The Columbus Wellness Center
124 Hyatts Rd Delaware, OH 43015 P: (833)336-7543 F:
info@thecolumbuswellnesscenter.com www.thecolumbuswellnesscenter.com

Progress Note

Copay: ______________ Deductible: ____________ ☐Deductible Met ☐Pt requires Superbill
Insurance Payer: ____________________________

Patient Name: ______________________
Contact #: _________________________ Email: ____. Preferred Contact Method (circle one): Text VM Email Messenger

Clinician: ____
Service Code: ____________ Location: ___________________ Dx Code: _______________
☐ Individual session ☐Group Session ☐ Joint Session # of Participants: ______________________

Date of Service: ______________ Start Time: ________ End Time: ______ Total time of session: _______

Current Mental Status:

Normal appropriate unremarkable euthymic congruent good excellent intact poor

☐Initial Assessment ☐Improved ☐Declined ☐Relapsed ☐No Change

(Circle one)
Orientation:
normal appropriate unremarkable euthymic dysthymic congruent good excellent intact poor

Insight:
normal appropriate unremarkable euthymic dysthymic congruent good excellent intact poor

General Appearance:
normal appropriate unremarkable euthymic dysthymic congruent good excellent intact poor

Judgement:
normal appropriate unremarkable euthymic dysthymic congruent good excellent intact poor

Impulse Control:
normal appropriate unremarkable euthymic dysthymic congruent good excellent intact poor

Dress:
normal appropriate unremarkable euthymic dysthymic congruent good excellent intact poor

Motor Activity: normal appropriate unremarkable euthymic dysthymic congruent good excellent intact poor

Interview Behavior: normal appropriate unremarkable euthymic dysthymic congruent good excellent intact poor

Speech: normal appropriate unremarkable euthymic dysthymic congruent good excellent intact poor

Mood: normal appropriate unremarkable euthymic dysthymic congruent good excellent intact poor

Affect: normal appropriate unremarkable euthymic dysthymic congruent good excellent intact poor

Risk Assessment:
☐ SI ☐HI ☐Patient reports no risk ☐ Contrary Indications ☐No contrary indications ☐Safety Plan

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Symptom Description in Clients own words: ____

____

Session Content:

Interventions Used: ____

Treatment Plan ☐ Continue from Previous Session Notes ☐ Maintain Plan

Updated Goal 1: ____
Time to complete: (#) ________ days Weeks Months

Updated Goal 2: ____
Time to complete: (#) ________ days Weeks Months

Updated Goal 3: ____
Time to complete: (#) ________ days Weeks Months

☐ Change in Treatment ☐ Maintain Treatment ☐ Patient is declining ☐ Patient is progressing

Prescribed Frequency of Tx: ☐ Terminate ☐ Maintain ☐ Change # ______weekly Monthly. yearly

Recommendation:
☐ Continue current therapeutic focus
☐ Terminate
☐ Refer: ____

Clinician Name: _______________________ Credentials: ______________

License #_________________, ________________, _____________

Signature: ____

I signed this note and declared this information to be accurate and complete on:

Date: _________________ Time: ______________