Community Support Services 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** _____

Treatment Intervention/Modality: ☐ **Intake*** ☐ **Follow-up*** ☐ **Crisis Intervention*** ☐ **Linkage*** (******signature required*)

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

Suicidal/Homicidal Ideation ❑**No** ❑**Yes** ❑**Ideation** ❑**Plan** ❑**Intent** ***If "YES, report action taken in summary.***

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)

Individual's Strengths: _____

Individual's Limitations/Barrier's to Achieving Goals: _____

Summary of Session: (What was the purpose/focus of the session?)

Treatment Plan Objectives Addressed: (As identified on the Community Support Activity Plan)

Assessment of Progress towards Objective Completion: (As related to the Objectives on the Community Support Activity Plan)

Plans for Future Therapeutic Activities:

Next Appointment _____/_____/_____

☐ **Community Support Services have been offered to me and I chose NOT to receive them.** *(If applicable)*

_____ _____
Individual's Signature/Collateral Contact Date

_____ _____
Service Provider's Signature and Credentials Date