



THE NEW YORK INSTITUTE FOR PSYCHOTHERAPY TRAINING
In Infancy, Childhood and Adolescence
 3701 Bedford Avenue
 Brooklyn, New York 11229

MONTHLY PATIENT SUMMARY

Forms are to be sent monthly to **Mary Tirolo, LCSW, Dean of Students, 435 5th Street, Brooklyn, NY 11215**
 Please make a copy of this form for yourself before submitting it.

Candidate _____ Month, Year _____
 Supervisor _____

A	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

1. In column A, enter the initials of each child patient.
2. For the month, put a T on the top line under each date on which there was a scheduled appointment, e.g. for September 7th, put a T in column 7.
3. For a parent collateral session, mark a C under the appropriate date.
4. If the appointment is kept, place a K on the second line.
5. If the appointment is cancelled or missed, put an X on the second line.

TOTAL NUMBER OF KEPT APPOINTMENTS FOR MONTH: _____ **FOR ACADEMIC YEAR:** _____