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, tast 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 reliableously(s) to person.
Person's Report of Progress Towards Goals/Objectives Since Last Session	Document person's self-report of progress towards goals since tast 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 hust but expressed concern regarding expense of car report. 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/Dipectives 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 is not already being addressed in the NP, check box indicating a 'CA. Update Required' and record notation this insure has been recorded on a Comprehensive Assessment Update of the same Date and write detailed namative on the appropriate CA Update as instructed in this manual. Also, the newly assessment update 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 Progress Notes For Individual Therapy

National Institute on Drug Abuse

Sample Progress Notes For Individual Therapy:

The Adult Psychotherapy Progress Notes Planner Arthur E. Jongsma, Jr., Katy Pastoor, David J. Berghuis, 2021-04-16 The Adult Psychotherapy PROGRESS NOTES PLANNER PracticePlanners THE BESTSELLING TREATMENT PLANNING SYSTEM FOR MENTAL HEALTH PROFESSIONALS Fully revised and updated throughout The Adult Psychotherapy Progress Notes Planner Sixth Edition enables practitioners to quickly and easily create progress notes that completely integrate with a client s treatment plan Each of the more than 1 000 prewritten session and patient presentation descriptions directly link to the corresponding behavioral problem contained in The Complete Adult Psychotherapy Treatment Planner Sixth Edition Organized around 44 behaviorally based problems aligned with DSM V diagnostic categories the Progress Notes Planner covers an extensive range of treatment approaches for anxiety bipolar disorders attention deficit hyperactivity disorder ADHD dependency trauma cognitive deficiency and more Part of the market leading Wiley PracticePlanners series The Adult Psychotherapy Progress Notes Planner will save you hours of time by allowing you to rapidly adapt your notes to each individual patient s behavioral definitions symptom presentations or therapeutic interventions An essential resource for psychologists therapists counselors social workers psychiatrists and other mental health professionals working with adult clients The Adult Psychotherapy Progress Notes Planner Provides more than 8 000 prewritten easy to modify progress notes summarizing patient presentation and the interventions implemented within the session Features sample progress notes conforming to the requirements of most third party health care payors and accrediting agencies including CARF The Joint Commission TJC COA and the NCQA Include a brand new chapter that coordinates with the Treatment Planner's chapter on loneliness Additional resources in the PracticePlanners series Treatment Planners cover all the necessary elements for developing formal treatment plans including detailed problem definitions long term goals short term objectives therapeutic interventions and DSMTM diagnoses Homework Planners feature behaviorally based ready to use assignments to speed treatment and keep clients engaged between sessions For more information on our PracticePlanners including our full line of Treatment Planners visit us on the Web at www wiley com practiceplanners The Addiction Progress Notes Planner David J. 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Wiger, 2010-02-02 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 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 clinicians bookshelf Lee A Ros n PhD Colorado State University Therapist's Guide to Writing in Psychotherapy Michael D. 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Clinical Documentation with Children and Adolescents Amy Marschall, 2023-08-29 This book addresses the unique challenges therapists face when documenting their clinical work with children providing insight into what ethical appropriate and culturally competent practice looks like Clinical documentation is vital for ethical and legal practice and good documentation helps clinicians leave room for client centered and age appropriate interventions such as play therapy Beginning with an overview of the important considerations unique to providers working with children Amy Marschall offers guidance on all aspects of clinical documentation such as intakes treatment plans mental status examinations progress notes safety plans and more Each chapter includes specific examples of clinical situations with guidance on how to document these situations effectively With chapters on client confidentiality and telehealth as well as special attention being paid to cultural awareness including race ethnicity gender sexual orientation and socioeconomic status this book includes blank templates of treatment plans progress notes and risk assessments for therapists to use in their practice This book is essential for any mental health professional who works with children in both individual and family work including psychologists licensed clinical social workers licensed professional counselors mental health counselors marriage and family therapists play therapists school counselors and therapist interns The Economics of Therapy Daniel Thomas, Vicky Abad, 2017-04-21 Arts therapy training does not generally cover building a professional practice even though business skills are essential for success in the field This book provides the economic fundamentals along with business strategies to develop an effective arts therapy practice that is profitable while affording ethical care to those who need it most **Language and Narratives in**

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Therapeutic Reasoning in Occupational Therapy - E-Book Jane Clifford O'Brien, Mary Beth Patnaude, Teressa Garcia Reidy, 2021-12-24 Build the clinical reasoning skills you need to make sound decisions in OT practice Therapeutic Reasoning in Occupational Therapy How to Develop Critical Thinking for Practice uses practical learning activities worksheets and realistic cases to help you master clinical reasoning and critical thinking concepts Video clips on the Evolve website demonstrate therapeutic reasoning and show the diverse perspectives of U S and international contributors Written by OT experts Jane Clifford O Brien Mary Elizabeth Patnaude and Teressa Garcia Reidy this how to workbook makes it easier to apply clinical reasoning in a variety of practice settings Dynamic interactive approach reinforces your understanding with learning activities in each chapter Case studies and experiential learning activities flow from simple to complex and represent occupational therapy across the lifespan AOTA's Occupational Therapy Practice Framework 4th Edition and

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