Therapy Progress Note

Community Counseling Services

Rev 01/17

Case Name _____

Case Id# _____

Date: _____

Service Code: _____

Location of Visit ☐ Home ☐ CMHC ☐ School ☐ Other _____ **Start Time:** _____ **End Time:** _____ **Minutes** _____

First hand observation **As reported by:** _____

Suicidal or Homicidal Ideation? ☐ **No** ☐ **Yes** ***If YES, report action taken in summary.*** Safety Contract Suicidal Form

Appearance:

Dress: ❑Neat ❑Appropriate ❑Disheveled ❑Unclean ❑Unusual ❑Bizarre

Motor Activity: ❑ Underactive ❑Overactive ❑Average ❑Fidgety ❑Restless ❑Tics

Eye Contact: ❑ Good ❑ Fair ❑Poor ❑_____

Posture: ❑ Catatonic ❑ Slumped ❑Rigid ❑Bizarre ❑Unremarkable ❑_____

Behavior General: ❑ Cooperative ❑Uncooperative ❑Nonverbal ❑Hostile ❑Submissive

❑ Aggressive ❑ Guarded ❑Shy ❑Verbal ❑Violent

❑ Compulsive ❑ Ritualistic ❑Disorganized ❑_____

Affect: ❑ Appropriate ❑ Inappropriate ❑ Flat ❑ Depressed ❑Anxious

❑ Angry ❑ Pleasant ❑ Fearful ❑Suspicious ❑Irritable

❑ Expansive ❑ Elevated ❑ Euphoric ❑ _____

Cognition:

Orientation: ❑Oriented x4 to time, place, person, situation ❑ Disoriented as to time, place, person, situation ❑Confused

Thinking: ❑Organized ❑Disorganized ❑Concrete ❑Autistic ❑Blocked

❑Circumstantial ❑Flight of Ideas ❑_____

Attention/ Concentration: ❑Average ❑Poor ❑Distracted ❑_____

Hallucinations: ❑Visual ❑ Auditory ❑Olfactory ❑Tactile ❑Taste ❑None reported

Paranoia: ❑Paranoid ❑Delusions ❑None Reported

Sleep pattern: _____

Eating pattern: _____

Medication Compliance

Reported by Individual: Agency prescribed medications ❑**Compliant** ❑**Non-Compliant** ❑**No Medications Prescribed** ❑**N/A**

Reported by Individual: Other prescribed medications ❑**Compliant** ❑**Non-Compliant** ❑**No Medications Prescribed** ❑**N/A**

Problems/Side Effects Reported: _____

Any Changes in Medications? □ **No** □ **Yes** **If Yes, List the changes:** _____

(Update Medication/Drug Use Profile Form)

Treatment Plan Objectives Addressed:

Objective 1:

Objective 2:

Objective 3:

Specific interventions provided: ☐ CBT ☐ Person Centered ☐ Reality ☐ REBT ☐ Solution Focused ☐ BX Modification

☐ Motivational Interviewing ☐ Psycho-Educational ☐ Emotion Regulation ☐ Trauma Focused ☐ Psychodynamic/insight oriented

☐ Crisis Intervention ☐ Behavioral ☐ Service Plan Update ☐ Annual Review

☐ Other_____

Summary of Session:

Assessment of Progress towards Objective Completion:

Plans for Future Therapeutic Activities:

Next Appointment _____/_____/_____

Homework Assigned: _____

_____ _____

Clinician's Signature and Credentials — Date

_____ _____

Supervisor's Signature and Credentials *(if applicable)* — Date