

CLIENT: \_\_\_\_\_ DATE OF SERVICE: \_\_\_\_\_ TIME: \_\_\_\_\_

<b>Appearance</b> <input type="checkbox"/> WNL <input type="checkbox"/> Unkempt <input type="checkbox"/> Dirty <input type="checkbox"/> Meticulous  <b>Speech</b> <input type="checkbox"/> WNL <input type="checkbox"/> Pressured <input type="checkbox"/> Poverty of <input type="checkbox"/> Impaired <input type="checkbox"/> Slow  <b>Mood/Affect</b> <input type="checkbox"/> WNL <input type="checkbox"/> Flat <input type="checkbox"/> Depressed <input type="checkbox"/> Manic <input type="checkbox"/> Anxious <input type="checkbox"/> Fearful <input type="checkbox"/> Irritable <input type="checkbox"/> Angry <input type="checkbox"/> Labile <input type="checkbox"/> Incongruent  <b>Behavior</b> <input type="checkbox"/> WNL <input type="checkbox"/> Guarded <input type="checkbox"/> Withdrawn <input type="checkbox"/> Defensive <input type="checkbox"/> Oppositional <input type="checkbox"/> Hostile <input type="checkbox"/> Manipulative <input type="checkbox"/> Impaired <input type="checkbox"/> Threatening <input type="checkbox"/> Impulsive <input type="checkbox"/> Tearful <input type="checkbox"/> Tired  <b>Cognitions</b> <input type="checkbox"/> WNL <input type="checkbox"/> Loose Assoc. <input type="checkbox"/> Scattered <input type="checkbox"/> Blocked <input type="checkbox"/> Obsessive <input type="checkbox"/> Paranoid <input type="checkbox"/> Psychotic	<b>SERVICES RENDERED</b> <input type="checkbox"/> Initial Evaluation (90791) <input type="checkbox"/> Psychotherapy: 90832/30" <input type="checkbox"/> 90834 /45" <input type="checkbox"/> 90837/60" <input type="checkbox"/> Family Psychotherapy w/patient (90847) <input type="checkbox"/> Family Psychotherapy w/o patient (90846) <input type="checkbox"/> Multi-Family Psychotherapy (90849) <input type="checkbox"/> Group Psychotherapy (90853) <input type="checkbox"/> Crisis Psychotherapy 90839/60" <input type="checkbox"/> +90840 each addl 30" <input type="checkbox"/> Other _____ <input type="checkbox"/> Other _____ <input type="checkbox"/> Other _____	<b>PROGRESS</b> <input type="checkbox"/> Exceptional <input type="checkbox"/> Steady <input type="checkbox"/> Slow <input type="checkbox"/> Regressing <input type="checkbox"/> Stable <input type="checkbox"/> Maintaining <input type="checkbox"/> Discharge Plan.	<b>CURRENT MEDS</b> Med: Dose:  Med: Dose:  Med: Dose:
Treatment Goal Addressed: _____			
Additional Client Concerns Today: _____			
_____			
Interventions: _____			
_____			
Client's Response to Intervention: _____			
_____			
_____			
Referred To: _____			
Home Work Assigned Today: _____			
_____			
Home Work Completed From Last Session? : _____			
Danger to Self or Others? : _____			
If yes, describe danger and intervention: _____			
_____			
Additional Comments: _____			
_____			
Rescheduled for: Day:_____ Date:_____ Time:_____ <input type="checkbox"/> Client will call or email to reschedule			
Fee Charged : _____ Payment:_____ <input type="checkbox"/> Check <input type="checkbox"/> Cash <input type="checkbox"/> Credit Card <input type="checkbox"/> Bill Insurance			

Therapist Signature: \_\_\_\_\_ Degree: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_