

Progress Note

Client's Name/ID#: _____ Date: _____

Suicidal Ideation: ___ No ___ Yes: describe: _____

Substance Use Issues: ___ No ___ Yes: describe: _____

Change in Mental Status Exam: _____

Appearance:

Affect:

Orientation:

Memory:

Concentration:

Attention:

Mood:

Speech:

Motor:

Impulse Control:

Judgment:

Thought Process:

Thought Content:

Clinical Assessment (progress toward goals): _____

Interventions: _____

Plan for crisis management: _____

Education: _____ Member stated understanding: Yes _____

Medication	Dosage

Preliminary Discharge Plan: _____

Referral (as appropriate): _____

Clinician Signature: _____ Date: _____

Diagnosis: _____ Follow-up Appointment: _____