

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 Of Psychotherapy Progress Note

**David J. Berghuis, L. Mark
Peterson, William P. McInnis, Arthur E.
Jongsma, Jr.**

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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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