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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Client Name** (First, MI, Last) | | | | | | | | | | | **Client No.** | | | |
| **Others Present at Session:** If others present, please list name(s) and relationship(s) to the client: Client Present Client No Show/Cancelled | | | | | | | | | | | | | | |
| **Stressor(s)/ Significant Changes in Client’s Condition** (for face-to-face visit) | | | | | | | | | | | | | | |
| **No Significant Change from Last Visit** | | | |  | | | | | | | | | | |
| **Mood/Affect** | | | |  | | | | | | | | | | |
| **Thought Process/Orientation** | | | |  | | | | | | | | | | |
| **Behavior/Functioning** | | | |  | | | | | | | | | | |
| **Substance Use** | | | |  | | | | | | | | | | |
| **Danger to:**  **None Self Others Property** | | | | | | **Ideation Plan Intent Attempt Other:** | | | | | | | | |
| **Goal(s)/Objective(s):** | | | | | | | | | | | | | | |
| **Therapeutic Intervention and Progress Toward Goal/s:** | | | | | | | | | | | | | | |
| **Recommendation for Modification and Update of the ISP if Applicable:** | | | | | | | | | | | | | | |
| **Provider Signature/Credentials** | | | | | **Date** | | **Supervisor Signature/Credentials** (if needed) | | | | | | **Date** | |
| **Medicare “Incident to” Services Only** | | | | | | | **Supervisor Signature/Credentials (if needed)** | | | | | | **Date** | |
| **Supervisor Consultation (if needed)** | | | | | | | | | | | | | | |
| **Date of Service** | **Staff ID No.** | **Loc. Code** | **Prcdr. Code** | **Mod 1** | | **Mod 2** | **Mod 3** | **Mod 4** | **Start Time** | **Stop Time** | | **Total Time** | | **Diagnostic Code** |
|  |  |  |  |  | |  |  |  |  |  | |  | |  |
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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Client Name** (First, MI, Last)  Betty Borderline | | | | | | | | | | | **Client No.**  5.0.5. | | | |
| **Others Present at Session:** If others present, please list name(s) and relationship(s) to the client:  Client Present Client No Show/Cancelled | | | | | | | | | | | | | | |
| **Stressor(s)/ Significant Changes in Client’s Condition** (for face-to-face visit) | | | | | | | | | | | | | | |
| **No Significant Change from Last Visit** | | | |  | | | | | | | | | | |
| **Mood/Affect** | | | |  | | | | | | | | | | |
| **Thought Process/Orientation** | | | |  | | | | | | | | | | |
| **Behavior/Functioning** | | | |  | | | | | | | | | | |
| **Substance Use** | | | |  | | | | | | | | | | |
| **Danger to:**  **None Self Others Property** | | | | | | **Ideation Plan Intent Attempt Other:** | | | | | | | | |
| **Goal(s)/Objective(s): G**oal 1/objective 1 | | | | | | | | | | | | | | |
| **Therapeutic Intervention and Progress Toward Goal/s:** Client reported she had strong thoughts of self-harm this week but had not acted on them. I asked how she had done this and labeled the skills she had used to assist her in circumventing these thoughts.  Affirmed validated her feelings noting she had done this without the people who usually are available to help her get through these difficult times. Discussed the reason for thoughts of self-harm to increase awareness of when thoughts could re-occur in order to plan to effectively manage these thoughts. Client commended for gaining the ego-strength to counteract urges to harm herself. Client recognized her dysfunctional thoughts were, in part, the result of a disrupted routine that created anxiety which triggered self- injurious thoughts. Client states that she does not currently have thoughts of self –harm. | | | | | | | | | | | | | | |
| **Recommendation for Modification and Update of the ISP if Applicable:** NA | | | | | | | | | | | | | | |
| **Provider Signature/Credentials**  *Thomas Therapist, LPC* | | | | | **Date**  12/23/10 | | **Supervisor Signature/Credentials** (if needed) | | | | | | **Date** | |
| **Medicare “Incident to” Services Only** | | | | | | | **Supervisor Signature/Credentials (if needed)** | | | | | | **Date** | |
| **Supervisor Consultation (if needed)** | | | | | | | | | | | | | | |
| **Date of Service** | **Staff ID No.** | **Loc. Code** | **Prcdr. Code** | **Mod 1** | | **Mod 2** | **Mod 3** | **Mod 4** | **Start Time** | **Stop Time** | | **Total Time** | | **Diagnostic Code** |
| 12/23/10 | 007 | 11 | 15 | HE | | - | - | - | 1:00 | - | | :60 | | 301.83 |
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OUTPATIENT TRAUMA FOCUS COGNITIVE BEHAVIORAL THERAPY (TFCBT) PROGRESS NOTE

