

Progress Note

Name: _____ DOB: _____ Session Date: _____

Start: _____ Stop: _____ Diagnosis: _____

Participants: _____ Medications: _____

Danger to: None Self Others Ideation Plan Intent Attempt Other _____

Status: No Change Improvement Setback Deteriorating _____

Response to TX: Engaged Uninterested Cooperative Combative _____

Notable Changes Since Last Session: _____

Appearance	Judgment	Insight	Speech	Thought Content
<input type="checkbox"/> Appropriate	<input type="checkbox"/> Excellent	<input type="checkbox"/> Full	<input type="checkbox"/> Appropriate	<input type="checkbox"/> Hallucinations
<input type="checkbox"/> Inappropriate	<input type="checkbox"/> Good	<input type="checkbox"/> Partial	<input type="checkbox"/> Slurred	<input type="checkbox"/> Delusions
<input type="checkbox"/> Disheveled	<input type="checkbox"/> Fair	<input type="checkbox"/> Limited	<input type="checkbox"/> Rapid	<input type="checkbox"/> Paranoid
<input type="checkbox"/> Poor	<input type="checkbox"/> Poor	<input type="checkbox"/> None	<input type="checkbox"/> Pressured	<input type="checkbox"/> Dissociation
<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____

Thought Process	Mood	Behavior	Affect
<input type="checkbox"/> Irrelevant Detail	<input type="checkbox"/> Depressed	<input type="checkbox"/> Appropriate	<input type="checkbox"/> Expansive
<input type="checkbox"/> Disorganized	<input type="checkbox"/> Anxious	<input type="checkbox"/> Poor Eye Contact	<input type="checkbox"/> Euthymic
<input type="checkbox"/> Interrupted Thinking	<input type="checkbox"/> Irritable	<input type="checkbox"/> Distant/Distracted	<input type="checkbox"/> Constricted
<input type="checkbox"/> Loose	<input type="checkbox"/> Angry	<input type="checkbox"/> Hostile	<input type="checkbox"/> Blunt
<input type="checkbox"/> Illogical Connections	<input type="checkbox"/> Elevated	<input type="checkbox"/> Agitated	<input type="checkbox"/> Flat
<input type="checkbox"/> False Beliefs	<input type="checkbox"/> Euthymic	<input type="checkbox"/> Overly Accommodating	<input type="checkbox"/> Dysphoric
<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____

Treatment Interventions:

<input type="checkbox"/> Cognitive Restructuring	<input type="checkbox"/> Psychoeducation	<input type="checkbox"/> Crisis Intervention	<input type="checkbox"/> Systemic Family Therapy
<input type="checkbox"/> DBT	<input type="checkbox"/> Mindfulness Training	<input type="checkbox"/> Positive Psychology	<input type="checkbox"/> Play or Art Therapy
<input type="checkbox"/> Anger Management	<input type="checkbox"/> Problem Solving Skills	<input type="checkbox"/> Humanistic Therapy	<input type="checkbox"/> Client-Centered Therapy
<input type="checkbox"/> Roleplay	<input type="checkbox"/> Solution-Focused	<input type="checkbox"/> Trauma Focused CBT	<input type="checkbox"/> Existential Therapy
<input type="checkbox"/> Coping Skills	<input type="checkbox"/> Stress Management	<input type="checkbox"/> EMDR	<input type="checkbox"/> Communication Training
<input type="checkbox"/> Supportive Reflections	<input type="checkbox"/> Building Support	<input type="checkbox"/> Attachment Therapy	<input type="checkbox"/> Grief Processing
<input type="checkbox"/> Other _____			

Goal(s)/Objective(s):

Progress Note

Name:

Session Content:

Assigned Homework:

Next Apt:

Therapist/Provider Signature

Date