



{ ALEINU } FAMILY RESOURCE CENTER

Mandated Assistance Program Monthly Follow Up Report

Name _____ Age _____ DOB ____/____/____

Date ____/____/____ School _____ Grade _____

Treatment Recommendation:

- Individual Counseling: _____ x per week for _____ weeks
- Family Counseling: _____ x per month for _____ months
- Group Counseling: _____ x per week for _____ weeks
- 12-step groups: _____ x per week for _____ weeks

Other Recommendations:

Week of:	Counselor Signature:
Student Complied: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> n/a	
Parents Complied: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> n/a	
Week of:	Counselor Signature:
Student Complied: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> n/a	
Parents Complied: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> n/a	
Week of:	Counselor Signature:
Student Complied: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> n/a	
Parents Complied: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> n/a	
Week of:	Counselor Signature:
Student Complied: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> n/a	
Parents Complied: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> n/a	

Comments:
