



Person's Name (First / MI / Last): Ramirez, Joel						Record #: 1234		DOB: 1/15/07			
Organization Name: Children and Family Services of Boston											
Modality		<input type="checkbox"/> Individual <input checked="" type="checkbox"/> Family <input type="checkbox"/> Couple									
List Names of Persons Present		<input checked="" type="checkbox"/> Person Present <input type="checkbox"/> Person No Show <input type="checkbox"/> Person Cancelled <input type="checkbox"/> Provider Cancelled									
		Explanation: <input checked="" type="checkbox"/> Others Present (please identify name(s) and relationship(s) to Person): mother									
Person's report of progress towards goals /objectives since last session: "I practiced my breathing and could do it"											
New Issue(s) Presented today: <input type="checkbox"/> None Reported <input type="checkbox"/> New Issue resolved, no CA update required <input checked="" type="checkbox"/> CA Update Required Joel's mother reported that Joel had a sick child visit due to upper respiratory infection and that the pediatrician did some testing and diagnosed Joel with asthma.											
Person's Condition		No Significant Changes Reported or Observed		Notable		Changes in Person's Condition					
Mood/Affect:		<input checked="" type="checkbox"/>		<input type="checkbox"/>							
Thought Process /Orientation:		<input checked="" type="checkbox"/>		<input type="checkbox"/>							
Behavior/Functioning:		<input type="checkbox"/>		<input checked="" type="checkbox"/>		Joel appeared to be very active, more than normal.					
Medical Condition:		<input checked="" type="checkbox"/>		<input type="checkbox"/>							
Substance Use: <input checked="" type="checkbox"/> NA		<input type="checkbox"/>		<input type="checkbox"/>							
Risk Assessment											
Danger To: <input checked="" type="checkbox"/> None <u>OR</u> Check all that apply below and record action taken in Therapeutic Interventions section below											
<input type="checkbox"/> Self: <input type="checkbox"/> Ideation <input type="checkbox"/> Plan <input type="checkbox"/> Intent <input type="checkbox"/> Attempt - Comments:											
<input type="checkbox"/> Others: <input type="checkbox"/> Ideation <input type="checkbox"/> Plan <input type="checkbox"/> Intent <input type="checkbox"/> Attempt / <input type="checkbox"/> Property: <input type="checkbox"/> Ideation <input type="checkbox"/> Plan <input type="checkbox"/> Intent <input type="checkbox"/> Attempt											
Goal(s) Addressed as Per Individualized Action Plan:											
<input checked="" type="checkbox"/> Goal 2 <input type="checkbox"/> Objective 1 ____ <input checked="" type="checkbox"/> Objective 2 ____ <input type="checkbox"/> Objective 3 ____ <input type="checkbox"/> Objective ____						<input checked="" type="checkbox"/> Goal 1 <input checked="" type="checkbox"/> Objective 1 ____ <input type="checkbox"/> Objective 2 ____ <input type="checkbox"/> Objective 3 ____ <input type="checkbox"/> Objective ____					
Therapeutic Interventions Delivered in Session: Joel was actively engaged in practicing his deep breathing. He did this 3 times and brought a favorite stuffed animal with him to practice, too. Joel taught his stuffed animal how to do deep breathing and was able to reinforce his own skills by demonstrating this. Throughout the session, Joel was visually cued to look at this clinician while speaking to her. This clinician praised Joel every time he was able to do this. Joel, with verbal cues, was also able to use his talking object (he chose a male doll). when it was his turn to talk											
Person's Response to Intervention/Progress Toward Goals and Objectives: Joel was able to follow a visual cue to look at this clinician 3 times during the session. In addition, he was able to utilize his doll to be a talking object for him and he was successful in using this object for the majority of the session, with prompts.											
Plan / Additional Information (Indicate action plan between sessions): Joel will continue to practice his deep breathing at home 4 times during the week with his mother's coaching. He will also use his talking object at home when he needs to communicate.											
Provider - Print Name/Credential: Jane Doe, LMHC						Supervisor - Print Name/Credential (if needed):					
Provider Signature:				Date: 5/1/13		Supervisor Signature (if needed):				Date:	
Person's Signature (Optional, if clinically appropriate):				Date:		Next Appointment: Date: 5/8/13 - Time: 2:30 <input type="checkbox"/> am <input checked="" type="checkbox"/> pm					
<input type="checkbox"/> Medicare "Incident To" Services Only (If Applicable):				Name and credentials of supervising professional on Site:							
Date of Service	Provider Number	Loc. Code	Prctr. Code	Mod 1	Mod 2	Mod 3	Mod 4	Start Time	Stop Time	Total Time	Diagnostic Code
5/1/13	135	S1						2:30 pm	3:15 pm	45 min	299.80