|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Practitioner Name:  |  |  | Session Date: |  |
|  |  |  |  |  |
| Session Start Time: |  |  | Session End Time: |  |
|  |  |  |  |  |
| Session: | [ ]  New | [ ]  Follow-up |  | Medical Record No.: |  |
|  |  |  |  |  |
| Location: |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Patient Name:  |  |  | DOB: |  |  | Gender: |  |

|  |  |
| --- | --- |
| **TREATMENT GOAL:** |  |
|  |  |
| Progress towards goal in today’s session: |  |
|  |  |
| Progress towards overall goal: |  |

|  |  |
| --- | --- |
| **D-DATA** |  |
| 🛈 | This section documents objective and information from the session, including direct observations of the client's behavior, communication, and significant events. |
|  |

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| **A-ASSESSMENT** |  |
| 🛈 | This section provides an analysis of the client's progress, strengths, challenges, and any pertinent insights regarding their current functioning and needs. |
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| --- | --- |
| **P-PLAN** |  |
| 🛈 | This section specifies the next steps for treatment or intervention, including goals, strategies to be used, and any follow-up or additional services required. |
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| --- | --- | --- |
|  | Practitioner’s Signature: |  |