FRESNO COUNTY MENTAL HEALTH PLAN
PROGRESS NOTE

Consumer Name: **SSN:**

Type of Treatment: *Individual* ☐ *Group* ☐ *Family* ☐ *Case Management* ☐ *Other*

Service Date: Duration: Service Location: Phone Contact: Yes ☐ No ☐ Billable Service: Yes ☐ No ☐

Appointment Cancellation: Yes ☐ No ☐ No show for Appointment: Yes ☐ No ☐ Action Taken:

Barrier(s) to Treatment: (*Eg: health problems, transportation, etc.)*

Current behavioral Goals as Stated in the Treatment Plan: *(functioning/impairments affecting daily living)*

Therapeutic Interventions: *(includes referrals & linkages to other agencies, treatment provided, clinical decisions made*)

Progress in Treatment:

Plan:

Clinician's Signature: ______________________ **Date:** ______________________

Title/Licensure: **ID#:**

Consumer Name: **SSN:**

Type of Treatment: *Individual* ☐ *Group* ☐ *Family* ☐ *Case Management* ☐ *Other*

Service Date: Duration: Service Location: Phone Contact: Yes ☐ No ☐ Billable Service: Yes ☐ No ☐

Appointment Cancellation: Yes ☐ No ☐ No show for Appointment: Yes ☐ No ☐ Action Taken:

Barrier(s) to Treatment: (*Eg: health problems, transportation, etc.)*

Current behavioral Goals as Stated in the Treatment Plan: *(functioning/impairments affecting daily living)*

Therapeutic Interventions: *(includes referrals & linkages to other agencies, treatment provided, clinical decisions made*)

Progress in Treatment:

Plan:

Clinician's Signature: ______________________ **Date:** ______________________

Title/Licensure: **ID#:**