Progress Notes and Psychotherapy Notes

This Appendix covers two kinds of notes written about psychotherapy—progress notes and psychotherapy notes—and highlights the practical value of this important distinction. Progress notes are part of the client record or file, as noted below. Psychotherapy notes are not part of the file. After an overview of the client file or record, the difference between these two kinds of notes is discussed along with guides for writing progress notes.

The Client File or Record

The record or file of a client's treatment at the Clinic consists of:

- Contact information
- Informed consent for treatment (including notification of rights)
- An intake report and/or,
- A written treatment plan or case formulation based on an initial assessment (i.e. interview information, formal assessment if used, and any other information collected from other sources)
- Progress notes documenting treatment, filed in reverse chronological order on the Clinic form *Progress Note*
- A termination note when work is concluded
- Other materials such as releases of information, test protocols, information obtained from other sources and so forth.
- The file or record does not contain *psychotherapy notes* (see below). Another way of saying this is that if it's in the file, it's not a psychotherapy note.

As context for progress notes versus psychotherapy notes, please also refer to the form in Appendix D *Brief Summary of Client Rights to Privacy and Access to Records and Consent to Behavioral Health Treatment* and to the document in that appendix entitled *Protecting the Privacy of Your Behavioral Health Information.*

A general intake outline is contained in Appendix C-4 *Intake Outline and Report* which can serve to organize information and begin treatment planning. Treatment planning will, to some degree vary by supervisor and may be organized around a diagnosis, a problem list, a set of treatment goals or a listing of directions for therapy. Therapy notes (either progress notes or psychotherapy notes) may be easier to write and later to interpret if written toward a good treatment plan.

Progress Notes versus Psychotherapy Notes: A Key Distinction.

Psychotherapy notes. Over the years, clinicians have debated about whether it was permissible to maintain a second set of notes which was not available to anyone except the therapist. One of the few substantive changes brought about by HIPAA is that psychotherapy notes are defined and are protected from normal release to the client, the courts or anyone else. This distinction is sufficiently important that the clinician should be familiar with the language of the federal regulation:

> *Psychotherapy notes* means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: Diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. 45 CFR 164.501.

A later section (45 CFR 164.524) gives individuals almost unlimited access to their records, but specifically excludes psychotherapy notes as defined above.

The key elements of this definition and its use are that psychotherapy notes:

- Are produced by a mental health professional
- Are separated from the rest of the medical record
- Don't include the basic treatment and record-keeping that goes in a standard progress note, and
- Are not open to disclosure to the client or anyone else.

Progress notes. Progress notes, then, are notes that are part of the regular file maintained in the Clinic. Because many of the functions of notes for the purposes of the treating clinician can be accomplished through psychotherapy notes, progress notes content can be kept to minimum. The following kinds of information go in a progress note (further guidelines and examples appear below).

- counseling session start and stop times,
- medication prescription and monitoring
- the modalities and frequencies of treatment furnished,
- results of clinical tests, and
- any summary of the following items:
    - Diagnosis,
    - functional status,
    - symptoms,
    - prognosis, and
    - progress to date.

Who Is The Audience?

In any writing project, the first and most important question is "who is the audience?" Throughout the writing process, one must step back occasionally and hear what is written using the ears of the potential audience(s). Often, as with the notes we'll be discussing here, there will be multiple audiences and you must keep each of them in mind while writing. Here is a listing, intended to be in order of likelihood, of those who will see and use progress notes:

- You, the therapist, will look back at the notes as needed in the course of treatment.
- The client or patient may want to look at the notes and the contents of the file and has this right under New Mexico guidelines and HIPAA regulations
- Another therapist who picks up the case at the Clinic or in another setting (with appropriate release of information).
- An evaluator for another agency may review therapy notes, again with the client's permission
- An attorney representing your client or (perhaps more importantly) an opposing attorney in a legal proceeding (this may be by release of information or through a "hidden permission" in a law suit claiming damages for "pain and suffering"—see the Clinic's document *Protecting the Privacy of Your Behavioral Health Information).*

These various potential readers of your notes create different concerns and expectations for the contents of your notes. What will be most useful to you in the future may very well not be what you would want your client to read and a note that works for you and your client may not be something you'd want in the hands of a attorney hostile to your client's interests. You won't know as you write which audience will see your notes, but need to keep in mind that you are writing for these different readers.

This is not, in practice a difficult task. First, keep in mind that your task in a *progress note* is to document that reasonable work occurred toward the goal of helping the client with her or his issues. Your note can be brief; to the extent that you can relate that day's work to treatment issues and methods you've defined previously in a treatment plan, the easier your documentation will be. Keep track of significant events—changes in medications, life events, names of important people that come up—that you will want to be able to easily reference in the future. As noted in the formats described below, include brief assessments of the client's status and progress as appropriate and remind yourself of plans you have for future sessions (homework assignments, topics to follow up on).

Leave longer thoughts, queries and reflections for your psychotherapy notes. The advantage that psychotherapy notes give us is that you can record any hypotheses, personal reactions, doubts, possible interpretations, supervisory recommendations, etc. in a form that will be maximally useful for you.

Where Are The Two Kinds Of Notes Kept?

In general, progress notes will be written immediately following a session and will be kept in reverse chronological order in the client's file locked in the appropriate drawer in the Clinic. The client's file may be removed only for purposes of writing and reviewing notes and replaced when you are finished. Supervisors will

come to the Clinic to review files periodically (at least each semester). If an occasion arises in which you want to remove the file from the Clinic, you need permission of the Clinic Director and need to put a check-out card where the file was so that staff know it is out. If you are in possession of a file, you are responsible for maintaining its confidentiality—keep it in your possession or keep it in a secure place.

