FRESNO COUNTY MENTAL HEALTH PLAN
PROGRESS NOTE

Consumer Name: ______________________________ **SNN:** ______________

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

Service Date: __________ Duration: ________ Service Location: __________ Phone Contact: Yes ☐ Billable: Yes ☐

Appointment Cancellation: ☐ No show: ☐ Action Taken: ______________________

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

Symptoms: ______________________________

Impairments: ______________________________

S:

O:

A:

P:

Clinician Signature and Title: ______________________________

ID# Date

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ID# Date