**CASE TYPE:** WRAP TFCBT; JOP/WRAP TFCBT; OUTPATIENT TFCBT; SCHOOL BASED TFCBT

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Client Name:**(Last, First) **Client #: Date of service: Staff ID, Name**: | | | | | | | | | |
| **Client Start Time** | | | **:** PM | **Client End Time** | | **:** PM | **Billable Time** | | ***0.00*** UNITS |
| **Staff Start Time** | | | **:** PM | **Staff End Time** | | **:** PM | **Total Time** | | ***0.00*** UNITS |
| ***Program RU***  ***<*** | | | | | ***Location***  ***< Other:*** | | | ***Modifier***  ***<*** | |
| ISP GOAL(S) ADDRESSED: #1 ; #2 ; #3 ; #4 | | | | | | | | | |
| **INTERVENTION** | | | | | | | | | |
| PSYCHOEDUCATIONAL: CLIENT | | | | PSYCHOEDUCATIONAL: PARENT | | | RELAXATION SKILLS | | |
| > | | | | > | | | > | | |
| AFFECT EXPRESSION | | | | COGNITIVE COPING TECHNIQUES | | | INVIVO DESENSITIZATION | | |
| > | | | | > | | | > | | |
| Narrative therapy techniques Safety planning  Identify and correct cognitive distortions  Preparation of child for sharing narration with parent using CBT and client centered techniques Other:  Other: | | | | | | | Identify and correct cognitive distortions Behavior management techniques Preparation of parent for sharing of narration Other:  Other: Other: | | |
| ***Briefly Describe***: | | | | | | | | | |
| **Progress:** N/A No Change Deterioration Improvement: If Deterioration or Improvement Noted, Briefly Describe | | | | | | | | | |
| **Significant Life Changes/Events**: N/A Yes, Explain: | | | | | | | | | |
| **Recommend Modification to ISP**: No Yes, refer to MHA Update | | | | | | | | | |
| **Change in Risk to Self or Others**: No Yes, refer to MHA update; Suicide Assessment; Duty to Protect | | | | | | | | | |
| My signature verifies that service occurred as documented on this progress note. I authorize Bellefaire/JCB to bill for the time documented as “billable” above. | | | | | | | | | |
| STAFF SIGNATURE CREDENTIAL DATE    SUPERVISOR SIGNATURE (If Applicable) CREDENTIAL DATE | | | | | | | | | |
| Conversion chart: | > |  | | | | | | | |

