services
Leslie Griffith
Assistant Director

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Monthly Client Progress Report

Date: _____ Social Worker: _____

Client: _____ Provider Agency: _____

Counselor Name: _____

Service/s Provided: _____

Dates of Attendance: _____

Statement of Prognosis:

Explanation of Prognosis and Estimated Length of Treatment:

Goals and Treatment Plan

Please explain goal and treatment plan. Then, in the treatment progress area, please rate each goal's progress according to the scale below (enter a * where the number is currently). If the client is progressing, please explain this progress or how the client is demonstrably meeting their goals.

Goal 1:	
Goal 1 Treatment Plan:	
Summary of Progress:	

Progress Declined		Remained Same			Improved			Approaching Completion	Completed
1	2	3	4	5	6	7	8	9	10

Goal 2:	
Goal 2 Treatment Plan:	
Summary of Progress:	

Progress Declined		Remained Same			Improved			Approaching Completion	Completed
1	2	3	4	5	6	7	8	9	10

Goal 3:	
Goal 3 Treatment Plan:	
Summary of Progress:	

Progress Declined		Remained Same			Improved			Approaching Completion	Completed
1	2	3	4	5	6	7	8	9	10

Goal 4:	
Goal 4 Treatment Plan:	
Summary of Progress:	

Progress Declined		Remained Same			Improved			Approaching Completion	Completed
1	2	3	4	5	6	7	8	9	10

Goal 5:	

Goal 5 Treatment Plan:	
Summary of Progress:	

Progress Declined		Remained Same			Improved			Approaching Completion	Completed
1	2	3	4	5	6	7	8	9	10

Treatment Recommendations:

Therapist Name/License # Date

NOTE: THIS REPORT SHOULD BE SENT TO HHSA SOCIAL WORKER AND NOT HHSA FISCAL DEPT.

** Phone: (530) 642-7100 * Fax (530) 626-7427 **

Vision Statement:

Transforming Lives and Improving Futures