Practice/Practitioner Name
Address
Phone/Email

PROGRESS NOTE

Service Date: _____ Service Duration: _____

Client(s) Name(s): _____

Type of counseling service provided (if applicable):

☐ Individual ☐ Couple ☐ Family ☐ Group

NOTES: _____

_____

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_____

Is this session telehealth? ☐ Yes ☐ No

Mode of session: ☐ Interactive audio ☐ Video ☐ Electronic communication

Client's physical location: _____

Local Emergency Contacts: _____

_____ _____ _____

Clinician's Signature *Clinician's Name* *Date*

SAMPLE