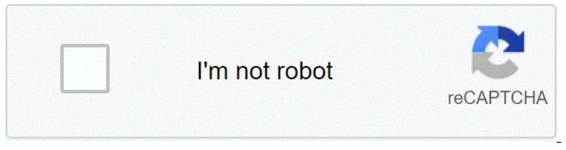


I'm not robot!

Sample of group therapy progress notes

Group therapy progress notes examples. Group progress notes examples. Group therapy notes examples. How to write group therapy progress notes.

Mental health progress notes… What are they? And why does everyone keep talking about them? Well… as a healthcare professional, remembering details about every session can take a tremendous toll on your mental load (and health), no matter how good your memory is. Writing everything down provides an important reference point for you and ensures you can build rapport with each client by remembering essential details about each session. So, progress notes are basically the best tool you'll have to be a great practitioner. Not to mention they're legally required in most countries. Still confused? Not to worry.That's why we have this article! Read to the end, and you'll be a progress note Pro 😀Client notes are at the core of any health professional's practice.They are essential documents created by the practitioner to document and maintain a client's medical records. They provide a paper trail of a client's treatment history and ensure that communication between clinicians within the healthcare sector is seamless and traceable. In addition to this progress, notes are legally required each time there is an interaction between a client and a practitioner to provide a record and ensure best practice within the practitioner community.

CLINICAL NOTE

Date: _____ Client Name: _____

SEEN: ___Individual ___Couple ___Collateral ___Family ___with Father ___with Mother Other _____
Failed Apt: ___Therapist Cancel ___Client Cancel ___No Show

MENTAL STATUS:

Orientation: ___Person ___ Place ___Time/Situation **Self-Perception:** ___WNL ___Depersonalization ___ Derealization
Insight: ___WNL ___Impaired: Minimal ___Moderate ___Severe **Judgment:** ___WNL ___Impaired: ___Minimal ___ Moderate ___Severe
Appearance: ___WNL ___Well-groomed ___Unkempt ___Dirty ___Meticulous ___Unusual

Behavior: ___WNL ___Guarded ___Withdrawn ___Provocative ___Hostile ___Impulsive ___Uncooperative ___ Suspicious ___Manipulative ___Hypoactive ___Belligerent ___Hyperactive ___Cooperative ___Pleasant ___Under-the-influence _____

Speech: ___WNL ___Delayed ___Soft ___Loud ___Slurred ___Excessive ___Pressured ___Perseveration ___Incoherent

Affect: ___WNL ___Congruent ___Incongruent ___Labile ___Expansive ___Constricted ___Blunted ___Flat
Mood: ___Euthymic ___Euphoric ___Irritable ___Fearful ___Anxious ___Dysphoric ___Angry ___Sad ___Hurt ___Shame

Insight: ___WNL ___Limited/Concrete ___Impaired ___Lacking
Judgment: ___WNL ___Critical ___Logical ___Impaired

Thought Process: ___Organized ___Disorganized ___Goal Directed ___Irrational ___Rigid ___Obsessive ___Tangential ___Circumstantial ___Preoccupied ___Loosening of Associations ___Blocked ___Flight of Ideas ___Memory Impairment (____Recent ____Remote)

Thought Content: ___Relevant **Hallucinations:** ___Not Present ___Auditory ___Visual ___ Mood Congruent ___Mood Incongruent Other:_____ ___Reality Based **Delusions:** ___Not Present ___Persecutory ___Erotomanic ___Grandiose ___Somatic ___Paranoid ___Jealous ___Reference ___Being Controlled ___Persecutory ___Thought Broadcasting ___Thought Insertion ___Mood Congruent ___Mood Incongruent Other_____

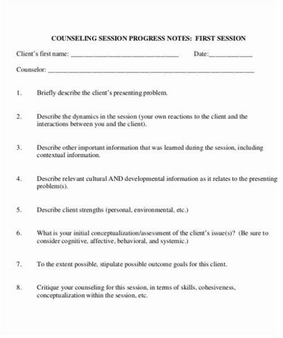
Sleep: ___WNL ___Impaired ___Difficulty Initiating ___Early Waking ___Excessive ___Fatigue

Appetite:___WNL ___Increased ___Decreased

Risk Assessment: **Suicidal Ideation:** ___No Evidence ___Denied ___No Intent ___Death Wishes ___ Plan:_____
Homicidal Ideation: ___No Evidence ___Denied ___No Intent Plan:_____
ETOH/Substance Use: ___No Evidence ___Denied ___Social ETOH Other :_____ ___Abuse ___Dependence