Psychotherapy notes *must be kept separate* from the main file. That could be in a different locked drawer at the Clinic (but never in the top drawer where active files are kept). It is likely that these are the notes you'll want with you for supervision and preparation for sessions, so you may keep them in your possession. If so, you must assure that confidential information is protected by securing these files in your home or office. Each clinician should develop habits and methods of protecting confidential information, for instance, psychotherapy notes and testing files that you may want in your possession and care outside the Clinic building.

A note regarding assessment files is in order at this point. You may be keeping assessment materials with you for scoring and writing outside the Clinic. The safest way to preserve confidentiality and secure the file is to keep name identification out of the file until you finalize it in a report. Then secure the original file and all materials at the Clinic.

Styles Of Progress Notes

The following are some suggestions for the content of progress notes:

1. Use the Clinic's standard Progress Note form (Appendix F-2) to provide the basic information about who was seen when by whom, for how long and for what purpose. Payment is recorded on this form as well in addition to the receipts filled out for the client and the Clinic.
2. The note may be brief but should include a description of the major events or topics discussed, specific interventions used, your observations and assessment of the client's status, and any plans you may have for the future.
3. It is not necessary that these notes be extensive. In fact, in future practice when time is of the essence, brevity and capturing the essence of the treatment in a session will be necessary. Two examples of structured systems for progress note writing are listed briefly below with references to more complete descriptions.

Compared to psychotherapy notes. By their nature, psychotherapy notes can be in any form that is useful to you and need not be readable by others (e.g. use of your own personal shorthand is acceptable). Think of psychotherapy notes as a form of self-consultation and preparation for supervision. It is here that you may feel free to detail what happened in a session in order, put your thoughts and feelings about what was going on, list hunches and hypotheses to explore further, and write questions to bring up with your supervisor. You may also want to jot notes from your supervisory session that you want to include in your thinking for future sessions.

D(R)AP format for progress notes. In hospital settings, the most common guideline for notes is the SOAP format (Subjective, Objective, Assessment, Plan) described briefly below. Many practitioners have found the SOAP format awkward or forced for recording progress in psychotherapy. The preferred format for notes at the Clinic uses the acronym DAP (Description, Assessment and Plan). Baird (2002) suggests a similar format and his thoughts on clinical documentation are useful. In a typical therapy session, a client may bring up two or three therapy-significant events or issues or describe the activity of carrying out a homework assignement. Each may be briefly documented in the DAP format.

Description, as Baird elaborates, provides information as to who was involved, where, and when a significant event occurred. It could also be a description of an issue of personal importance discussed by the client and how they experienced the event. A description could also be the way a client carried out an assignment and the difficulties or success they experienced. Baird includes a separate section (R for Response) for what the clinician does in response to the client's issue. We recommend that clinician behavior be woven into description.

Response (per Baird) is what you did after listening and observing and reflecting on what the client brought to the session. This may be an interpretation offered, a clarification, information given, a homework assignment, a challenge to narrow thinking about an issue, formal problem solving around the event, empathetic/supportive behavior on your part, functional analysis of a situation, a normalizing comment, or whatever is appropriate from the therapeutic conceptualization you are using. If the situation is a serious one involving detailed

assessment of danger or legal issues, you would document what you did in whatever detail is necessary to show that you attended to the issues involved.

Assessment is your understanding of what the event means if you know. Baird recommends thinking about how the event or behavior relates to precipitating factors, to previous behavior, to other events in the client's life, to the treatment plan. The important part of this aspect of your thinking and writing is your reflection on the events in the client's life in terms of treatment. Assessment may also record your observations about the client's physical or emotional state and such factors as severity of symptoms, riskiness of behavior, dangerousness, suicidality and so forth
.

Treatment Plan is your plan for future treatment. Baird notes that this may be as brief as "Scheduled for next Wed". If you give homework assignments or want to note topics to follow up on or actions to take before the next session, they can be entered here as reminders.

Examples of DAP notes are given on the Clinic website.

SOAP format notes. SOAP is an acronym for Subjective-Objective-Assessment-Plan and is a part of Problem Oriented medical records developed by L. L. Weed (see Cameron and Turtle-song, 2002 on the Clinic webpage for a fuller description). This method was developed in the medical setting to standardize entries in the patient file (e.g. S(ubjective): "Patient complained of …"; O(bjective): Blood pressure, lab results, results of physical examination; A(ssessment): clinical diagnosis of symptoms; P(lan): prescriptions, treatments recommended, etc.). In psychology practice, Assessment and [Treatment] Plan are similar to what Baird describes.

The SOAP format is widely used especially in hospital settings and is required in some agencies for psychological and psychiatric progress notes as well as medical notes. But some have noted (e.g. Baird, 2004) that the format it may become arbitrary or rigid, for instance, what material goes in which section. It is especially difficult in psychotherapy to sort out what is objective and what is subjective and the meaning of events may be lost. Student-clinicians may find this format useful, however, and examples are given on the Clinic website.

Unformatted notes. Clinicians may write notes in a less or differently structured fashion, such as integrating Baird's sections in a narrative form, providing a chronological sequence of events in a session (process notes) or referring notes to specific issues in the treatment plan. The above discussion, and additional reflection on one's own treatment approach, may stimulate the student to develop their own format for notes that better suit their method and style. Students are encouraged to discuss with their supervisor approaches to progress notes.

