# Progress Note

|  |  |
| --- | --- |
| Clinician: | Date and Time: |
| Patient: | Duration: |
| Account Number | Service Code: |
|  | Location: |
| Participants: |

# Diagnosis

|  |  |
| --- | --- |
|  |  |
|  |  |
|  |

# Current Mental Status

|  |  |  |  |
| --- | --- | --- | --- |
| Orientation: | Choose an item. | Insight: | Choose an item. |
| General Appearance: | Choose an item. | Judgment/Impulse Control: | Choose an item. |
| Dress: | Choose an item. | Memory: | Choose an item. |
| Motor Activity: | Choose an item. | Attention/Concentration: | Choose an item. |
| Interview Behavior: | Choose an item. | Thought Process: | Choose an item. |
| Speech: | Choose an item. | Thought Content: | Choose an item. |
| Mood: | Choose an item. | Perception: | Choose an item. |
| Affect: | Choose an item. | Functional Status: | Choose an item. |

# Risk Assessment

[ ]  Patient denies all areas of risk. No contrary clinical indications present.

## Area of Risk:

|  |
| --- |
| Choose an item. |

**Level of Risk:** Low / Medium / High / Imminent

**Intent to Act:** Yes / No / Not Applicable

**Plan to Act:** Yes / No / Not Applicable

**Means to Act:** Yes / No / Not Applicable

**Risk Factors:** Current Ideation / Impulsivity / Access to means / Hopelessness / History of attempts/behaviors / Recent loss / Alcohol/Substance use / Family History

**Protective Factors:** Positive social support / Life satisfaction / Cultural/religious beliefs / Positive coping skills / Social responsibility / Sufficient problem-solving skills / Children in the home / Strong therapeutic rapport

**Additional Details:**

|  |
| --- |
|  |



## Medications

Click or tap here to enter text.

## Symptom Description and Subjective Report

Click or tap here to enter text.

## Objective Content

Click or tap here to enter text.

## Interventions Used



 



 

 

 

 

 



Other: Click or tap here to enter text.

## Treatment Plan Progress

### Objective 1 – Client will practice emotional regulation techniques at least 1x daily for a period of 90 days.

Progress: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Additional Notes / Assessment

|  |
| --- |
| Click or tap here to enter text. |

## Plan

|  |
| --- |
| Click or tap here to enter text. |

### Recommendation:







### Prescribed Frequency of Treatment:

Choose an item.

