|  |  |  |
| --- | --- | --- |
| Client Name: | | |
| Date of Service: | Length of Session: | |
| CPT Code: | Diagnosis/ICD Code: | |
| **Present at Session** | | |
| Client Present  Client No showed/Cancelled  Others Present, List name(s) and relationship to client: | | |
| **Significant Changes in Client’s Condition** | | |
| No significant change from last visit | | |
| Mood/Affect | | |
| Thought Process/Orientation | | |
| Behavior/Functioning | | |
| Substance Use | | |
| Physical Health Issues | | |
| Other, Explain: | | |
| **Danger to:**  Self  Others  Property  None  Ideation  Plan  Intent  Means  Attempt | | |
| **Specifics Regarding Risk Assessment** | | |
| (Include safety planning, reports made, etc.) | | |
| **Evaluation Management** (Include required number of elements based on E/M billed): | | |
| **History:** | | |
| **Examination:** | | |
| **Current medication(s)/medication change(s):**  Refills  No side effects or adverse reactions noted or reported | | |
| **Medical Decision Making:** | | |
| **Lab Tests:** | | |
| Ordered  Reviewed  Describe: | | |
| **Recommendations and/or Referrals** | | |
|  | | |
| Follow-up Appointment: | | |
| **Provider Information** | | |
| Provider Signature & Credentials (if signature illegible, include printed name): | | Date of Signature: |