Progress Note

Date:
Client: Medicaid #:
Service: Session Start: Session End:
Type of Session:
Diagnosis:
Others Attending/Relationship to client:
Current Medication/Changes/Dosages:
Next Scheduled Medication Check:

Content/Process

Goal (From TX Plan):
New/Current Symptoms/Change in Stressors:
Interventions/Client Response:

Session Content (Narrative)

Subjective Report:
Objective Report:
Assessment:
Progress toward Goal:
Barriers:
Client Strengths:

Risks (Plan if necessary)

Risk of harm to self or others:
Substance use:
Risk of Violence:
Other:

Discharge/Transition Plan (Narrative)

Community Support Considered:
Treatment/Coordination Needed:
Plan for next session/Date of next session:

Therapist_____ Date_____

Supervising Practitioner_____ Date_____