**Progress Note for Client # \_\_\_\_\_\_\_**

**Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**Time**:\_\_\_\_:\_\_\_\_ [ ]  am/[ ]  pm **Session Length**: [ ]  45 min. [ ]  60 min. [ ]  Other: \_\_\_\_\_\_\_\_minutes

**Present**: [ ]  Adult Male [ ]  Adult Female [ ]  Child Male [ ]  Child Female [ ]  Other: \_\_\_\_\_

**Billing Code:** [ ]  90791 (eval) [ ]  90834 (45 min. therapy) [ ]  90837 (60 min. therapy) [ ]  90847 (family) [ ]  other: \_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| **Symptom(s)** | **Duration and Frequency Since Last Visit** | **Progress** |
| 1:  |  | **Select** |
| 2:  |  | **Select** |
| 3:  |  | **Select** |

*Explanatory Notes on Symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**In-Session Interventions and Assigned Homework**

**Client Response/Feedback**

**Plan**

[ ]  Continue with treatment plan: plan for next session:

[ ]  Modify plan:

*Next session*: Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time:\_\_\_:\_\_\_ [ ]  am/[ ]  pm

**Crisis Issues**: [ ]  No indication of crisis/client denies [ ] Crisis assessed/addressed: describe below

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

Clinician’s Signature, License/Intern Status Date

**Case Consultation/Supervision** **[ ]** Not Applicable

*Notes:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Collateral Contact [ ]** Not Applicable

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_Time:\_\_\_\_:\_\_\_\_ [ ] am/[ ] pm

[ ]  Written release on file: [ ]  Sent/[ ]  received [ ]  in court docs [ ]  other: \_\_\_\_\_\_

*Notes*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

Clinician’s Signature, License/Intern Status Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

Supervisor’s Signature, License Date