RESTORATIVE CLINIC

Therapy/Counselling Reporting Form

Patient's name:……………………………………………………………..………..Age:……………………..
Patient's Verification ID…………..……………………………………………………..………………..
Gender:……………………….. Date…………………. Time……………………..
Duration of session:……………………………………………………………………………………..…
Psychiatric diagnosis…………………………………………………………………………………………
Session number:……………………...……………………Session participants:…………………………
…….
Therapy method: Individual/Family/Couple/Group Therapy
Objectives of the session:
1.
2.
3.
Key issues/themes discussed: (Psychosocial stressors/Interpersonal problems/Intrapsychic conflicts/Crisis situations/Conduct difficulties/Behavioural difficulties/ Emotional difficulties/ Developmental difficulties/ Adjustment issues/ Addictive behaviours/Others)
Therapy techniques used:………………………………………………………………………………
Therapist observations and reflections:
………………………………………………………………………..
(if required additional sheets can be added)
Plan for next session:
Date for next session:
Psychiatrist's Name:……………………………Signature……………..…………..
Reg No……………………….. Date:…………………………….
(As per the Mental Healthcare Act, 2017, Sec 25 specifies that all persons with mental illness shall have the
right to access their basic medical records and it is prescribed in the Mental Healthcare (Rights of Persons with
Mental Illness) Rules, 2018 Rule 6(3), Form B