Psychotherapy Notes: Reprise

The greater protection provided to psychotherapy notes by HIPAA regulations may allow student-clinicians greater latitude to abbreviate their progress notes and expand on the reflection, reactions, thoughts and feelings that may safely be recorded in psychotherapy notes. To return to an earlier theme, the primary audience for psychotherapy notes is yourself: your client acknowledges in the Clinic's consent for treatment that such notes may be kept and are not available for client inspections. This allows you greater freedom to reflect on difficulties, hunches and questions and make these written reflections a greater learning experience in the context of your supervision.

Suggested Readings

Baird, B. N. (2004) *The Internship, Practicum, and Field Placement Handbook: A Guide for the Helping Professions* (4th ed.). Prentice Hall

Cameron, S. & turtle-song, i. (2002) Learning to write case notes using the SOAP format. *Journal of Counseling & Development, 80,* 286-292.

Wiger, Donald E. (1999) *The Clinical Documentation Sourcebook: A Comprehensive Collection of Mental Health Practice Forms, Handouts, and Records* (2nd ed.). Wiley.

Zuckerman, E. L. (2005) *Clinician's Thesaurus: The Guide to Conducting Interviews and Writing Psychological Reports* (6th ed.). Guilford Press.

Psychotherapy Progress Note
Psychiatric Social Worker

Date of Exam: 4/28/2012
Time of Exam: 9:00:56 AM

Patient Name: Conner, Andrea
Patient Number: 1000010644560

Improvement is occurring. "My social life now revolves around exercise instead of drinking with my friends."

Problem Pertinent Review of Symptoms:
Feelings of anxiety are denied. Andrea denies experiencing dysphoric moods. Sleep disturbance is not reported. Andrea describes rare substance cravings. She denies the temptation to use. Andrea denies use. Andrea reports that she has been regularly attending AA meetings. A sample for urine drug screening was obtained. She has maintained sobriety. Impulsive behaviors are not reported.

Content of Therapy: The patient's substance abuse problems were the main issue this session. Feelings of shame were also expressed.

Therapeutic Interventions: The focus of today's session was on helping the patient increase insight and understanding. The main therapeutic techniques used involved the exploration of the patterns of certain behaviors. Therapeutic efforts also included aiding the patient in identifying the precipitants of unproductive feelings and behaviors. . The importance of abstinence was also reviewed.

MENTAL STATUS: Andrea is alert, attentive, casually groomed, and relaxed. She exhibits speech that is normal in rate, volume, and articulation and is coherent and spontaneous. Language skills are intact. Mood is entirely normal with no signs of depression or mood elevation. Affect is appropriate, full range, and congruent with mood. Insight into illness is normal. Social judgment is intact. Signs of chemical withdrawal are exhibited by Andrea. Mild signs of anxiety which appear to be secondary to withdrawal are present.

DIAGNOSES: The following Diagnoses are based on currently available information and may change as additional information becomes available.

Axis I: Alcohol Abuse, 305.00 (Active)

INSTRUCTIONS / RECOMMENDATIONS / PLAN:

Link to Treatment Plan Problem: **Substance Abuse**

Short Term Goals:
Andrea will make plans for a recreation activity that does not involve alcohol or drugs, within one week.
Target Date: 4/29/2012

Excellent progress in reaching these goals and resolving problems seemed evident today.
Recommend that the interventions and short term goals for this problem be re-written at the next Treatment Team meeting.

Return 2 weeks or earlier if needed.

NOTES & RISK FACTORS:
History of Subst. Abuse

90806 PSYTX, Office, 45-50 MIN

Time spent counseling and coordinating care: 45-50 min

Session start: 9:00 AM
Session end: 9:50 AM

John Smith, LCSW

Electronically Signed
By: John Smith, LCSW
On: 4/22/2012 11:07 AM

INTAKES, PROGRESS NOTES, & PYCHOTHERAPY NOTES

Therapists need to ensure that documentation in records is accurate and reflects the services provided. The records document profession work in order to facilitate provision of services by the therapist or other professionals, to ensure accountability, continuity of care, and to meet other requirements of institutions or the law.

Therapists' records, in general, fall in three categories (Intakes, Progress Notes, and Psychotherapy Notes). Other records are usually evaluations for specific purposes (e.g., Forensic or Neuropsychological Evaluations). The intake and notes are discussed below with content suggestions.

Progress Notes and Psychotherapy Notes differ and are afforded different degrees of privacy under the law. The Health Information Portability and Accountability Act (HIPAA) protects the privacy of Psychotherapy Notes. The differences are explained below.

INTAKES

An Intake Assessment should help the therapist conceptualize the problems and treatment. Biological, psychological and sociocultural functioning should be documented. The evidence should be integrated in a manner designed to maximize treatment effectiveness. A good intake should reflect the therapist's appreciation for the person in his or her entirety. In case of a minor, a therapist may wish to get information from multiple parties including teachers, parents and siblings. While intakes differ among therapists, there should be commonalities that run throughout. An example of an intake form covering relevant areas is presented below.

