Pfeiffer Medical Center

3S721 West St. #300
Warrenville, IL 60555
(630) 505-0300 F – 630-836-0667
info@hriptc.org

PROGRESS REPORT – FIRST MONTH

Patient Name: _____ Date Completed: _____

Person Completing: _____ Date Program Began: _____

Best Contact Number: _____ Height (w/o shoes): _____

Best Contact Time: _____ Weight (lbs): _____

Treatment Form (mark all that apply)
- ☐ Capsules
- ☐ Pills
- ☐ Chewables
- ☐ Powders
- ☐ Liquids

Compliance Difficulty
- ☐ No Problems
- ☐ Minor Problems
- ☐ Major Difficulty
- ☐ Extreme Difficulty

Times Missed This Month
- Morning: _____
- Dinnertime: _____
- Bedtime: _____
- Other: _____

Describe any changes from the prescribed program:	
Current prescription medications and dosages:	
Current Over-the-Counter (OTC) medications:	
Please describe any illnesses, injuries, or unusual stresses:	

- Then indicate the severity of the problem, 1-5 with 5 being the most severe.

PROBLEM	At Evaluation	At 1st Month			
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
8.					
9.					
10.					
11.					
12.					

Please add any comments you have to the back of this form.

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PROGRESS REPORT – SECOND MONTH

Patient Name: _____ Date Completed: _____

Person Completing: _____ Date Program Began: _____

Best Contact Number: _____ Height (w/o shoes): _____

Best Contact Time: _____ Weight (lbs): _____

Treatment Form (mark all that apply)
- ☐ Capsules
- ☐ Pills
- ☐ Chewables
- ☐ Powders
- ☐ Liquids

Compliance Difficulty
- ☐ No Problems
- ☐ Minor Problems
- ☐ Major Difficulty
- ☐ Extreme Difficulty

Times Missed This Month
- Morning: _____
- Dinnertime: _____
- Bedtime: _____
- Other: _____

Describe any changes from the prescribed program:	
Current prescription medications and dosages:	
Current Over-the-Counter (OTC) medications:	
Please describe any illnesses, injuries, or unusual stresses:	

- Then indicate the severity of the problem, 1-5 with 5 being the most severe.

PROBLEM	At Evaluation	At 1st Month	At 2nd Month		
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
8.					
9.					
10.					
11.					
12.					

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PROGRESS REPORT – THIRD MONTH

Patient Name: _____ Date Completed: _____

Person Completing: _____ Date Program Began: _____

Best Contact Number: _____ Height (w/o shoes): _____

Best Contact Time: _____ Weight (lbs): _____

Treatment Form (mark all that apply)
- ☐ Capsules
- ☐ Pills
- ☐ Chewables
- ☐ Powders
- ☐ Liquids

Compliance Difficulty
- ☐ No Problems
- ☐ Minor Problems
- ☐ Major Difficulty
- ☐ Extreme Difficulty

Times Missed This Month
- Morning: _____
- Dinnertime: _____
- Bedtime: _____
- Other: _____

Describe any changes from the prescribed program:	
Current prescription medications and dosages:	
Current Over-the-Counter (OTC) medications:	
Please describe any illnesses, injuries, or unusual stresses:	

- Then indicate the severity of the problem, 1-5 with 5 being the most severe.

PROBLEM	At Evaluation	At 1st Month	At 2nd Month	At 3rd Month	
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
8.					
9.					
10.					
11.					

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12.					

PROGRESS REPORT – FOURTH MONTH

Patient Name: _____ Date Completed: _____

Person Completing: _____ Date Program Began: _____

Best Contact Number: _____ Height (w/o shoes): _____

Best Contact Time: _____ Weight (lbs): _____

Treatment Form (mark all that apply)
- ☐ Capsules
- ☐ Pills
- ☐ Chewables
- ☐ Powders
- ☐ Liquids

Compliance Difficulty
- ☐ No Problems
- ☐ Minor Problems
- ☐ Major Difficulty
- ☐ Extreme Difficulty

Times Missed This Month
- Morning: _____
- Dinnertime: _____
- Bedtime: _____
- Other: _____

Describe any changes from the prescribed program:	
Current prescription medications and dosages:	
Current Over-the-Counter (OTC) medications:	
Please describe any illnesses, injuries, or unusual stresses:	

- Then indicate the severity of the problem, 1-5 with 5 being the most severe.

PROBLEM	At Evaluation	At 1st Month	At 2nd Month	At 3rd Month	At 4th Month
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
8.					
9.					
10.					

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11.					
12.					

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