

CLIENT: _____ DATE OF SERVICE: _____ TIME: _____

Appearance <input type="checkbox"/> WNL <input type="checkbox"/> Unkempt <input type="checkbox"/> Dirty <input type="checkbox"/> Meticulous Speech <input type="checkbox"/> WNL <input type="checkbox"/> Pressured <input type="checkbox"/> Poverty of <input type="checkbox"/> Impaired <input type="checkbox"/> Slow Mood/Affect <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 Behavior <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 Withdrawn 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 Cognitions <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	SERVICES RENDERED <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 _____	PROGRESS <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.	CURRENT MEDS Med: Dose: Med: Dose: Med: Dose:
Treatment Goal Addressed: _____			
Subjective Data/Clinical Impressions: _____ _____ _____ _____			
Objective Data/Behavioral Observations: _____ _____ _____			
Assessment: _____ _____ _____			
Plan: _____ _____ _____			
Danger to Self or Others? : _____ If yes, describe danger and intervention: _____ _____			
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: _____