INTAKE ASSESSMENT (EXAMPLE)

Patient:

Date of Birth:

Intake Date:

Presenting Problem(s): _____

_____

Presenting Symptoms: _____

_____

Presenting Problem History: _____

_____

Family History: _____

_____

Education and Occupational History: _____

_____

Medical Problems: _____

Current Prescription Medications:

Name: _____

Dosage: _____

Estimated Start Date: _____

Alcohol, Nicotine, and Drug History: _____

_____

Mental Health Treatment History (Patient & Family): _____

Legal History: _____

Spiritual Life: _____

Exercise: _____

Mental Status: _____

(This should provide a basis for understanding the patient's presentation)_____

a. Appearance
b. Manner and Approach
c. Orientation, Alertness and Thought Processes
d. Mood & Affect (Including suicidal and/or homicidal ideation

Summary and Conclusions: _____

_____

Treatment Recommendations and Prognosis:_____

Diagnoses:

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: _____

Current _____ High Previous Year_____

Signature and License

PROGRESS NOTES

Progress notes summarize sessions, are part of the medical record, and do not require the patient's authorization for disclosure. They can be released to the patient and third party payers. Progress notes contain the following types of information.

a. Date of session
b. Start and stop times
c. Modality of treatment provided
d. Medication prescription and monitoring
e. Any summary of the following items:
    - Diagnosis
    - Functional status
    - Symptoms
    - Prognosis
    - Progress
    - Suicidal or homicidal ideation
    - Next appointment

An example of a Progress Note Form in shown below.

PROGRESS NOTES (EXAMPLE)

Patient:

Date:

Start & Stop Time:

Treatment Modality: _____

Problems Addressed:

_____

Progress:

_____

Suicidal & Homicidal Ideation:

_____

Scheduled Appointment: _____

Signature and License

PSYCHOTHERAPY NOTES

Psychotherapy notes are treated differently than other medical records. Psychotherapy notes, according to HIPAA, are protected from normal release to the patient, the courts or anyone else, unless stipulated by state law. The key elements of psychotherapy notes are:

- They are produced by a mental health profession
- They are separated from the rest of the medical record
- They don' t include the basic treatment and record-keeping that goes in a standard progress note

By their nature, psychotherapy notes can be in any form that the therapist wants. They can be used to detail what happened in a session. They can be reviewed to produce hunches and hypothesis and help direct therapy. Issues can be detailed that the therapist would want to keep private.

APPLESEED COMMUNITY MENTAL HEALTH CENTER, INC.
COUNSELING PROGRESS NOTE

Client Name (First, MI, Last)	**Client No.**

Others Present at Session: If others present, please list name(s) and relationship(s) to the client:
☐ Client Present ☐ Client No Show/Cancelled

Stressor(s)/ Significant Changes in Client's Condition (for face-to-face visit)

☐ **No Significant Change from Last Visit**	
☐ **Mood/Affect**	
☐ **Thought Process/Orientation**	
☐ **Behavior/Functioning**	
☐ **Substance Use**	

Danger to: ☐ **None** ☐ **Self** ☐ **Others** ☐ **Property**	☐ **Ideation** ☐ **Plan** ☐ **Intent** ☐ **Attempt** ☐ **Other:**

Goal(s)/Objective(s):

Therapeutic Intervention and Progress Toward Goal/s:

Recommendation for Modification and Update of the ISP if Applicable:

Provider Signature/Credentials	**Date**	**Supervisor Signature/Credentials** (if needed)	**Date**
☐ **Medicare "Incident to" Services Only**		**Supervisor Signature/Credentials (if needed)**	**Date**

Supervisor Consultation (if needed)

Date of Service	Staff ID No.	Loc. Code	Prcdr. Code	Mod 1	Mod 2	Mod 3	Mod 4	Start Time	Stop Time	Total Time	Diagnostic Code

APPLESEED COMMUNITY MENTAL HEALTH CENTER, INC.
COUNSELING PROGRESS NOTE

Client Name (First, MI, Last)	**Client No.**
Betty Borderline	5.0.5.

Others Present at Session: If others present, please list name(s) and relationship(s) to the client:
☒ Client Present ☐ Client No Show/Cancelled

Stressor(s)/ Significant Changes in Client's Condition (for face-to-face visit)

☒ **No Significant Change from Last Visit**	
☐ **Mood/Affect**	
☐ **Thought Process/Orientation**	
☐ **Behavior/Functioning**	
☐ **Substance Use**	

Danger to:
☒ **None** ☐ **Self** ☐ **Others** ☐ **Property**
☐ **Ideation** ☐ **Plan** ☐ **Intent** ☐ **Attempt** ☐ **Other:**

Goal(s)/Objective(s): Goal 1/objective 1

Therapeutic Intervention and Progress Toward Goal/s: Client reported she had strong thoughts of self-harm this week but had not acted on them. I asked how she had done this and labeled the skills she had used to assist her in circumventing these thoughts. Affirmed validated her feelings noting she had done this without the people who usually are available to help her get through these difficult times. Discussed the reason for thoughts of self-harm to increase awareness of when thoughts could re-occur in order to plan to effectively manage these thoughts. Client commended for gaining the ego-strength to counteract urges to harm herself. Client recognized her dysfunctional thoughts were, in part, the result of a disrupted routine that created anxiety which triggered self-injurious thoughts. Client states that she does not currently have thoughts of self –harm.

Recommendation for Modification and Update of the ISP if Applicable: NA

Provider Signature/Credentials	**Date**	**Supervisor Signature/Credentials** (if needed)	**Date**
Thomas Therapist, LPC	12/23/10		
☐ **Medicare "Incident to" Services Only**		**Supervisor Signature/Credentials (if needed)**	**Date**

Supervisor Consultation (if needed)

Date of Service	Staff ID No.	Loc. Code	Prcdr. Code	Mod 1	Mod 2	Mod 3	Mod 4	Start Time	Stop Time	Total Time	Diagnostic Code
12/23/10	007	11	15	HE	-	-	-	1:00	-	:60	301.83

BELLEFAIRE JCB
OUTPATIENT TRAUMA FOCUS COGNITIVE BEHAVIORAL THERAPY (TFCBT) PROGRESS NOTE

CASE TYPE: ☐ WRAP TFCBT; ☐ JOP/WRAP TFCBT; ☐ OUTPATIENT TFCBT; ☐ SCHOOL BASED TFCBT

Client Name: (Last, First)		**Client #:**		**Date of service:**	
Staff ID, Name:					
Client Start Time	: PM	**Client End Time**	: PM	**Billable Time**	***0.00*** UNITS
Staff Start Time	: PM	**Staff End Time**	: PM	**Total Time**	***0.00*** UNITS
Program RU <		***Location*** < ***Other:***		***Modifier*** <	

ISP GOAL(S) ADDRESSED: ☐ #1 ; ☐ #2 ; ☐ #3 ; ☐ #4

INTERVENTION

PSYCHOEDUCATIONAL: CLIENT	PSYCHOEDUCATIONAL: PARENT	RELAXATION SKILLS
>	>	>
AFFECT EXPRESSION	COGNITIVE COPING TECHNIQUES	INVIVO DESENSITIZATION
>	>	>

☐ Narrative therapy techniques	☐ Identify and correct cognitive distortions
☐ Safety planning	☐ Behavior management techniques
☐ Identify and correct cognitive distortions	☐ Preparation of parent for sharing of narration
☐ Preparation of child for sharing narration with parent using CBT and client centered techniques	☐ Other:
☐ Other:	☐ Other:
☐ Other:	☐ Other:

Briefly Describe:

Progress: ☐ N/A ☐ No Change ☐ Deterioration ☐ Improvement: If Deterioration or Improvement Noted, Briefly Describe

Significant Life Changes/Events: ☐ N/A ☐ Yes, Explain:

Recommend Modification to ISP: ☐ No ☐ Yes, refer to MHA Update

Change in Risk to Self or Others: ☐ No ☐ Yes, refer to ☐ MHA update; ☐ Suicide Assessment; ☐ Duty to Protect

My signature verifies that service occurred as documented on this progress note. I authorize Bellefaire/JCB to bill for the time documented as "billable" above.

_____	_____	_____
STAFF SIGNATURE	CREDENTIAL	DATE
_____	_____	_____
SUPERVISOR SIGNATURE (If Applicable)	CREDENTIAL	DATE

Conversion chart: >

March 2010

BELLEFAIRE JCB
BEHAVIORAL HEALTH COUNSELING
OUTPATIENT TRAUMA FOCUS COGNITIVE BEHAVIORAL THERAPY (TFCBT) PROGRESS NOTE

CASE TYPE: ☐ WRAP TFCBT; ☐ JOP/WRAP TFCBT; ☐ OUTPATIENT TFCBT; ☒ SCHOOL BASED TFCBT

Client Name: (Last, First) [redacted]		**Client #:** [redacted]		**Date of service:** 3/2/2010	
Staff ID, Name: [redacted]					
Client Start Time	***01:15*** PM	**Client End Time**	***02:10*** PM	**Billable Time**	***0.92*** UNITS
Staff Start Time	***01:15*** PM	**Staff End Time**	***02:10*** PM	**Total Time**	***0.92*** UNITS
Program RU ***624 BHC***		***Location*** ***03 School*** ***Other:***		***Modifier*** ***F0 F:F w/Client(IP)***	

ISP GOAL(S) ADDRESSED: ☐ #1 ; ☒ #2 [redacted] will demonstrate improved coping skills to better manage difficult feelings, including those surrounding her history of trauma, as evidenced by guardian and school reports of rule compliance and improved scores in the areas of arguing with others, getting into fights, yelling, screaming, fits of anger, breaking rules, lying, can't sit still, feeling lonely, having nightmares and breaking the law on her Ohio Scales. ; ☒ #3 [redacted] will improve her communication skills as evidenced by family reports of improved satisfaction in relationship with IP and improved scores in the areas of arguing, fights, yelling and screaming, fits of anger, breaking rules, lying, feeling lonely and breaking the law on IPs Ohio Scales. ; ☐ #4

INTERVENTION

PSYCHOEDUCATIONAL: CLIENT	PSYCHOEDUCATIONAL: PARENT	RELAXATION SKILLS
Rationale for completing narrative	>	>
AFFECT EXPRESSION	COGNITIVE COPING TECHNIQUES	INVIVO DESENSITIZATION
Feeling Identification	Cognitive positive self talk	Exploration development of self efficacy

☐ Narrative therapy techniques	☐ Identify and correct cognitive distortions
☐ Safety planning	☐ Behavior management techniques
☒ Identify and correct cognitive distortions	☐ Preparation of parent for sharing of narration
☒ Preparation of child for sharing narration with parent using CBT and client centered techniques	☐ Other:
☐ Other:	☐ Other:
☐ Other:	☐ Other:

Briefly Describe: Ip stated that she feels alright about starting her trauma narrative. IP stated an understanding of why the trauma narrative will be used. IP did very well writing out her positive internal traits paragraphs and appears to be getting better with her impulsivity of crossing things out quickly. As IP was writing her positive traits this worker assisted in the identification of cognitive distortions and turning negative statements into positive ones.

