

# Progress Notes for Mental Health Counselors Template

## Client Information

John Doe  
First Name Last Name

12/22/1990  
Date of Birth

Date/Time	Progress Note
10/04/2022 9:00 - 9:45am	John reported his feelings of anxiety have reduced in intensity, although he still feels "somewhat anxious pretty much all the time". Spent the session discussing anxiety coping mechanisms including how John can practice replacing anxiety triggers with calming thoughts. John presented neatly and was well groomed. He showed normal awareness of his presenting symptoms. No suicidal ideation present. Compliance with medication is good. Will continue with current treatment plan and weekly sessions.
10/11/2022 9:05 - 9:50am	Session focused on an event at work: John is struggling with feelings of low self-worth, saying he feels like he "isn't good at anything he does". Practiced replacing negative self-talk with positive self-talk. John's feelings of anxiety are associated with low self-esteem. Compliance with medication is good. Insight into anxiety is normal. John will focus on strengthening professional relationships with colleagues. Weekly sessions to continue.
10/18/2022 9:00 - 9:45am	John says he is "enjoying work a bit more". John attended a work event and said it made him feel "better about his relationships". John has demonstrated an improvement with his feelings of low self-esteem. Continue working on this area. John arrived to session promptly and was neatly dressed and well groomed. John's anxiety continues to decrease in intensity. Continue with treatment plan to continue.
10/25/2022 9:00 - 9:45am	John says he feels "better" but still can't "shake the anxiety feeling". Session focused on identifying causes of anxiety (apart from work). Anxiety may be associated with social relationships. John is struggling to find time to maintain his friendships. John will reach out to friends and organize a social event. Work anxiety has reduced significantly. John is showing improvement. Current treatment plan to continue.
11/01/2022 9:05 - 9:50am	John caught up with a friend and said he opened up about his work-related struggles, saying the conversation made him feel "so much better". John's anxiety at work continues to reduce. He practices replacing negative self-talk with positive self-talk and this appears to be improving his anxiety. Treatment plan will continue, but will reduce therapy sessions to once every fortnight. John will continue focusing on strengthening his relationships with friends, family members, and colleagues.

Counselor Name

Dr Jane Example

Counselor Signature



# Mental Health Progress Notes

**Sherry Borcherding, Marie J. Morreale**

## **Mental Health Progress Notes:**

**The Severe and Persistent Mental Illness Progress Notes Planner** David J. Berghuis, Arthur E. Jongsma, Jr., 2008-07-10 The flexible format of The Severe and Persistent Mental Illness Progress Notes Planner 2nd Edition enables you to choose between evidence based and traditional best practice treatment approaches for your patients Fully revised to meet your needs as a mental health professional working in today s long term care facilities this time saving resource will save you hours of time consuming paperwork without sacrificing your ability to develop customized progress notes This guide is organized around 31 behaviorally based issues from employment problems and family conflicts to financial needs and homelessness to intimate relationship conflicts and social anxiety *Mental Health and Psychiatric Nursing* Janet L. Davies, Ellen Hastings Janosik, 1991 *The OTA's Guide to Writing SOAP Notes* Sherry Borcherding, Marie J. Morreale, 2007 Written specifically for occupational therapy assistants The OTA s Guide to Writing SOAP Notes Second Edition is updated to include new features and information This valuable text contains the step by step instruction needed to learn the documentation required for reimbursement in occupational therapy With the current changes in healthcare proper documentation of client care is essential to meeting legal and ethical standards for reimbursement of services Written in an easy to read format this new edition by Sherry Borcherding and Marie J Morreale will continue to aid occupational therapy assistants in learning to write SOAP notes that will be reimbursable under Medicare Part B and managed care for different areas of clinical practice New Features in the Second Edition Incorporated throughout the text is the Occupational Therapy Practice Framework along with updated AOTA documents More examples of pediatrics hand therapy and mental health Updated and additional worksheets Review of grammar documentation mistakes Worksheets for deciphering physician orders as well as expanded worksheets for medical abbreviations Updated information on billing codes HIPAA management of health information medical records and electronic documentation Expanded information on the OT process for the OTA to fully understand documentation and the OTA s role in all stages of treatment including referral evaluation intervention plan and discharge Documentation of physical agent modalities With reorganized and shorter chapters The OTA s Guide to Writing SOAP Notes Second Edition is the essential text to providing instruction in writing SOAP notes specifically aimed at the OTA practitioner and student This exceptional edition offers both the necessary instruction and multiple opportunities to practice as skills are built on each other in a logical manner Templates are provided for beginning students to use in formatting SOAP notes and the task of documentation is broken down into small units to make learning easier A detachable summary sheet is included that can be pulled out and carried to clinical sites as a reminder of the necessary contents for a SOAP note Updated information expanded discussions and reorganized learning tools make The OTA s Guide to Writing SOAP Notes Second Edition a must have for all occupational therapy assistant students This text is the essential resource needed to master professional documentation skills in today s healthcare environment **The Clinical Documentation**

