

<b>Progress Note Checklist</b>	<b>Check if addressed</b>
<b>Chief Complaint</b>	
<b>Your observation of the current condition and client statements</b>	
1) What is the client wanting help with, and what are their thoughts, concerns, and observations?	
2) What does the provider observe during the session: current impairment, appearance, cognitive capacity, body language, mood, symptoms affecting functioning.	
<b>Intervention</b>	
<b>Methods used to address goals, objectives, observations</b>	
1) What goals and objectives were addressed during this session?	
2) Describe how the interventions are addressing the client's mental health condition	
<b>Response</b>	
<b>Client's response to the intervention(s)</b>	
1) What is the client's current response to the intervention?	
<b>Progress Towards Objectives</b>	
<b>Document if progress was or was not made</b>	
1) Care Plan: note any changes in plan, referrals, homework	
<b>Overall Risk</b>	
<b>Identify client risk for DTS/DTO</b>	
<b>General Checklist</b>	
1) Does the note link with the client's individualized treatment plan?	
2) Are client strengths and limitations in achieving goals noted and considered?	
3) Are impairments distinguished from symptoms, and are the current impairments due to the documented mental health diagnosis?	
4) Do not document historical symptoms and impairments, stay current.	
5) Do interventions link with the client's impairment due to the mental health Dx?	
6) Does the note reflect any changes in client status (e.g. improved functioning)?	
7) Double check billing indicators to ensure accuracy (service location, appt type)	
8) Are any non-routine calls, missed session, or professional consultations documented accurately?	
9) Would someone not familiar with this case be able to read this note and understand exactly what has occurred in treatment?	
10) Spell-check using F7 key	