

**The Hammond Group, Inc.**  
**Phone: 866-984-2665 Fax: 866-634-2131**

**Progress Note**

Referral Agency: \_\_\_\_\_ Case Manager: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Provider: \_\_\_\_\_

Date: \_\_\_\_\_ Start Time: \_\_\_\_\_ AM/PM End Time: \_\_\_\_\_ AM/PM Hours: \_\_\_\_\_

Type of Service:  Mentor  Behavioral Assistant  Intensive In Community ( Bachelors  Masters  Licensed)

Data: (check all that apply)

Appearance:  Groomed  Unkempt  Bizarre Combinations

Behavior:  Cooperative  Uncooperative  Suspicious  Threatening  Hyperactive  
 Poor Attention  Impulsive

Speech:  Normal  Slow  Pressured  Rambling  Incoherent

Thought:  Appropriate  Delusions  Logical  Hallucinations

Ideation:  Suicidal  Denies (if present, describe): \_\_\_\_\_  
 Homicidal  Denies (if present, describe): \_\_\_\_\_

Mood: \_\_\_\_\_  
Describe Mood

Goal(s) addressed: (Be specific, remember to utilize ISP, ICP or treatment plan)

Behavioral Observations: (Please include what you noticed throughout your session)

Action to work on before next session: (this must be completed)

Summary: (please include any additional information and summarize the session)

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Supervisor Signature: \_\_\_\_\_ Date: \_\_\_\_\_