HUMAN BEHAVIOR INSTITUTE
Full Service Behavioral Health

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# PROGRESS NOTES

| Client Name: | Length of visit: | Page #: |
|---|---|---|
| Provider Name & Title: | Date of Service: | |

Name of Primary Counselor & Title (if different from Provider):

## I. TYPE OF VISIT

### I.a. Psychotherapy

| | | | | |
|---|---|---|---|---|
| ☐ Individual | ☐ Family w/ patient | ☐ Group w/ patient | ☐ CD-IOP | ☐ Re-evaluation |
| ☐ Conjoint | ☐ Family w/o patient | ☐ Group w/o patient | ☐ MH-IOP | ☐ Testing |

### I.b. Rehabilitative Services

| | | | |
|---|---|---|---|
| ☐ Home Visit | ☐ School Visit | ☐ Group | ☐ Community Setting |

| Basic Skills Training | | Psychosocial Rehab | |
|---|---|---|---|
| ☐ Individual living and self-care | ☐ Effective communication | ☐ Life-skills building | ☐ Effective communication |
| ☐ Problem-solving | ☐ Parent/Guardian training | ☐ Problem identification & resolution | ☐ Illness management |
| ☐ Social skills | ☐ Transitional living skills | ☐ Social skills and competency | ☐ Emotional & behavioral mgt. |

### I.c. Crisis Stabilization

| | |
|---|---|
| ☐ Child/Adolescent | ☐ Adult |

### I.d. Case Management

| | | |
|---|---|---|
| ☐ Office Visit | ☐ Home/Community visit | ☐ Telephone |

## II. Targeted Issues:

## III. Progress from prior session ➢ ⓪ None ① Minimal ② Need improvement ③ Improving ④ Progressing ⑤ Target achieved

## IV. Obstacles to progress:

## Notes:

Follow-up recommended: ☐ Daily ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Other (*specify*):

| Provider Signature: | Supervisor Signature: |
|---|---|
| Date: | Date: |