# Progress Note

**START TIME** _____ **am pm**

**CLIENT NAME** _____

**STOP TIME** _____ **am pm**

**SERVICE CODE** Individual session Family session Group session Phone Call No Show Cancel/Reschedule Consultation _____

**SYMTOM STATUS** improved maintained deteriorated **DIAGNOSTIC CHANGE?** no yes **If yes, new diagnosis:**

**LIST CURRENT SYMPTOMS** _____

_____

_____

_____

**LIFE EVENT?** no yes **If yes, describe:**

_____

**MEDICATION** compliance noncompliance side effect instructed to contact psychiatrist n/a

**SAFETY** suicidal homicidal none If yes, action taken:

_____

_____

_____

**Check if goals/objectives section below N/A because treatment plan not yet completed per clinic policy**

**GOALS/OBJECTIVES ADDRESSED (from treatment plan)**

Goal # ___ Objective # ___ Achieved? no partial yes Goal # ___ Objective # ___ Achieved? no partial yes

Goal # ___ Objective # ___ Achieved? no partial yes Goal # ___ Objective # ___ Achieved? no partial yes

**OVERALL PROGRESS TOWARD GOAL:** 1 2 3 4 5

NONE MIN MOD MAX MET

**REVISED GOALS/OBJECTIVES?** no yes If yes, Goal # ___ Objective # ___

new goal/objective:_____

_____

_____

_____