Progress Note for Psychotherapy Template

Client Information

Remi Lopez C First Name Last Name I

04/04/1984 Date of Birth 02/12/2022 14:00 Date/Time

Problem

Remi has improved in managing her mood swings, and practicing emotional regulation techniques. However, she still has difficulties in concentrating on her work and motivating herself to complete tasks. Remi states that, "no matter how big or small, or what I'm feeling, I just struggle to work on both my mental state and my life."

Assessment

Remi has been diagnosed with bipolar disorder (type 1), and has faced issues with managing mood swings in the past. However, she has made significant progress, and now struggles to attend to work tasks in addition to focusing on her emotional regulation processes. It is recommended that she is given concentration techniques to help develop strategies to combat work imbalances.

Intervention

Remi has been provided with concentration techniques, as well as a structured plan to help her divide time for herself and for her day to day responsibilities. Remi is happy with this plan, and has responded positively to taking little steps.

Medication

Remi continues with her Lithium dosage. If improvements continue in future sessions, we may look at gradually decreasing this.

Plan

Remi will see me in 2 weeks, and will report back on her concentration techniques as well as her work/self-care balance. We will amend strategies, and revise medication routes if improvements are not made.

Dr Lucy Smith

Clinician Name (Printed)



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Sherry Borcherding, Marie J. Morreale

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The Clinical Documentation Sourcebook Donald E. Wiger, 2009-12-31 All the forms handouts and records mental health professionals need to meet documentation requirements fully revised and updated 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 Now fully updated and revised the Fourth Edition of The Clinical Documentation Sourcebook provides you with a full range of forms checklists and clinical records essential for effectively and efficiently managing and protecting your practice The Fourth Edition offers Seventy two ready to copy forms appropriate for use with a broad range of clients including children couples and families Updated coverage for HIPAA compliance reflecting the latest The Joint Commission TJC and CARF regulations A new chapter covering the most current format on screening information for referral sources Increased coverage of clinical outcomes to support the latest advancements in evidence based treatment A CD ROM with all the ready to copy forms in Microsoft Word format allowing for customization to suit a variety of practices From intake to diagnosis and treatment through discharge and outcome assessment The Clinical Documentation Sourcebook Fourth Edition offers sample forms for every stage of the treatment process Greatly expanded from the Third Edition the book now includes twenty six fully completed forms illustrating the proper way to fill them out Note CD ROM DVD and other supplementary materials are not included as part of eBook file Physical Therapy Documentation Mia Erickson, Mia L. Erickson, Rebecca McKnight, Ralph Utzman, 2008 Complete accurate documentation is one of the essential skills for a physical therapist This book covers all the fundamentals includes practice exercises case studies throughout The Psychotherapy **Documentation Primer** Donald E. Wiger, 2020-12-03 Everything you need to know to record client intake treatment and progress incorporating the latest managed care accrediting agency and government regulations Paperwork and record keeping are day to day realities in your mental health practice Records must be kept for managed care reimbursement for accreditation agencies for protection in the event of lawsuits to meet federal HIPAA regulations and to help streamline patient care in larger group practices inpatient facilities and hospitals The standard professionals and students have turned to for quick and easy yet comprehensive guidance to writing a wide range of mental health documents the Fourth Edition of The Psychotherapy Documentation Primer continues to reflect HIPAA and accreditation agency requirements as well as offer an abundance of examples Fully updated to include diagnostic criteria of the DSM 5 The Psychotherapy Documentation Primer 4th Edition is designed to teach documental skills for the course of psychotherapy from the initial interview to the discharge The documentation principles discussed in the text satisfy the often rigid requirements of third party insurance companies regulating agencies mental health licensing boards and federal HIPAA regulations More importantly it provides students and professionals with the empirical and succinct documentation techniques and skills that will allow them to

provide clear evidence of the effects of mental health treatment while also reducing the amount of their time spent on paperwork Note Designer Patricia Csank Baldwin, 2023 This second edition of Note Designer provides step by step guidelines tips and instruction on how to create and write psychotherapy treatment notes and reports The book includes information and guidance on how to write intake reports treatment plans treatment progress notes for individual psychotherapy couples therapy and child and family therapy risk assessments and termination reports A number of sample notes reports and templates are provided The book also includes hundreds of representative statements for therapists to use in their own progress notes and reports A valuable resource for experienced mental health professionals and trainees alike

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 Family Therapy Progress Notes Planner David J. Berghuis, Arthur E. Jongsma, Jr., 2004-07-22 The Family Therapy Progress Notes Planner contains complete prewritten session and patient presentation descriptions for each behavioral problem in The Family Therapy Treatment Planner The prewritten progress notes can be easily and quickly adapted to fit a particular client need or treatment situation Saves you hours of time consuming paperwork yet offers thefreedom to develop customized progress notes Organized around 38 main presenting problems that range fromfamily business conflicts and inheritance disputes to alcoholabuse physical verbal psychological abuse and religious spiritual conflicts Features over 1 000 prewritten progress notes summarizing patient presentation themes of session and treatmentdelivered Provides an array of treatment approaches that correspond withthe behavioral problems and DSM IV TR TM diagnostic categories in The Family Therapy Treatment Planner Offers sample progress notes that conform to the requirements of most third party payors and accrediting agencies including the JCAHO and the NCQA The Family Therapy Progress Notes Planner Arthur E. Jongsma, Jr., David J. Berghuis, 2010-07-06 The Bestselling treatment planning system for mental health professionals The Family Therapy Progress Notes Planner Second Edition contains complete prewritten session and patient presentation descriptions for each behavioral problem in The Family Therapy Treatment Planner Second Edition The prewritten progress notes can be easily and quickly adapted to fit a particular client need or treatment situation Saves you hours of time consuming paperwork yet offers the freedom to develop customized progress notes Organized around 40 behaviorally based presenting problems including family of origin interference depression in family members divorce financial conflict adolescent and parent hostility friction within blended families traumatic life events and dependency issues Features over 1 000 prewritten progress notes summarizing patient presentation themes of session and treatment delivered Provides an array of treatment approaches that correspond with the behavioral problems and DSM IV TRTM diagnostic categories in The Family Therapy Treatment Planner Second Edition Offers sample progress notes that conform to the requirements of most third party payors and accrediting agencies including CARF The Joint Commission TJC COA and the NCQA Presents new and updated information on the role of evidence based practice in progress notes writing and the special status of progress notes under HIPAA The Counselor's Steps for Progress Notes Rhonda Sutton, 2015-06-21 Dr Rhonda Sutton's second edition of the straightforward guide to progress notes includes additional examples information documentation and clinical language that expands on the utility and readability of the first book Additional case studies provide examples of how to use the STEPs to format notes New chapters include information on clinical language and documentation This book covers everything about progress notes from how to write them to how to store them and even what to do when someone requests to them In addition clinical terms and abbreviations are included as well as suggestions for other clinical documentation such as termination letters privacy statements and professional disclosure statements Suited for all types of mental health clinicians this book will help therapists improve upon their progress notes and other forms of clinical documentation Documentation for Rehabilitation - E-Book Lori Quinn, James Gordon, 2024-04-12 Better patient management starts with better documentation Documentation for

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