

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: _____