Clinical Treatment Note 08-10AM

Any competent and compliant clinician will keep a detailed set of progress notes for each client they see.Working as a mental health practitioner, you will encounter many different types of documentation. It is quite a common occurrence for providers to get confused between progress notes and psychotherapy notes. To help you avoid getting them conflated, here is an overview of the purpose and use of these two types of documentation. Although every practitioner will have their own preference for how to write progress notes, here are some of the most commonly used terminologies that are useful to know:Client behavior, affect, performance:CommunicativeAttentiveEngagedEnthusiasticResponding appropriately to medicationNoncompliant with medicationDisengagedApatheticAgitatedIrritableAnxious Intervention terminology:Actively listenedConfrontedParticipated Examined benefits of…Identified triggersProblem solvedProvided feedbackUtilized Worked on treatment planTaught coping skill While the general purpose of group and individual therapy notes is the same, their layout and content differs in certain ways. Essentially, all progress notes should include information regarding the patient/s current health condition and relevant details from the specific session. Where an individual note will focus on the specific client’s behaviors and responses during the session, a group note will also include information regarding the purpose of the session, the group leader’s interventions and some comments about each participant’s behaviors and responses. Here is an example of an individual progress note, written using the SOAP format: Date of session: 03/09/2022Time of session: 10:03am Patient name: Jane SmithSubjective: Jane stated that she is “feeling better”. She has been sleeping 7-8 hours per night and has been exercising 1-2 times during the week. Jane reports being compliant with her medication and has been practicing replacing negative self-talk with positive self-talk. Feelings of worthlessness have declined. Objective: Jane shows reduced anxiety and mild depressive symptoms.
Medication compliance is good. Jane has actively included stress relieving methods into her daily life. Her affect has improved since her last session and she shows increased attentiveness and engagement. Assessment: Jane is responding well to treatment. She is seeking practical ways to reduce her feelings of anxiety and applies these to her personal life. Compliance with medication is improving anxiety symptoms. Plan: Jane is to continue with her current medication dosage. Meetings will continue weekly.Here is an example of an individualized group therapy progress note:Date of session: 10/09/2022Time of session: 2:35pm Patient name: Jane Smith Group topic: The session was concerned with maintaining sobriety and drug use. Group participants were first asked to share any recent changes in their lives. They spoke about their cravings and then discussed different coping mechanisms to prevent relapsing. Interventions by group leader: Facilitated group discussion and ensured all group members had the opportunity to speak. Led conversation away from triggering topics. Encouraged honesty and openness. Assisted with setting boundaries and identifying healthy coping mechanisms. Individual participant’s behavior: Jane was subdued during the session. She spoke 1-2 times and didn’t offer information about her personal life.



COUNSELING SESSION PROGRESS NOTES: FIRST SESSION

Client's first name: _____ Date:_____

Counselor: _____

1. Briefly describe the client's presenting problem.
2. Describe the dynamics in the session (your own reactions to the client and the interactions between you and the client).
3. Describe other important information that was learned during the session, including contextual information.
4. Describe relevant cultural AND developmental information as it relates to the presenting problem(s).
5. Describe client strengths (personal, environmental, etc.)
6. What is your initial conceptualization/assessment of the client's issue(s)? (Be sure to consider cognitive, affective, behavioral, and systemic.)
7. To the extent possible, stipulate possible outcome goals for this client.
8. Critique your counseling for this session, in terms of skills, cohesiveness, conceptualization within the session, etc.

Jane admitted having cravings but denied drug use.Progress notes are a contract between the client and their clinician. They are where treatment goals and plans can be discussed and decided on before they are put into a document to track the treatment progression. Without the right formula writing progress, notes can be a lengthy process. Using a format such as SOAP means that the product is far more informative and concise. SOAP is an acronym for subjective, objective, assessment, and plan.
It helps ensure that each part of the therapy note has a purpose and that no critical details are missed from a progress note. In addition to a formula such as SOAP notes, we've provided you with some templates to outline what you can expect to see ineffective progress notes… think of these templates as 'progress note goals' kinda like the Obama's are to 'relationship goals' but maybe a little easier to achieve…For counselors, progress notes often take a journal-like form, focusing on the process between therapist and client and the counselor's own thoughts and feelings in the work.

