

Session # _____

Client Name: _____ Date: _____

Start Time: _____ End Time: _____ Length of Appointment: _____

Participants & Relationship to Client: Client Spouse Mom Dad Other: _____

Functional Impairment (Current and Treatment Target)

Marriage	Job/School Performance	Family
Disability Leave	Job/School Jeopardy	Friends/ Peer Relationships
Financial Situation	Hobbies/ Interests	Physical Health
Activities of Daily Living	Cognitive	Sexual Function
Other: _____		

Current Signs/ Symptoms (Check all that apply)

Depressed Mood	Guilt	Anxiety/ Worry
Energy	Hopelessness/ Helplessness	Panic/ Phobias
Sleep	Somatic Complaints	Obsessions/ Compulsions
Irritability/ Anger	Racing Thoughts	Delusion/ Hallucination
Oppositional	Concentration	Substance Abuse
Appetite	Impulsivity	Other: _____

Interventions/ Techniques

Behavioral	Insight Oriented	Communication Modeling
Cognitive	Solution Focused	Homework Evaluations
Support	Play Therapy	Education Provided
Assessment	Crisis Management	Other: _____

Assessment/ Response (Since last appointment)

Suicide/ Homicide/ Violence Risk: None Ideation Only Threat Plan Gesture

Applicable specifics: _____

Compliance: None Low Partial Full

Goals: No Progress Deteriorating Gradual Progress Significant Progress

Functional Change: Improving Stable Retrogression

Sign/ Symptom Change: Improving Stable Retrogression

Diagnosis Change: No Yes Specify: _____

Plan: (Objectives for next session, changes, referrals)

Next Appointment: 1wk 2wks 3wks 1mo. Other: _____

Need Appointment to: Symptom Functioning Consolidate Gains Improve Compliance

Prepare for termination Other: _____

Continue to work toward goal achievement Referral: _____

Bibliotherapy Community Referral: _____

Homework: _____ Other: _____

