Out Patient Addictions Counselor Time Sheet

Counselor Name: _____
Counselor ID: _____

	Date:	Date:	Date:	Date:	Date:	Date:	Date:
Start time							
End time							
Minus Lunch Time							
Total hours worked							
Service	Time	Time	Time	Time	Time	Time	Time
Direct contact with client individually in counseling session							
Direct contact with client with family member present							
Case management activities, Referrals, case coordination, etc.							
Paperwork documentation outside of the client session.							
Travel affiliated with client							
Receiving Supervision (one-on-one or group)							
Receiving Training							
Providing Training							
Providing Community Education							
Staff meetings							
Other, Specify _____							
Other, Specify _____							
Total time							

CBAT Client Log (Client's seen each day)

Date:	Client Case No ***(REQUIRED)***	Gender M / F	Code of Client	Time with Client	Intake or Treat (Circle one)		Client Name
					Intake	Treat	
					Intake	Treat	
					Intake	Treat	
					Intake	Treat	
					Intake	Treat	
					Intake	Treat	
					Intake	Treat	
					Intake	Treat	
					Intake	Treat	
					Intake	Treat	