MENTAL HEALTH PROGRESS NOTE

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