March 2010

BEHAVIORAL HEALTH COUNSELING



OUTPATIENT TRAUMA FOCUS COGNITIVE BEHAVIORAL THERAPY (TFCBT) PROGRESS NOTE

**CASE TYPE:** WRAP TFCBT; JOP/WRAP TFCBT; OUTPATIENT TFCBT;  SCHOOL BASED TFCBT

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Client Name:**(Last, First) | |  | | **Client #: Date of service:** 3/2/2010 | | | | | | |
| **Staff ID, Name**: | | | | | | | | | | |
| **Client Start Time** | | | ***01*:*15*** PM | | **Client End Time** | | ***02*:*10*** PM | **Billable Time** | | ***0.92*** UNITS |
| **Staff Start Time** | | | ***01*:*15*** PM | | **Staff End Time** | | ***02*:*10*** PM | **Total Time** | | ***0.92*** UNITS |
| ***Program RU 624 BHC*** | | | | | | ***Location***  ***03 School Other:*** | | | ***Modifier***  ***F0 F:F w/Client(IP)*** | |
| ISP GOAL(S) ADDRESSED: #1 ;  #2 will demonstrate improved coping skills to better manage difficult feelings, including those surrounding her history of trauma, as evidenced by guardian and school reports of rule compliance and improved scores in the areas of arguing with others, getting into fights, yelling, screaming, fits of anger, breaking rules, lying, can’t sit still, feeling lonely, having nightmares and breaking the law on her Ohio Scales. ;  #3 will improve her communication skills as evidenced by family reports of improved satisfaction in relationship with IP and improved scores in the areas of arguing, fights, yelling and screaming, fits of anger, breaking rules, lying, feeling lonely and breaking the law on IPs Ohio Scales. ; #4 | | | | | | | | | | |
| **INTERVENTION** | | | | | | | | | | |
| PSYCHOEDUCATIONAL: CLIENT | | | | | PSYCHOEDUCATIONAL: PARENT | | | RELAXATION SKILLS | | |
| Rationale for completing narrative | | | | | > | | | > | | |
| AFFECT EXPRESSION | | | | | COGNITIVE COPING TECHNIQUES | | | INVIVO DESENSITIZATION | | |
| Feeling Identification | | | | | Cognitive positive self talk | | | Exploration development of self efficacy | | |
| Narrative therapy techniques Safety planning  Identify and correct cognitive distortions  Preparation of child for sharing narration with parent using CBT and client centered techniques Other:  Other: | | | | | | | | Identify and correct cognitive distortions Behavior management techniques Preparation of parent for sharing of narration Other:  Other: Other: | | |
| ***Briefly Describe***: Ip stated that she feels alright about starting her trauma narrative. IP stated an understanding of why the trauma narrative will be used. IP did very well writing out her positive internal traits paragraphs and appears to be getting better with her impulsivity of crossing things out quickly. As IP was writing her positive traits this worker assisted in the identification of cognitive distortions and turning negative statements into positive ones. | | | | | | | | | | |
| **Progress:** N/A  No Change Deterioration Improvement: If Deterioration or Improvement Noted, Briefly Describe | | | | | | | | | | |
| **Significant Life Changes/Events**:  N/A Yes, Explain: | | | | | | | | | | |
| **Recommend Modification to ISP**:  No Yes, refer to MHA Update | | | | | | | | | | |
| **Change in Risk to Self or Others**:  No Yes, refer to MHA update; Suicide Assessment; Duty to Protect | | | | | | | | | | |
| My signature verifies that service occurred as documented on this progress note. I authorize Bellefaire/JCB to bill for the time documented as “billable” above. | | | | | | | | | | |
| LPC 3/12/10  STAFF SIGNATURE CREDENTIAL DATE    SUPERVISOR SIGNATURE (If Applicable) CREDENTIAL DATE | | | | | | | | | | |
| Conversion chart: | > |  | | | | | | | | |

