FAMILY COUNSELING SERVICES
PROGRESS NOTES

Client(s):
Date: Time: Session Length:
Mode of Treatment: ☐Individual Therapy ☐Couple ☐Family ☐Group ☐Consultation

Topics/Themes Discussed:
☐ Homework Assignment:
☐ Marriage/Partner Issues:
☐ Family Issue(s):
☐ Stressors:
☐ Work/School:
☐ Alcohol/Drug:
☐ Childhood/Family of Origin:
☐ Sexual Issue(s):
☐ Parenting:
☐ Sleep Issue(s):
☐ Behavioral Goals:
☐ Anger:
☐ Depression:
☐ Anxiety/Panic:
☐ Medical/Medication:
☐ Other:

Treatment/Interventions:
☐ Insights:
☐ Cognitive/Behavioral:
☐ Homework Given:
☐ Family/Relationships:
☐ Problem Solving:
☐ Support:
☐ Other:

Assessments:
Dress/Grooming: ☐Poor ☐Fair ☐Good ☐WellOther:
Mood: ☐Normal/Eutthymic ☐Anxious ☐Depressed ☐Angry ☐Euphoric
Affect: ☐Normal/Appropriate ☐Intense ☐Blunted ☐Inappropriate ☐Labile
Mental Status: ☐Normal ☐Lessened Awareness ☐Memory Deficiencies ☐Disoriented
☐Disorganized ☐Vigilant ☐Delusional ☐Hallucinating ☐Other:
Suicide/Violence Risk: ☐None ☐Low ☐Moderate ☐High Other:
Sleep Quality: **Appetite**:
Treatment Compliance: ☐Full ☐Partial ☐Low ☐Noncompliant
Response to Treatment: ☐Better than expected ☐As expected ☐Poorer ☐Very Poor

Changes to Diagnosis: ☐No ☐Yes
Changes to Treatment Plan: ☐No ☐Yes

Clinical Assessment:

Plan/Objective:

Notes:
Clinician Signature: _____ **Date**: _____

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