

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#: