

## Psychotherapy Progress Note

Use this note to document individual, family or couples psychotherapy sessions and person's response to the intervention during a specific contact.

Data Field	
<b>Person's Name</b>	Record the first name, last name, and middle initial of the person. Order of name is at agency discretion.
<b>Record Number</b>	Record your agency's established identification number for the person.
<b>Person's DOB</b>	Record the person's date of birth.
<b>Organization Name:</b>	Record the organization for whom you are delivering the service.
<b>Modality</b>	Check appropriate box to indicate the type of session: individual, family or couple.
<b>List Name(s) of Person(s) Present</b>	Check appropriate box to indicate whether the person is Present, is a No Show/Cancelled or the Provider Cancelled. For cancellations, complete Explanation as needed. Check appropriate box to indicate if others are present, list name(s) and relationship(s) to person.
<b>Person's Report of Progress Towards Goals/Objectives Since Last Session</b>	Document person's self-report of progress towards goals since last session including other sources of information, such as family, case manager, etc.
<b>New Issue(s) Presented Today</b>	<p>There are four options available for staff using this section of the progress note:</p> <ol style="list-style-type: none"> <li>1. If person does not report/present any new issues, mark "None Reported" and proceed to planned intervention/goals.</li> <li>2. If person reports a new issue that was resolved during the session, check the "New Issue resolved, no CA Update required" box. Briefly document the new issue, identify the interventions used in the Therapeutic Interventions Section, and indicate the resolution in the Response Section of the progress note. Example: Person described being involved in a minor car accident today. Person was not hurt but expressed concern regarding expense of car repair. Person felt more relieved after identifying ways to cover expense over the next two weeks.</li> <li>3. If person presents an issue that has been previously assessed and for which Goals/Objectives and services have been ordered, then the information may be briefly documented as an indicator of the progress or lack of progress achieved.</li> <li>4. If person presents any new issue(s) that represent a therapeutic need that is not already being addressed in the IAP, check box indicating a "CA Update Required" and record notation that new issue has been recorded on a Comprehensive Assessment Update of the same Date and write detailed narrative on the appropriate CA Update as instructed in this manual. Also, the newly assessed therapeutic information may require a new goal, objective, therapeutic intervention or service that will require further use of the IAP Review/Revision form.</li> </ol> <p><b>Example:</b> Person reported for the first time that she was a victim of abuse/neglect at the age of twelve as recorded on the Comprehensive Assessment Update of this date.</p>

# Sample Of Psychotherapy Progress Note

**Rhonda Sutton**



## **Sample Of Psychotherapy Progress Note:**

**The Adult Psychotherapy Progress Notes Planner** David J. Berghuis, Arthur E. Jongsma, Jr., 2004-05-07 The Adult Psychotherapy Progress Notes Planner Second Edition contains complete prewritten session and patient presentation descriptions for each behavioral problem in The Complete Adult Psychotherapy Treatment Planner Third Edition The prewritten progress notes can be easily and quickly adapted to fit a particular client need or treatment situation Saves you hours of time consuming paperwork yet offers the freedom to develop customized progress notes Organized around 42 main presenting problems including anger management chemical dependence depression financial stress low self esteem and Obsessive Compulsive Disorder OCD Features over 1 000 prewritten progress notes summarizing patient presentation themes of session and treatment delivered Provides an array of treatment approaches that correspond with the behavioral problems and DSM IV TR TM diagnostic categories in The Complete Adult Psychotherapy Treatment Planner Third Edition Offers sample progress notes that conform to the requirements of most third party payors and accrediting agencies including the JCAHO and the NCQA

*The Clinical Documentation Sourcebook* Donald E. Wiger, 2009-12-31 All the forms handouts and records mental health professionals need to meet documentation requirements fully revised and updated The paperwork required when providing mental health services continues to mount Keeping records for managed care reimbursement accreditation agencies protection in the event of lawsuits and to help streamline patient care in solo and group practices inpatient facilities and hospitals has become increasingly important Now fully updated and revised the Fourth Edition of The Clinical Documentation Sourcebook provides you with a full range of forms checklists and clinical records essential for effectively and efficiently managing and protecting your practice The Fourth Edition offers Seventy two ready to copy forms appropriate for use with a broad range of clients including children couples and families Updated coverage for HIPAA compliance reflecting the latest The Joint Commission TJC and CARF regulations A new chapter covering the most current format on screening information for referral sources Increased coverage of clinical outcomes to support the latest advancements in evidence based treatment A CD ROM with all the ready to copy forms in Microsoft Word format allowing for customization to suit a variety of practices From intake to diagnosis and treatment through discharge and outcome assessment The Clinical Documentation Sourcebook Fourth Edition offers sample forms for every stage of the treatment process Greatly expanded from the Third Edition the book now includes twenty six fully completed forms illustrating the proper way to fill them out Note CD ROM DVD and other supplementary materials are not included as part of eBook file