**Sourcebook** Donald E. Wiger,2005-03-04 All the forms handouts and records mental health professionals need to meet documentation requirements The paperwork required when providing mental health services continues to mount Keeping records for managed care reimbursement accreditation agencies protection in the event of lawsuits and to help streamline patient care in solo and group practices inpatient facilities and hospitals has become increasingly important This updated and revised Third Edition provides you with a full range of forms checklists and clinical records essential for effectively and efficiently managing your practice From intake to diagnosis and treatment through discharge and outcome assessment The Clinical Documentation Sourcebook Third Edition offers sample forms for every stage of the treatment process Greatly expanded from the second edition the book now includes twenty six fully completed forms illustrating the proper way to fill them out as well as fifty two ready to copy blank forms The included CD ROM also provides these forms in Word format so you can easily customize them to suit your practice With The Clinical Documentation Sourcebook Third Edition you'll spend less time on paperwork and more time with clients Includes documentation for child family and couples counseling Updated for HIPAA compliance as well as to reflect the latest JCAHO and CARF regulations New focus on clinical outcomes supports the latest innovations in evidence based practice

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**Future Directions** Elias Aboujaoude,Lina Gega,Michelle Burke Parish,Donald M. Hilty,2020-04-01 **Documentation**

**Survival Handbook for Psychiatrists and Other Mental Health Professionals** Stephen Michael Soreff,Mary Ann

McDuffee,1993 *The Intellectual and Developmental Disability Treatment Planner, with DSM 5 Updates* David J.

Berghuis,Arthur E. Jongsma, Jr.,Kellye H. Slaggert,2012-03-05 This timesaving resource features Treatment plan components for 28 behaviorally based presenting problems Over 1 000 prewritten treatment goals objectives and interventions plus space to record your own treatment plan options A step by step guide to writing treatment plans that meet the requirements of most insurance companies and third party payors The Intellectual and Developmental Disability Treatment Planner provides all the elements necessary to quickly and easily develop formal treatment plans that satisfy the demands of HMOs managed care companies third party payers and state and federal review agencies Saves you hours of time consuming paperwork yet offers the freedom to develop customized treatment plans for the severely and persistently mentally ill Organized around 28 main presenting problems from family conflicts to paranoia parenting health issues and more Over 1 000 clear statements describe the behavioral manifestations of each relational problem and includes long term goals short term objectives and clinically tested treatment options Easy to use reference format helps locate treatment plan components by behavioral problem or DSM 5TM diagnosis Includes a sample treatment plan that conforms to the requirements of most third party payers and accrediting agencies including TJC and NCQA *Note Designer* Patricia C Baldwin,2016-03-23 This book provides step by step guidelines tips and instruction on how to create and write psychotherapy treatment notes Information and guidance are provided on how to write a treatment intake report treatment progress notes and termination summary A

number of sample notes reports and templates are provided The book also includes hundreds of representative statements for therapists to use in the design of their own psychotherapy progress notes A valuable resource for experienced mental health professionals and trainees alike from the creator of Note Designer therapy note writing software A time saving reference to capture the essence and the methods of professional note writing for psychotherapists Easy to apply and great to keep close by when writing reports and progress notes Alexandre Smith Peter Psy D candidate Basic Concepts of Psychiatric-mental Health Nursing Louise Rebraca Shives,1998 This updated Seventh Edition will equip psychiatric and mental health nurses with the essential clinical knowledge and skills needed to practice with confidence Spanning the continuum of care this text will help nurses excel in a range of settings improve client and family education skills and build the self awareness a nurse needs as a member of the interdisciplinary care team This edition includes a new chapter on forensic nursing new content on spirituality updated psychopharmacological information current DSM IV TR diagnostic criteria and Evidence Based Practice Boxes throughout the text A bound in CD ROM includes clinical simulations for major depression and schizophrenia psychotropic drug monographs over 300 NCLEX style questions and movie viewing guides

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