

Client Name

Client Number

Date:

Unit SubUnit Therapist # Service Total Time

Person Place Contact Type Appointment Type Intensity Type

Focus of Session:

Describe relevant aspects of client care/treatment (target symptom and functional impairment; client/family presenting problem(s) today; significant mood, appearance, behavioral or other observations; health risk factors, including SI/HI, if present).

Clinical Decisions & Interventions: Describe your specific, individualized interventions or decisions aimed at reducing the impairment. If you taught a coping skill or a recovery tool, monitored progress or developed a plan, describe what you did here.

Client's Response / Progress in Treatment: Describe how the client/family responded to your intervention(s). Describe client's progress toward his/her objective(s).

Plan / Referrals / Follow-up Care Needed:

Therapist's Signature: _____

Therapist's Name/Licensure:

Date Note Written: