Listed below are samples of progress notes. You are welcome to use the progress notes as examples for creating your own.

Priscilla’s Examples:

**(First Session)**

**DESCRIPTION OF THE THERAPEUTIC ACTIVITY**

Individual psychotherapy with Liza was provided to initiate therapy process. Clinician reviewed Professional Disclosure Statement (PDS), HIPAA, limits to confidentiality, communication policy, insurance information, and no-show/late cancellation policy. Psychotherapy was provided to review client symptomology, mental health diagnosis, identified problems, and treatment goals. Liza spoke openly and collaboratively. She reported minimal symptoms of distress and precontemplation about her goals.

No imminent risk of SI, HI, or other safety concerns were identified as assessed by clinician.

**PLAN FOR SUBSEQUENT THERAPEUTIC CONTACT:**

Liza will return for individual therapy on 2/8/21. Liza will spend time brainstorming her future goals. Clinician recommended the book “The Happiness Curve.”

**(Later session with new suicidal thoughts)**

**DESCRIPTION OF THE THERAPEUTIC ACTIVITY**

Individual psychotherapy with Liza was provided to address symptoms of depression. Liza reported that she is struggling with sleep and experienced passive suicidal thoughts. Psychotherapy was provided to assess the suicidal thoughts and sleep deprivation. Liza reported making steps to support herself and reached out to friends to assist her. Liza began acupuncture to help with sleep and has regularly scheduled sessions. Liza was agreeable to contact a naturopathic doctor or PCP for medication management. Clinician reviewed sleep hygiene recommendations.

Liza declined any plan or intention. She identified protective factors to keep her from acting on suicidal thoughts. No imminent risk of SI, HI, or other safety concerns were identified as assessed by clinician.

**PLAN FOR SUBSEQUENT THERAPEUTIC CONTACT:**

Liza will return for individual therapy on 8/16/21. Liza declined a sooner appointment. She reported confidence that she would be ok and will contact clinician if needed.

**(Session a couple weeks after suicidal thought session)**

**DESCRIPTION OF THE THERAPEUTIC ACTIVITY**

Individual psychotherapy with Liza was provided to address symptoms of depression. Psychotherapy was provided to elicit, amplify, and reinforce the coping skills and coherent narrative work that Liza implemented. Liza was euthymic. She reported personal insights about her recent depressive and suicidal experiences. Liza was able to identify her growth experiences. She reported success in sharing her story with a local friend.

No imminent risk of SI, HI, or other safety concerns were identified as assessed by clinician.

**PLAN FOR SUBSEQUENT THERAPEUTIC CONTACT:**

Liza will return for individual therapy on 9/20/21. Liza will return for therapy in three weeks. She will evaluate her need for continuing treatment.

**DESCRIPTION OF THE THERAPEUTIC ACTIVITY**

Individual psychotherapy with Shandal was provided to address transitional distress. Psychotherapy was provided to address Shandal’s experience of burnout. Shandal reported practicing more coping skills and drinking more water, she reported increased focus and energy. She identified vocational stress. Clinician and Shandal reviewed options for clarifying her work goals and expectations, self-advocacy, and cognitive assessments of negative thoughts. Shandal spoke openly and collaboratively with clinician. She reported willingness to attempt the identified tasks.

No imminent risk of SI, HI, or other safety concerns were identified as assessed by clinician.

**PLAN FOR SUBSEQUENT THERAPEUTIC CONTACT:**

Shandal will return for individual therapy on 9/2/21

Blake’s Progress Note Example:

Description:

[Client Name] was on time for individual appointment. Clinician provided therapy utilizing CBT techniques. [Client Name] shared what she has been dealing with. Clinician highlighted and reinforced the positive coping skills she is using, utilized Socratic style questioning, and provided psychoeducation. [Client Name] reported it was helpful to talk.

Assessment:

[Client Name] presented as a bit teary eyed today. [Client Name] lives with her husband and a roommate. She reports her faith is an important aspect of her life. She has been dealing with depression (see intake for symptoms). [Client name] denies any current suicidal ideation. [Client Name] is open to feedback and seems willing to do what she needs to to achieve her goals.

Plan:

Continue to meet regularly and continue to work on finding coping skills to move towards goals.

**Natalie Progress Note Example:**

Session time: [exact start and exact end]

**DESCRIPTION OF THE THERAPEUTIC ACTIVITY**

Individual psychotherapy session with Client was provided to address symptoms of PTSD. Session was held virtually via a HIPAA compliant platform. Client was located at their home (address on file), and has signed informed consent for telehealth. Client updated clinician on stressors with her partner. Client also reported an increase in fear.

Clinician utilized CBT to help client increase in recognition of patterns of behavior when they experience fear and learn TIPP skills for grounding when they are feeling the distress of fear.

Client reported that they will practice TIPP skills today so they knew how they felt in response to clinician’s intervention.

Client was oriented by person, place, time and situation. Client presented in an anxious mood and their affect was congruent. They were tearful throughout session.

Client appears to be making progress by increased desire to feel more emotions, especially those that bring them discomfort.

No SI/HI reported. Clinician will continue to assess.

**PLAN FOR SUBSEQUENT THERAPEUTIC CONTACT**

Client will return for individual therapy on [date] and will continue with current tx plan.