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				
Person's Name	Record the first name, last name, and middle initial of the person. Order of name is at agency discretion.			
Record Number	Record your agency's established identification number for the person.			
Person's DOB	Record the person's date of birth.			
Organization Name:	Record the organization for whom you are delivering the service.			
Modality	Check appropriate box to indicate the type of session: individual, family or couple.			
List Name(s) of Person(s) Present	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.			
Person's Report of Progress Towards Goals/Objectives Since Last Session	Document person's sett-report of progress towards goals since last session including other sources of information, such as family, case manager, etc			
New Issue(s) Presented Today	There are four options available for staff using this section of the progress note. 1. If person does not report/present any new issues, mark 'None Reported' and proteed to planned intervention/goals. 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, identity 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 report. Person helt more relieved after identifying ways to cover expense over the next two weeks. 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 tack of progress achieved. 4. If person presents any new issue(s) that represent a therapeutic need that is not already being addressed in the NP, 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 namative on the appropriate GA Update as instructed in this manual. Also, the newly assessment Update of the same Date and write detailed manative on the appropriate GA Update is information may require a new goal, objective, therapeutic intervention or service that will require further use of the UAP Review/Revision form. Example: 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 that date.			

Sample Of Psychotherapy Progress Note

G Thomas

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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 Adolescent Psychotherapy Progress Notes Planner David J. Berghuis, L. Mark Peterson, William P. McInnis, Arthur E. Jongsma, Jr., 2014-03-17 Save hours of time consuming paperwork with the bestselling therapist's resource The Adolescent Psychotherapy Progress Notes Planner Fifth Edition contains more than 1 000 complete prewritten session and patient descriptions for each behavioral problem in The Adolescent Psychotherapy Treatment Planner Fifth Edition The prewritten notes can be easily and quickly adapted to fit a particular client need or treatment situation The Fifth Edition Provides an array of treatment approaches that correspond with the behavioral problems and new DSM 5 diagnostic categories in the corresponding companion Treatment Planner Organizes treatment for over 30 main presenting problems including conduct disorder chemical dependence low self esteem suicidal ideation ADHD sexual acting out and eating disorders Provides over 1 000 prewritten progress notes summarizing patient presentation and treatment delivered Offers sample progress notes that conform to the requirements of most third party payors and accrediting agencies including The Joint Commission COA CARF and NCQA Saves clinicians hours of time consuming paperwork yet offers the freedom to develop customized progress notes Presents new and update information on the role of evidence based practice in progress notes writing and the special status of progress notes under HIPAA 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

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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 The Veterans and Active Duty Military Psychotherapy **Progress Notes Planner** Arthur E. Jongsma, Jr., David J. Berghuis, 2010-01-19 The Veterans and Active Duty Military Psychotherapy Progress Notes Planner contains complete prewritten session and patient presentation descriptions for each behavioral problem in The Veterans and Active Duty Military Psychotherapy Treatment Planner The prewritten progress notes can be easily and guickly 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 39 behaviorally based presenting problems including nightmares post deployment reintegration combat and operational stress reaction amputation and or loss of mobility adjustment to killing and depression 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 diagnostic categories in The Veterans and Active Duty Military Psychotherapy Treatment Planner Offers sample progress notes that conform to the requirements of most third party payors and accrediting agencies including CARF The Joint Commission TJC COA and the NCQA Presents new and updated information on the role of evidence based practice in progress notes writing and the special status of progress notes under HIPAA Therapy Progress Notes Planner Arthur E. Jongsma, Jr., David J. Berghuis, 2010-07-06 The Bestselling treatment planning system for mental health professionals The Family Therapy Progress Notes Planner Second Edition contains complete prewritten session and patient presentation descriptions for each behavioral problem in The Family Therapy Treatment Planner Second 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 40 behaviorally based presenting problems including family of origin interference depression in family members divorce financial conflict adolescent and parent hostility friction within blended families traumatic life events and dependency issues 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 TRTM diagnostic categories in The Family Therapy Treatment Planner Second Edition Offers sample progress notes that conform to the requirements of most third party payors and accrediting agencies including CARF The Joint Commission TJC COA and the NCQA Presents new and updated information on the role of evidence based practice in progress notes writing and the special status of progress notes under HIPAA Record Keeping in Psychotherapy and Counseling Ellen T. Luepker, 2012-04-27 Record Keeping in Psychotherapy and Counseling provides an essential framework for understanding record keeping within legal ethical supervisory and clinical contexts Compelling case examples identify dilemmas and strategies in protecting confidentiality More than a simple reference book this text introduces the concept of using records as

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