

Date of Exam: 6/9/2016
Time of Exam: 3:38:08 PM

Patient Name: Little, Aimee
Patient Number: 1000010659748

Psychotherapy Progress Note

Mrs. Little seems to have had an inadequate response to treatment as yet. Symptoms of depression continue to be described. Her symptoms, as noted, are unchanged and they are just as frequent or intense as previously described. Mrs. Little describes feeling sad. Mrs. Little denies suicidal ideas or intentions. Mrs. Little's anxiety symptoms continue. Mrs. Little reports the symptoms of this disorder continue unchanged. The subjective feeling of apprehension is occurring. Hypervigilance is occurring more frequently.

BEHAVIOR:

Her self care is reduced and less attention is being paid to these tasks. She reports the feeling that the performance of domestic tasks has to be forced and are performed with difficulty. She is socially isolated. Sleep problems are reported. Difficulty staying asleep is reported.

CONTENT OF THERAPY:

The patient today spoke mainly about issues involving coping with depression. Problems in the family were also discussed by the patient. Mrs. Little shared the following pertinent details during this session: "I miss my husband terribly and wonder if I will ever get over this." Feelings of loss were also expressed. Feelings of grief were also expressed.

THERAPEUTIC INTERVENTION:

This session the therapeutic focus was on facilitating communication of feelings. Patient urged to ask for help and support from staff member or therapist when feeling depressed. Aimee will use session to deal with grief over loss as demonstrated by the expression of painful feelings along with associated affect. She was encouraged to ventilate. Ways to reduce stress were also discussed with the patient.

Diagnoses:

Adjustment disorder with depressed mood, F43.21 (ICD-10) (Active)
Generalized anxiety disorder, F41.1 (ICD-10) (Active)
Histrionic personality disorder, F60.4 (ICD-10) (Active)

Instructions / Recommendations / Plan:

The risks and benefits of outpatient therapy were explained to Mrs. Little. She was encouraged to join a grief support group held at her church.

Return 1 week, or earlier if needed.

Notes & Risk Factors:

Acute Grief: Death of husband 4/1/15

90834 Psychotherapy 45 min.

Therapy Progress Notes Examples

Julius Stieglitz



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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

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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 Borcharding, 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 Borcharding 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

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