Progress: ☐ N/A ☒ No Change ☐ Deterioration ☐ Improvement: If Deterioration or Improvement Noted, Briefly Describe

Significant Life Changes/Events: ☒ N/A ☐ Yes, Explain:

Recommend Modification to ISP: ☒ No ☐ Yes, refer to MHA Update

Change in Risk to Self or Others: ☒ No ☐ Yes, refer to ☐ MHA update; ☐ Suicide Assessment; ☐ Duty to Protect

My signature verifies that service occurred as documented on this progress note. I authorize Bellefaire/JCB to bill for the time documented as "billable" above.

[redacted]	LPC	3/12/10
STAFF SIGNATURE	CREDENTIAL	DATE
SUPERVISOR SIGNATURE (If Applicable)	CREDENTIAL	DATE

Conversion chart: >

March 2010

Affix CLIENT label

Greater Cincinnati Behavioral Health Services

Counseling Progress Note

Affix STAFF label

Client Name: | ***Client ID:***

Staff Name: | ***Staff ID:***

Date of Service M M / D D / Y Y Y Y | ***Start Time*** : ☐ *am* ☐ *pm* | ***End Time*** : ☐ *am* ☐ *pm*

Program: ☐ **CTU** ☐ **Counseling**	**Team:**	**Service Code: H0004**	☐ **HE**-face-to- face ☐ **HQ**-group	**# in group**
Client Location (check only one)	☐ ***53****-GCB* ☐ ***12****-Client Home* ☐ ***99-Community*** ☐ ***51****-Summit* ☐ ***09****-Incarcerated*	☐ **UK**- client not present		**Date entered:**

Observed/Reported changes in condition:

☐ **None**

Stressors/Extraordinary Events:

☐ **None** ☐ **No significant change from last visit**

Client Condition

Appearance			☐ unusual/bizarre	☐ poor hygiene
☐ appropriate	☐ casual and neat	☐ fastidious	☐ appears younger	☐ apprehensive
☐ inappropriate	☐ unkempt	☐ disheveled	☐ appears older	☐ other:
Behavior				
☐ cooperative	☐ guarded	☐ aggressive	☐ passive	☐ agitated
☐ unusual/bizarre	☐ impulsive	☐ fearful	☐ dramatic	☐ other:
Stream of Thought				
☐ clear & coherent	☐ impoverished	☐ rapid	☐ flight of ideas	☐ incoherent
☐ fragmented	☐ disordered	☐ loose	☐ tangential	☐ other:
Abnormalities of Thought Content				
☐ none	☐ phobias	☐ concrete thinking	☐ paranoid ideation	☐ delusions
☐ overvalued ideas	☐ ideas of reference	☐ poverty of thought	☐ obsessions	☐ other:
Perceptual Disturbances				
☐ none	☐ depersonalization	☐ derealization	☐ auditory	☐ visual
☐ illusions	☐ tactile	☐ olfactory	☐ other:	
Affect				
☐ appropriate	☐ inappropriate	☐ expansive	☐ guilty	☐ bright
☐ congruent	☐ incongruent	☐ labile	☐ heightened	☐ depressed
☐ full range	☐ constricted	☐ blunted	☐ flat	☐ other:
Mood				
☐ euthymia	☐ elevated	☐ euphoria	☐ angry/irritable	☐ apprehensive
☐ anxious	☐ depressed	☐ dysphoria	☐ apathetic	☐ other:
Orientation				
☐ oriented x 3	☐ not time	☐ not place	☐ not person	
Insight				
☐ present	☐ adequate	☐ limited	☐ impaired	☐ faulty
Judgment				
☐ good	☐ fair	☐ impaired	☐ poor	☐ grossly inadequate

Affix CLIENT label

Greater Cincinnati Behavioral Health Services

Counseling Progress Note

Client Name:	***Client ID:***

Issue(s) presented today:

- ☐ symptoms or impairment such as attitudes about illness:
- ☐ early life experiences:
- ☐ emotional distress:
- ☐ maladaptive behavior patterns:
- ☐ personality growth and development:
- ☐ stabilization of mental status or functioning:
- ☐ issues related to establishing therapeutic relationship:
- ☐ coping strategies or techniques:
- ☐ other:

Goal(s)/Objective(s) Addressed from ISP:

Recommended Revision to ISP: ☐ None ☐ Revise ISP

Therapeutic interventions provided OR Group Topic/Activity/Intervention

Response to intervention/Progress toward goals OR Group Participation

Additional information/Plan

Provider Signature/Credential: **Date:**	**Client Signature (Optional Based on Client Preference):**
Counter-Signature/Credential: **Date:**	**Date:** _____

Date/Time of next Appointment:	**Client rating of progress:** (write number in box) Have you made progress toward your goals today? ⟶ (Not Rated = **0**; None = **1** Some Progress = **2**; or Good Progress= **3**	

Affix CLIENT label

Greater Cincinnati Behavioral Health Services

Counseling Progress Note

Affix STAFF label

Client Name:	Client ID:
Staff Name:	Staff ID:

Date of Service: 03 / 01 / 2010 (M M / D D / Y Y Y Y)

Start Time: 09:38 ☒ am ☐ pm

End Time: 10:29 ☒ am ☐ pm

Program: ☐ CTU ☐ Counseling	Team:	Service Code: H0004	☐ HE-face-to- face ☐ HQ-group	# in group
Client Location (check only one)	☐ 53-GCB ☐ 12-Client Home ☐ 99-Community ☐ 51-Summit ☐ 09-Incarcerated		☐ UK- client not present	Date entered:

Observed/Reported changes in condition:

☒ None

Stressors/Extraordinary Events:

☐ None ☐ No significant change from last visit

Clt. was found not-guilty of assault at trial last week. Clt had to testify. Reported new prescriptions for pain meds for back pain & Med.

