

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 self-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 proceed 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, 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. 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. 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. 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 this date.

Sample Progress Notes For Individual Therapy

Tao Wei



Sample Progress Notes For Individual Therapy:

The Adult Psychotherapy Progress Notes Planner Arthur E. Jongsma, Jr., Katy Pastoor, David J. Berghuis, 2021-05-11
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The Addiction Progress Notes Planner David J. Berghuis, Katy Pastoor, Arthur E. Jongsma, Jr., 2022-05-03 An invaluable practice resource for practitioners engaged in addictions treatment In The Addiction Progress Notes Planner Sixth Edition a team of distinguished mental health professionals delivers complete pre-written session and patient presentation descriptions for every behavioral problem in the Addictions Treatment Planner Sixth Edition Each note can be simply and quickly adapted to fit a real world client need or treatment situation while remaining completely unified with the client's treatment plan This new edition offers new and revised evidence based objectives and interventions organized around 46 behavior based presentations including alcoholism nicotine dependence substance abuse problem gambling eating disorders and sexual addictions The resource also offers A wide array of treatment approaches that correspond to the behavioral problems and DSM V diagnostic categories included in

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The Child Clinician's Report-writing Handbook Ellen Braaten, 2007-02-08 What an incredible resource Braaten has written what is clearly the most comprehensive child assessment handbook available This indispensable book carefully walks the clinician through the entire assessment process and covers all conceivable areas of inquiry This is an essential guide for the beginning practitioner and one that is sure to become a mainstay on every child clinician's bookshelf Lee A Ros n PhD Colorado State University **The OTA's Guide to Writing SOAP Notes** Sherry Borcharding, Marie J. Morreale, 2007 Written specifically for occupational therapy assistants The OTA's Guide to Writing SOAP Notes Second Edition is updated to include new features and information This valuable text contains the step by step instruction needed to learn the documentation required for reimbursement in occupational therapy With the current changes in healthcare proper documentation of client care is essential to meeting legal and ethical standards for reimbursement of services Written in an easy to read format this new edition by Sherry Borcharding and Marie J Morreale will continue to aid occupational therapy assistants in learning to write SOAP notes that will be reimbursable under Medicare Part B and managed care for different areas of clinical practice New Features in the Second Edition Incorporated throughout the text is the Occupational Therapy Practice Framework along with updated AOTA documents More examples of pediatrics hand therapy and mental health Updated and additional worksheets Review of grammar documentation mistakes Worksheets for deciphering physician orders as well as expanded worksheets for medical abbreviations Updated information on billing codes HIPAA management of health information medical records and electronic documentation Expanded information on the OT process for the OTA to fully understand documentation and the OTA's role in all stages of treatment including referral evaluation intervention plan and discharge Documentation of physical agent modalities With reorganized and shorter chapters The OTA's Guide to Writing SOAP Notes Second Edition is the essential text to providing instruction in writing SOAP notes specifically aimed at the OTA practitioner and student This exceptional edition offers both the necessary instruction and multiple opportunities to

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The Psychotherapy Documentation Primer Third Edition continues to be the benchmark record keeping reference for working professionals reflecting the latest in documentation and reporting requirements A Therapist's Guide to Writing in Psychotherapy Michael D. Reiter, 2023-06-29 This guide practically aids mental health professionals in understanding and improving their therapeutic and academic writing demonstrating how the written word is an invaluable tool to document assess and promote change with those in and outside the therapy room Exploring the various ways writing occurs in psychotherapy professions Michael D Reiter comprehensively covers the range of the written word from progress notes and assessment documentation to journaling and therapeutic letters as well as contacting larger systems such as report writing and grant applications Chapters are formatted to include the purpose and function of a particular type of writing before providing multiple examples so therapists can apply this in their own practice This book aims to help all therapists regardless of academic training or therapeutic modality to incorporate these ideas into their work This book is designed for mental health professionals in a variety of settings including counselors therapists social workers family therapists and clinical psychologists This book is useful for graduate students as well as those already in practice **Treatment Program Monograph Series** National Institute on Drug Abuse, 1977 Wilkins' Clinical Practice of the Dental Hygienist Linda D. Boyd, Lisa F. Mallonee, 2023-06-05 Wilkins Clinical Practice of the Dental Hygienist Fourteenth Edition progresses through crucial topics in dental hygiene in a straightforward format to ensure students develop the knowledge and skills they need for successful evidence based practice in today's rapidly changing oral health care environment This cornerstone text used in almost every dental hygiene education program in the country has been meticulously updated by previous co authors Linda Boyd and Lisa Mallonee to even better meet the needs of today's students and faculty while reflecting the current state of practice in dental hygiene Maintaining the hallmark outline format the Fourteenth Edition continues to offer the breadth and depth of coverage necessary not only for foundation courses but for use throughout the entire dental hygiene curriculum

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