



Partners in Hope. Solutions for Life.

Safe Harbor  
CHRISTIAN COUNSELING

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## PROGRESS NOTE FORM

Client Name:

Date:

Insurance ID or SS#:

Medications:

CPT Code:

Type of Service: \_\_\_ Individual \_\_\_ Family \_\_\_ Group

Date of Birth:

Symptoms:

### MENTAL STATUS EXAM

Appearance Dress  Appropriate  Inappropriate Hygiene  Good  Fair  Poor Eye Contact  Appropriate  Inappropriate

Manifest Behavior  Cooperative  Oppositional  Passive  Hostile  Threatening  Attention Seeking  Guarded  Fidgety

→ Psychomotor Retardation  Clearly Hyperactive  Slowed Activity  Tics Present  Shy  Intrusive  Age Appropriate  Restless

Speech  Normal Rate  Pressured  Excessively Slowed  Articulation Defect  Fluent  Normal Volume  Soft  Loud

Affect  Full Range  Anxious  Depressed  Labile  Hostile  Constricted  Blunt  Flat  Appropriate  Inappropriate

Mood \_\_\_\_\_ (Patient's Words) If applicable

Thought Processes  Logical  Circumstantial  Tangential  Goal-Directed  Derailment  Blocking

Unusual Thought Content  Suicidal Ideation  Homicidal Ideation Other \_\_\_\_\_

Perceptual Disturbances  Auditory  Visual  Somatic  Tactile  Illusions  Delusions  Not Elicited

Sleep Disturbances  None  Mild  Moderate  Severe Comments, if present \_\_\_\_\_

Eating Habits  Normal  Abnormal  Severe Problems Comments, if present \_\_\_\_\_

Attention  Age-Appropriate  Distractible Concentration  Good  Fair  Poor Insight/Judgement  Good  Fair  Poor

Other Reported Behavior: Home  Good  Fair  Poor School/Work  Good  Fair  Poor Community  Good  Fair  Poor

Substance Usage: Current \_\_\_\_\_ Past \_\_\_\_\_

PROGRESS NOTE: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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Interventions Used: \_\_\_\_\_

Homework: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

GAF: \_\_\_\_\_

Therapist Signature w/Degree \_\_\_\_\_