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| --- | --- | --- |
| Session Date |  | In-Person at Office \_\_\_\_ Video: \_\_\_\_ Phone: \_\_\_\_ |
| Service Type / CPT Code |  | Ct location: Home \_\_\_\_ Other:  |
| Therapy Start & Stop Times  |  | Diagnosis: |
| Attendees other than client |  | Telehealth Consent Obtained: Yes \_\_\_ N/A \_\_\_\_ |
| **Problem(s) discussed:** Focus of session, topics discussed – what issues, stressors is client reporting, dealing with? |  |
| **Symptoms/Impairment:** When appropriate, relate to diagnosis, and include specific frequency, type, and severity of symptoms and impact on functioning |  |
| **Status of Risk issues,** if any, (substance use, danger to self/others, etc.) or "ct. did not present risk issues." |  |
| **In-session Interventions** (ex. "helped identify cognitive distortions," "taught progressive relaxation"), **referrals made, and homework assigned** |  |
| **Progress toward treatment goals** (or lack of) /response to treatment, changes to diagnosis / treatment plan. Ongoing lack of progress should lead to treatment plan changes | \_\_\_\_ Ct progressing \_\_\_\_ Needs maintenance \_\_\_ Ct not progressing/worseningAs evidenced by:  |
| **If applicable: Medical Necessity for 90837 sessions**  |  |
| **Next session date** (note reason if frequency change) |  |
| **Therapist legible signature** (electronic OK) w/ license  |  |