Provider: _____ Client: _____
Address: _____ DOB: _____

PROGRESS NOTE

Date of Session: Time session started: am/pm Time session Ended: am/pm
Length of session: ☐16-37 min ☐38-52 min ☐>53 min ☐Other
Medicaid CT Telephone only: ☐ 99442 - 11-20 Minutes ☐99443 - 21-30 Minutes

Type of Session: ☐In Person ☐Video Session ☐Telephone Session ☐Other:

Modality: ☐Individual ☐Intake Assessment ☐ Couples/Family ☐Crisis ☐Group :

Provider Location: ☐ State: ☐In Office ☐In Provider Home ☐In Client Home ☐ Other:

Client Location: ☐ State Reported by Client: ☐In Provider's Office ☐In Client Home ☐Other:

Collaterals: ☐ None ☐ Present:

Employment: ☐Full-time ☐Part-time ☐Not Employed **Education:** ☐ N/A ☐ Full-time ☐Part-time

Medication: ☐N/A ☐Compliant ☐Non-compliant ☐Corrective Action

Substance Use: ☐N/A ☐Denies ☐Attending groups ☐Contact w/sponsor ☐Last use:

BRIEF MENTAL STATUS EXAM

Consciousness: ☐ Alert ☐ Clouded ☐ Other: **Orientation:** ☐ x3 ☐ x4 Other:

Mood: ☐Stable ☐Depressed ☐Manic ☐Anxious ☐Other:

Affect: ☐ Unrestricted ☐ Restricted ☐Other: **Thoughts:** ☐Goal directed ☐Other:

Psychotic sx: ☐N/A ☐Denies ☐Aud Halluc ☐Command Halluc ☐Visual Halluc ☐ Delusions

Suicidal: ☐No current safety concerns ☐Denies ☐Ideation ☐Means ☐Plan ☐Intent ☐Safety Plan Competed

Homicidal: ☐No current safety concerns ☐Denies ☐Ideation ☐Means ☐Plan ☐Intent ☐Safety Plan Competed

Diagnosis:

S:

O:

A:

P:

Return: ☐Weekly ☐Biweekly ☐As scheduled ☐Other: Signature:

☐ note continued on other side Provider: _____