Contact Form

UNIQUE OUTCOMES, INC.

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CONTACT FORM

Client's Name: _____ **Date of Service:** _____ dd / mm / yyyy

Start Time: _____ **End Time:** _____

No high risk symptoms noted.

Diagnosis Code: _____

Mode of Session

◯ in person ◯ telehealth

Session Type

◯ Individual ◯ Couples ◯ Family

Therapeutic Technique

- ☐ Cognitive Behavioral
- ☐ Behavior Modification
- ☐ Narrative
- ☐ Mindfulness
- ☐ Person/client-centered (Insight-Oriented,Supportive)

Goals

arrived at the session on-time. #####was oriented to person, place, and time. His eye contact and speech were appropriate. ##### readily engaged in conversation with the therapist, showing no signs of guardedness. #### mood and affect were congruent.

This writer met with ## for an individual session.

Homework

Next session: _____