Client Condition

Appearance			☐ unusual/bizarre	☐ poor hygiene
☐ appropriate	☒ casual and neat	☐ fastidious	☐ appears younger	☐ apprehensive
☐ inappropriate	☐ unkempt	☐ disheveled	☐ appears older	☐ other:
Behavior				
☐ cooperative	☐ guarded	☐ aggressive	☐ passive	☒ agitated
☐ unusual/bizarre	☐ impulsive	☐ fearful	☐ dramatic	☐ other:
Stream of Thought				
☐ clear & coherent	☐ impoverished	☐ rapid	☐ flight of ideas	☐ incoherent
☐ fragmented	☐ disordered	☐ loose	☒ tangential	☐ other:
Abnormalities of Thought Content				
☒ none	☐ phobias	☐ concrete thinking	☐ paranoid ideation	☐ delusions
☐ overvalued ideas	☐ ideas of reference	☐ poverty of thought	☐ obsessions	☐ other:
Perceptual Disturbances				
☒ none	☐ depersonalization	☐ derealization	☐ auditory	☐ visual
☐ illusions	☐ tactile	☐ olfactory	☐ other:	
Affect				
☐ appropriate	☐ inappropriate	☐ expansive	☐ guilty	☐ bright
☐ congruent	☐ incongruent	☐ labile	☒ heightened	☐ depressed
☐ full range	☐ constricted	☐ blunted	☐ flat	☐ other:
Mood				
☐ euthymia	☐ elevated	☐ euphoria	☒ angry/irritable	☐ apprehensive
☐ anxious	☐ depressed	☐ dysphoria	☐ apathetic	☐ other:
Orientation				
☒ oriented x 3	☐ not time	☐ not place	☐ not person	
Insight				
☐ present	☐ adequate	☒ limited	☐ impaired	☐ faulty
Judgment				
☐ good	☐ fair	☒ impaired	☐ poor	☐ grossly inadequate

Affix CLIENT label

Greater Cincinnati Behavioral Health Services

Counseling Progress Note

Client Name: | **Client ID:**

Issue(s) presented today:

- [x] symptoms or impairment such as attitudes about illness: increased anxiety/anger-recent arguments w/ JFS staff re benefits; fought w/ clerk
- [ ] early life experiences:
- [x] emotional distress: increased anxiety due to court & problems @ work
- [ ] maladaptive behavior patterns:
- [ ] personality growth and development:
- [ ] stabilization of mental status or functioning:
- [x] issues related to establishing therapeutic relationship: clt had to be re-directed several times to stay on topic and decrease volume of voice & anger reactions
- [x] coping strategies or techniques: clt did not complete diary card or practice breathing techniques; decreased self-care and time management
- [ ] other:

Goal(s)/Objective(s) Addressed from ISP: To increase control over emotions and express them effectively and appropriately

Recommended Revision to ISP: [x] None [ ] Revise ISP

Therapeutic interventions provided OR Group Topic/Activity/Intervention

Assisted clt in reviewing self-care and how lack of self-care has led to increased mood problems. Reviewed current use of meds & encouraged clt to see Psychiatrist re: current stressors and SAMI hx. Prompted clt to identify barriers to using coping skills. Encouraged clt to contact physical therapist re: back injury. Role-played home-visit w/ children's services. Identified triggers and anger responses.

Response to intervention/Progress toward goals OR Group Participation

Clt was able to recognize her tone, body language and word choices as inconsistent with keeping calm. Clt has continued to fill schedule w/ activities instead of self-care. Agreed to make appointments with Psychiatrist and Physical Therapist to reduce pain med use.

Additional information/Plan

Will review diary card and self care skills at next session

Provider Signature/Credential:	Date:	Client Signature (Optional Based on Client Preference):
Mg Counselor, LISW	3/1/2010	
Counter-Signature/Credential:	Date:	Date: _____

Date/Time of next Appointment:	Client rating of progress: (write number in box) Have you made progress toward your goals today? → (Not Rated = 0; None = 1 Some Progress = 2; or Good Progress= 3	
3/9/10		2

OUTPATIENT PSYCHIATRIC CLINIC
2121 Main Street
Raleigh, NC 27894
919-291-1343

Date of Exam: 3/13/2012
Time of Exam: 10:45 am

Patient Name: Smith, Anna
Patient Number: 1000010544165

TREATMENT PLAN FOR ANNA SMITH

Treatment Plan Meeting
A Treatment Plan meeting was held today, 3/13/2012, for Anna Smith.

Diagnosis:
Axis I: Generalized Anxiety Disorder, 300.02 (Active)
Axis II: None V71.09
Axis III: See Medical History
Axis IV: None
Axis V: 60

Current Psychotropics:
Paxil 10 mg PO QAM
Buspirone 10 mg PO QAM
Ambien CR 6.25 mg PO QHS
Synthroid 50 mcg PO QAM

Problems:
Problem #1: anxiety

_____
_____

Problem = ANXIETY

Anna's anxiety has been identified as an active problem in need of treatment. It is primarily manifested by:
Generalized Anxiety Disorder - with excessive worrying - with impairment in functioning.

