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Progress Note Sample

For this example, this note represents the fourth session of therapy. Following the initial assessment, the therapist continued to assess Josh and has refined diagnosis to reflect he meets criteria for a Major Depressive Episode, recurrent. As a result of the change in diagnosis, the therapist updated the treatment plan to reflect the new diagnosis and another long-term goal addressing use of CBT techniques was added.

Patient information:

Patient Name: John Smith

Session information:

Date: 11/22/2021
State Time: 10:00 am
End Time: 10:50 am
CPT Code: 90834

Clinical:

Diagnosis: F33.1 Major Depressive Disorder, recurrent episode, moderate

Subjective (patient report): “Things feel better since starting therapy. I feel like there’s hope.”

Objective (factual account of what was observed, mental health status): John arrived at the session on-time. He was oriented to person, place, and time. His eye contact and speech were appropriate. John readily engaged in conversation with the therapist, showing no signs of guardedness. His mood and affect were congruent.

Assessment: John’s insight remains fair. He is gaining understanding about how his choices influence his mental well-being. John continues to demonstrate motivation to improve his sleep hygiene. His sleep has improved to a steady 5 hours a night and he is less agitated and irritable with his partner. John continues to deny the presence of suicidal or homicidal ideation.

Clinical intervention: Provided more psychoeducation about CBT techniques and the cognitive triangle. Used three examples with John to demonstrate the relationship between thoughts, feelings, and behaviors. Provided example of thought log as potential structure for Josh to reference between sessions.

Progress: John has made progress on his first long-term goal to improve sleep hygiene. He has successfully implemented two behaviors in his routine at least twice a week. Additionally, John has demonstrated understanding of the cognitive triangle and how his thoughts, behaviors, and emotions influence his insomnia. Results of the PHQ-9 indicate depressive symptoms have remained the same.

Plan: John will continue with weekly individual therapy sessions.

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Progress Note Sample 2

For this example, this note is written after four months of therapy. Therapist updated the treatment plan after three months as Josh met his initial long-term treatment goals and is currently reducing frequency of sessions while continuing to focus on improving interpersonal relationships

Patient information:

Patient Name: John Smith

Session information:

Date: 02/02/2022
State Time: 4:41 am
End Time: 5:30 pm
CPT Code: 90834

Clinical:

Diagnosis: F33.1 Major Depressive Disorder, recurrent episode, moderate

Subjective (patient report): “Things were hard last week. I really had to focus on using my skills.”

Objective (factual account of what was observed, mental health status): John arrived 10 minutes late to the session today. He was oriented to person, place, and time. His eye contact was appropriate. John often spoke rapidly and appeared restless. Although he expressed a happy mood, his affect appeared angry and agitated.

Assessment: John demonstrated increased insight into how his behavior impacts interpersonal relationship conflicts. Discussed three conflicts with his supervisor. He verbalizes accountability for his actions instead of blaming others (which was a previous way of coping). Although his mood and affect were incongruent during the session, his affect was aligned with the content of what he shared with the therapist. John continues to deny the presence of suicidal or homicidal ideation.
Clinical intervention: Processed the situations that were challenging to John and identified helpful CBT skills. Used a role-play situation to help build confidence in using positive communication skills with his supervisor.

Progress: John has made steady progress in treatment. Having met his initial goals for treatment, he is ready to step down care to biweekly sessions while continuing to work on current goal focusing on interpersonal relationships. John continues to maintain his learned skills with positive communication. However his functional assessment CQ results indicate he continues to need support with improving relationships. John has maintained a good sleep hygiene routine and continues to keep alcohol consumption to one beer, two nights a week.

Plan: John will begin attending biweekly therapy sessions. Next session will be an adjunct couples session with his partner.