Weekly Treatment Check-In Form

Date: _____

Name: _____

Number of treatment sessions: _____

Number of physical sexual contact this week: _____

Other sexual behavior this week: _____

Area(s) of functionality:

Work: _____

_____

_____

Family: _____

_____

_____

Social: _____

_____

_____

Recreation: _____

_____

_____

Any special stressors : _____

_____

_____