Long Term Goal(s):
- will reduce overall level, frequency, and intensity of anxiety so that daily functioning is not impaired.
Target Date: 4/25/2012

Short Term Goal(s):
Anna will have anxiety symptoms less than 50% of the time for one month.
Target Date: 4/25/2012

In addition, Anna will exhibit increased self-confidence as reported by client on a self-report 0-10 scale weekly for two months.
Target Date: 5/13/2012

Intervention(s):
• Prescriber to monitor side effects and ADJUST MEDICATION DOSAGE to increase effectiveness and decrease SIDE EFFECTS, as appropriate for anxiety disorder once per week for one month.

Comprehensive Treatment Plan Barriers

Emotional problems interfere with treatment.
- Anna is fearful that her apprehensive symptoms will never be under good control.

Comprehensive Treatment Plan Strengths
Anna's strengths include:

cognitive
- Intellectually bright

communicative
- Has good communicative skills

family
- Good relationship with family

_____

Upon completion of Long Term Goal, Discharge or Transition Plan includes:

Continue with current therapist: Name _____

Continue with current psychiatrist: Name _____

Refer for follow up with: Name _____ Arranged by: _____

Refer for follow up with: Name _____ Arranged by: _____

Other: _____

Signature below indicates that this Treatment Plan has been reviewed and approved:

Date:_____ Clinician: _____ Title:_____

Date:_____ Clinician: _____ Title:_____

Date:_____ Clinician: _____ Title:_____

Date:_____ Clinician: _____Title:_____

Date:_____ Clinician: _____ Title:_____

Date:_____ Patient: _____

Date:_____ Parent/Guardian: _____

Date:_____ Other: _____

A copy of this treatment plan was: _____ given to the patient/family OR _____ declined by the patient/family.:

Date:_____ Clinician: _____ Title:_____

Elizabeth Lobao, MD

Electronically Signed
By: Liz Lobao, MD
On: 3/13/2012 10:48:09 AM

PSYCHIATRIC HOSPITAL
1234 Main Street
Anywhere, USA

Date of Exam: 6/29/2012
Time of Exam: 1:33:31 PM

Patient Name: Jennifer Smiley
Patient Number: 1000010645495

TREATMENT PLAN FOR JENNIFER SMILEY

Treatment Plan Meeting
A Treatment Plan meeting was held today, 6/29/2012, for Jennifer Smiley.

Diagnosis:

Axis I:	Major Depressive Disorder, Single, Severe w/o Psychotic Features, 296.23 (Active)
	Alcohol Dependence, 303.90 (Active)
Axis II:	Deferred Diagnosis 799.99
Axis III:	See Medical History
Axis IV:	Primary Support Group
	Occupational
	Grief: Death of daughter in 2011
Axis V:	50
	85 (Highest GAF in past 12 months)

Current Psychotropic:
#1) Prozac 30 mg. PO QAM
#2) Antabuse 250 mg. PO QAM
#3) Synthroid 100 mcg. PO QAM
#4) Ambien CR 6.25 mg PO at Hour of Sleep

Problems:
Problem #1: depressed mood

Problem = DEPRESSED MOOD

Jennifer's depressed mood has been identified as an active problem in need of treatment. It is primarily manifested by:
Thoughts of death or suicide - experienced almost daily.

Long Term Goal(s):
- Will score within normal Limits on the Beck Depression Scale.
- Will maintain compliance with psychotropic medications.

Target Date: 9/12/2012

Short Term Goal(s):
Jennifer will recognize and report thoughts of death to staff daily for one week.
She will attend daily grief support group.
She will attend 3 recreation activities per week.

Target Date: 5/1/2012

Intervention(s):
• Prescriber will examine patient and order consultations and lab as needed to arrive at all appropriate DIAGNOSES

• Prescriber to prescribe medications, monitor side effect, and adjust dosage to STABILIZE MOOD and minimize side effects.

• Prescriber will educate patient (patient's family) as to the RISKS AND BENEFITS of treatment and obtain informed consent, if appropriate.

• Therapist will provide emotional SUPPORT and encouragement, and help patient focus on sources of pleasure and meaning.

Status:

6/29/2012: The undersigned therapist met with the patient on the date above in a face to face meeting to work with him/her in developing this Treatment Plan.

Comprehensive Treatment Plan Barriers

Emotional problems interfere with treatment.
- Emotional problems will be dealt with via treatment plan.
- Jennifer is encouraged to keep a personal journal to assist in sorting out her thoughts and goals.

Comprehensive Treatment Plan Strengths
Jennifer's strengths include:

Cognitive
- Intellectually bright
- Can make needs known

Physical
- Is physically healthy

Upon completion of Long Term Goal, Discharge or Transition Plan includes:

Expected length of stay: 7 days

Continue with current therapist: Jason Jones, MD

Continue with current psychiatrist: Karen Johnston, MD

Other: _____

Signature below indicates that this Treatment Plan has been reviewed and approved:

Date: _____ Clinician: _____ Title: _____

Date: _____ Clinician: _____ Title: _____

Date: _____ Clinician: _____ Title: _____

Date: _____ Clinician: _____ Title: _____

Date: _____ Patient: _____

A copy of this treatment plan was: _____ given to the patient/family OR _____ declined by the patient/family.:

Date: _____ Clinician: _____ Title: _____

Electronically Signed
By: Elizabeth Lobao (MD)
On: 6/29/2012 1:35:59 PM

Note: Each member of the treatment team has the ability to e-sign this clinical record.