March 2010

***Affix CLIENT label***

**Greater Cincinnati Behavioral Health Services**

# Counseling Progress Note

***Affix STAFF label***

***Client ID:***

**Client Name:**

***Staff ID:***

**Staff Name:**

***Date of Service***

***M M D D Y Y Y Y***

***Start Time***

* ***am***
* ***pm***

***End Time***

* ***am***
* ***pm***

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Program: CTU Counseling** | | | **Team:** | | **Service Code: H0004** | | □**HE-**face-to- face □ **HQ-**group | | | **# in group** |
| ***Client Location***  ***(check only one)*** | *□* ***53-****GCB □* ***12-****Client Home □* ***99-Community*** *□* ***51-****Summit □****09-****Incarcerated* | | | | | | | □ **UK-** client not present | | **Date entered:** |
| **Observed/Reported changes in condition:** | | | | | | | | | | |
| **None** | | | | | | | | | | |
|  | | | | | | | | | | |
|  | | | | | | | | | | |
| **Stressors/Extraordinary Events:** | | | | | | | | | | |
| **None No significant change from last visit** | | | | | | | | | | |
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| **Client Condition** | | | | | | | | | | |
| **Appearance** | | | | | | unusual/bizarre | | | poor hygiene | |
| appropriate | | casual and neat | | fastidious | | appears younger | | | apprehensive | |
| inappropriate | | unkempt | | disheveled | | appears older | | | other: | |
| **Behavior** | | | | | | | | | | |
| cooperative | | guarded | | aggressive | | passive | | | agitated | |
| unusual/bizarre | | impulsive | | fearful | | dramatic | | | other: | |
| **Stream of Thought** | | | | | | | | | | |
| clear & coherent | | impoverished | | rapid | | flight of ideas | | | incoherent | |
| fragmented | | disordered | | loose | | tangential | | | other: | |
| **Abnormalities of Thought Content** | | | | | | | | | | |
| none | | phobias | | concrete thinking | | paranoid ideation | | | delusions | |
| overvalued ideas | | ideas of reference | | poverty of thought | | obsessions | | | other: | |
| **Perceptual Disturbances** | | | | | | | | | | |
| none | | depersonalization | | derealization | | auditory | | | visual | |
| illusions | | tactile | | olfactory | | other: | | | | |
| **Affect** | | | | | | | | | | |
| appropriate | | inappropriate | | expansive | | guilty | | | bright | |
| congruent | | incongruent | | labile | | heightened | | | depressed | |
| full range | | constricted | | blunted | | flat | | | other: | |
| **Mood** | | | | | | | | | | |
| euthymia | | elevated | | euphoria | | angry/irritable | | | apprehensive | |
| anxious | | depressed | | dysphoria | | apathetic | | | other: | |
| **Orientation** | | | | | | | | | | |
| oriented x 3 | | not time | | not place | | not person | | |  | |
| **Insight** | | | | | | | | | | |
| present | | adequate | | limited | | impaired | | | faulty | |
| **Judgment** | | | | | | | | | | |
| good | | fair | | impaired | | poor | | | grossly inadequate | |

***Affix CLIENT label***

**Greater Cincinnati Behavioral Health Services**

# Counseling Progress Note

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Client Name:** | | ***Client ID:*** | | | |
| **Issue(s) presented today:** | | | | |  |
| symptoms or impairment such as attitudes about illness: | | | | |
| early life experiences: | | | | |
| emotional distress: | | | | |
| maladaptive behavior patterns: | | | | |
| personality growth and development: | | | | |
| stabilization of mental status or functioning: | | | | |
| issues related to establishing therapeutic relationship: | | | | |
| coping strategies or techniques: | | | | |
| other: | | | | |
| **Goal(s)/Objective(s) Addressed from ISP:** | | | | |
|  | | | | |
|  | | | | |
| **Recommended Revision to ISP: None Revise ISP** | | | | |
|  | | | | |
| **Therapeutic interventions provided OR Group Topic/Activity/Intervention** | | | | |
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| **Response to intervention/Progress toward goals OR Group Participation** | | | | |
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| **Additional information/Plan** | | | | |
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|  | | | | |
| **Provider Signature/Credential: Date:** | | | **Client Signature (Optional Based on Client Preference):**  **Date:** | |
| **Counter-Signature/Credential: Date:** | | |
| **Date/Time of next Appointment:** | **Client rating of progress:** (write number in box) Have you made progress toward your goals today?  ( Not Rated = **0**; None = **1** Some Progress = **2**; or Good Progress= **3** | | |  |