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**Note Designer** Patricia Csank Baldwin, 2023 This second edition of Note Designer provides step by step guidelines tips and instruction on how to create and write psychotherapy treatment notes and reports The book includes information and guidance on how to write intake reports treatment plans treatment progress notes for individual psychotherapy couples therapy and child and family therapy risk assessments and termination reports A number of sample notes reports and templates are provided The book also includes hundreds of representative statements for therapists to use in their own progress notes and reports A valuable resource for experienced mental health professionals and trainees alike

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**The AMHCA Handbook of Essential Forms and Marketing Strategies** Mark Vellucci,2000 This manual provides essential information for counselors in private practice who are either just starting out or have established practices It is organized into six sections which contain forms relating to different aspects of practice The material can be used to create new forms or adapted for individual use They can also serve to generate marketing ideas help work with managed care organizations and improve billing Chapter 1 concerns office policy and procedures and contains sample letters to clients on policy discontinuation of therapy and other acknowledgements Chapter 2 deals with billing to insurance companies and individuals Chapter 3 considers client release and consent forms Chapter 4 discusses intake clinical evaluations and progress monitoring Chapter 5 presents marketing ideas Chapter 6 explains how to work with managed care organizations A CD ROM accompanies the manual JDM

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The Psychotherapy Documentation Primer Donald E. Wiger,2012-06-25 Everything you need to know to record client intake treatment and progress incorporating the latest managed care accrediting agency and government regulations Paperwork and record keeping are day to day realities in your mental health practice Records must be kept for managed care reimbursement for accreditation agencies for protection in the event of lawsuits to meet federal HIPAA regulations and to help streamline patient care in larger group practices inpatient facilities and hospitals The standard professionals and students have turned to for quick and easy yet comprehensive guidance to writing a wide range of mental health documents the Third Edition of The Psychotherapy Documentation Primer continues to reflect HIPAA and accreditation agency requirements as well as offer an abundance of examples The new edition features Revised examples of a wider range of

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Berghuis, Arthur E. Jongsma, Jr., 2004-07-22 The Family Therapy Progress Notes Planner contains complete prewritten session and patient presentation descriptions for each behavioral problem in The Family Therapy Treatment Planner The prewritten progress notes can be easily and quickly adapted to fit a particular client need or treatment situation Saves you hours of time consuming paperwork yet offers the freedom to develop customized progress notes Organized around 38 main presenting problems that range from family business conflicts and inheritance disputes to alcohol abuse physical verbal psychological abuse and religious spiritual conflicts Features over 1 000 prewritten progress notes summarizing patient presentation themes of session and treatment delivered Provides an array of treatment approaches that correspond with the behavioral problems and DSM IV TR TM diagnostic categories in The Family Therapy Treatment Planner Offers sample progress notes that conform to the requirements of most third party payors and accrediting agencies including the JCAHO and the NCQA **The**

**Addiction Treatment Planner** Robert R. Perkinson, Arthur E. Jongsma, Jr., Timothy J. Bruce, 2022-03-29 Clarify simplify and accelerate the treatment planning process so you can spend more time with clients The Addiction Treatment Planner Sixth Edition provides all the elements necessary to quickly and easily develop formal treatment plans that satisfy the demands of HMOs managed care companies third party payers and state and federal agencies This valuable resource contains treatment plan components for 48 behaviorally based presenting problems including depression intimate relationship conflicts chronic pain anxiety substance use borderline personality and more You ll save hours by speeding up the completion of time consuming paperwork without sacrificing your freedom to develop customized treatment plans for clients This updated edition includes new and revised evidence based objectives and interventions new online resources expanded references an expanded list of client workbooks and self help titles and the latest information on assessment instruments In addition you ll find new chapters on some of today s most challenging issues Opioid Use Disorder Panic Agoraphobia Loneliness and Vocational Stress New suggested homework exercises will help you encourage your clients to bridge their therapeutic work to home Quickly and easily develop treatment plans that satisfy third party requirements Access extensive references for treatment techniques client workbooks and more Offer effective and evidence based homework exercises to clients with any of 48 behaviorally based presenting problems Enjoy time saving treatment goals objectives and interventions plus space to record your own customized treatment plan This book s easy to use reference format helps locate treatment plan components by presenting behavioral problem or DSM 5 diagnosis Inside you ll also find a sample treatment plan that conforms to the requirements of most third party payors and accrediting agencies including CARF The Joint Commission TJC COA and the NCQA The Addiction Treatment Planner Sixth Edition will liberate you to focus on what s really important in your clinical work **The Counselor's Steps for Progress Notes** Rhonda Sutton, 2015-06-21 Dr Rhonda Sutton s second edition of the

straightforward guide to progress notes includes additional examples information documentation and clinical language that expands on the utility and readability of the first book Additional case studies provide examples of how to use the STEPs to format notes New chapters include information on clinical language and documentation This book covers everything about progress notes from how to write them to how to store them and even what to do when someone requests to them In addition clinical terms and abbreviations are included as well as suggestions for other clinical documentation such as termination letters privacy statements and professional disclosure statements Suited for all types of mental health clinicians this book will help therapists improve upon their progress notes and other forms of clinical documentation

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