IOWA | Department of Inspections, Appeals, & Licensing

IOWA PROFESSIONAL HEALTH PROGRAMS

Quarterly Report - Therapist Form

Participant Name:	Therapist Name and Credentials: Contact Information:

Indicate which quarter this report covers:

☐ 1st Quarter ☐ 2nd Quarter ☐ 3rd Quarter ☐ 4th Quarter

Dates of Therapy Sessions during this reporting quarter:

Primary Focus in Treatment:

Secondary Focus of Treatment:

	YES	NO
Has progress been demonstrated towards their goals? Please give an explanation.	☐	☐
What is the appointment frequency? Do you recommend a change in frequency? Please Explain.	☐	☐
Is the participant compliant with treatment (willing participant, attends appointments as scheduled, demonstrates motivation to work toward goals, etc)?	☐	☐
Does the participant have insight in to their condition? Please explain.	☐	☐

	YES	NO
Has there been a change in the participant's diagnosis? If yes, please explain.	☐	☐
Does the current diagnosis affect the participant's ability to safely practice in the field they are licensed in? Please explain.	☐	☐
Has the participant signed releases for you to communicate with their medical provider?	☐	☐
Have you communicated with the participant's medical physician this quarter?	☐	☐
To your knowledge, is the participant adherent with their IPHP contract?	☐	☐
Would you like the IPHP staff to contact you?	☐	☐
Any further Comments, Questions or Concerns?		
Therapist Signature: Date:		

PROGRAM CONTACTS:

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