Practitioner Name:______________________________

Address:______________________________

Phone/Email:______________________________

# PROGRESS NOTE

Service Date: ____________________ Service Duration:____________________

Client(s) Name(s):______________________________

Type of counseling service provided (if applicable):

☐ Individual ☐ Couple ☐ Family ☐ Group

NOTES:______________________________

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*Is this session telehealth?* ☐ Yes ☐ No

Mode of session: ☐ Interactive audio ☐ Video ☐ Electronic communication

Client's physical location: ______________________________

Local Emergency Contacts: ______________________________

| ____________________ | ____________________ | __________ |
|---|---|---|
| *Clinician's Signature* | *Clinician's Name* | *Date* |