

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	<p>There are four options available for staff using this section of the progress note:</p> <ol style="list-style-type: none"> 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. <p>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.</p>

Case Progress Notes Sample And Therapy

Hobart Amory Hare, Walter Chrystie



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Becoming a Marriage and Family Therapist Eugene Mead, 2013-01-29 Becoming a Marriage and Family Therapist is a practical how to guide designed to help trainee therapists successfully bridge the gap between classroom and consulting room Readers will learn how to apply empirically based methods to the core tasks of therapy in order to improve competency establish effective supervision and deliver successful client outcomes A practical guide to improving competency across the core tasks of therapy based on over 40 years of observation and teaching by an internationally acclaimed author Presents treatment protocols that show how to apply therapy task guidelines to a range of empirically supported marriage and family treatments Provides extended coverage on assessing and beginning treatment with crisis areas such as suicidal ideation and family violence with children elders and spouses Suggests how supervisors can support trainees in dealing with crisis and other challenging areas to build competence and successful delivery *Documentation for Rehabilitation - E-Book* Lori Quinn, James Gordon, 2024-04-12 Better patient management starts with better documentation Documentation for Rehabilitation 4th Edition demonstrates how to accurately document treatment progress and patient outcomes using a framework for clinical reasoning based on the International Classification for Functioning Disability and Health ICF model adopted by the American Physical Therapy Association APTA The documentation guidelines in this practical resource are easily adaptable to different practice settings and patient populations in physical therapy and physical therapy assisting Realistic examples and practice exercises reinforce the understanding and application of concepts improving skills in both documentation and clinical reasoning Workbook textbook format with examples and exercises in each chapter helps reinforce understanding of concepts Coverage of practice settings includes documentation examples in acute care rehabilitation outpatient home care nursing homes pediatrics school and community settings Case examples for a multitude of documentation types include initial evaluations progress notes daily notes letters to insurance companies Medicare documentation and documentation in specialized settings NEW Movement Analysis Linking Activities and Impairments content addresses issues related to diagnosis NEW An eBook version included with print purchase provides access to all the text figures and references with the ability to search customize content make notes and highlights and have content read aloud Updated case examples provide clinical context for patient documentation Revised content including updated terminology from the latest updates to the Guide to Physical Therapist Practice provides the most current information needed to be an effective practitioner Updated references ensure content is current and applicable for today's practice **Textbook of Basic Nursing** Caroline Bunker Rosdahl, Mary T. Kowalski, 2008 Now in its Ninth Edition this comprehensive all in one textbook covers the basic LPN LVN curriculum and all content areas of the NCLEX PN Coverage includes anatomy and physiology nursing process growth and development nursing skills and pharmacology as well as medical surgical maternal neonatal pediatric and psychiatric mental health nursing The book is written in a student friendly style and has an attractive

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