COMPANY NAME
Address
City, State Zip
Phone: (xxx) xxx-xxxx **www.yourwebsite.com** **Fax: (xxx) xxx-xxxx**

CHILD PROGRESS NOTES

_____ ____ _____
Client Age Session #

Subjective (feelings and/or concerns of child):
_____
_____
_____

Objective (facts and issues):
A. Play Themes:_____
_____
_____

B. Verbal Themes: _____
_____
_____

C. Changes in play behavior (first time happenings or discontinued behavior):
_____
_____
_____

D. Limits set: _____
_____
_____

Assessment (general impression and clinical understanding of the session):
_____
_____
_____

Description of plan of care:
_____
_____

Professional intervention services: ___ Social Worker ___ Nutritionist ___ Nurse ___ School Counselor ___ Other specialist ___ None needed If services needed please describe:

Transportation needed so parent can seek services: ___ yes ___ no If yes please describe purpose, type needed, and arrangements:

Referral to community services: ___ mental health ___ substance abuse ___ domestic violence shelter ___ ECI ___ parenting classes ___ medical ___ educational assistance ___ child care ___ homeless services ___ food/clothing ____ childbirth classes ___no services needed

Describe services needed:

Describe coordination with medical care providers:

Describe coordination with mental health professionals:

_____ _____
Therapist **Date**

Many counselors often choose to use a SOAP (subjective, objective, assessment, plan) format as it allows for a consistent structure. Counseling progress note exampleSubjective: Tom stated that he has been feeling tired. He “isn’t sleeping well, around 3-4 hours a night”. Tom is having difficulty completing everyday tasks and isn’t socializing frequently. He states he feels “isolated and alone”. Objective: Tom presented with a slow speech and flat affect during the session. Relationships with family and friends are reduced. Tom’s sleeping patterns are irregular. Normal food intake. Weight remains unchanged. Assessment: Tom presented with mild depressive symptomatology. Tom was calm and adequately responsive. There are signs of mild anxiety. Plan: Tom has another session next week at 1pm on 12/05/2022. He has a goal to reach out to a close friend and open up about how he has been feeling.Click here to see more examples. This link includes:Detailed progress note examples for counselorsInsight into what information to include in a progress noteWhat the SOAP format looks like in relation to a counseling patient If you are looking for a downloadable SOAP template, you’ve come to the right place:Carepatron’s downloadable SOAP template for counseling progress notesPsychotherapy progress notes are notes taken by mental health professionals for the purpose of documenting or analyzing the content of a conversation during a therapy session. Psychotherapy progress note exampleSubjective: Angela says her cravings for heroin have reduced to “1-2 times a day”. Angela denies use and says she has been regularly attending AA meetings. Her eating habits have improved and she is eating up to 4 meals a day. Angela expressed gratitude for improved relationships with her friends. Objective: Angela presented as calm and attentive. She was dressed neatly and appeared well groomed. She exhibited speech that was normal in rate, volume and articulation. Mood appeared normal. Assessment: Angela is effectively managing her sobriety. Angela shows improvement in her ability to withstand cravings. Plan: Angela will continue weekly sessions. Next appointment is at 11am on 11/09/2022. Short term goals include exercising 1-2 times a week and increasing her part-time work hours.Click here to see other examples. These SOAP notes can be used for:Creating a reusable template Understanding the type of information to be used in a progress notePsychotherapists who are looking to improve their progress notesLooking for a psychotherapy SOAP note template? You’ve come to the right place:Carepatron’s downloadable SOAP template for psychotherapy progress notesMedical progress notes are the part of a medical record where practitioners record details to document a patient's clinical status or progression during the course of hospitalization or over the course of outpatient care. They're a bit different.Medical progress note exampleSubjective: Sarah stated that she has had bouts of “serious chest pain” over the past 2 weeks. Sarah explained it feels like “sharp stabbing” and she experiences “breathlessness”. Sarah had never experienced a similar pain. Objective: Sarah has had tests and labs done with no significant results. Referred to the clinic by the hospital. Assessment: Sarah is experiencing panic attacks. Attributed feelings of intense anxiety to the recent separation from her husband. Plan: Sarah to begin weekly sessions. Sarah was taught breathwork exercises to prevent panic attacks. When intense feelings of anxiety arise, Sarah will use 5,4,3,2,1 technique.Click here to see further examples. This progress note examples includes:Information about a patient at a hypertension follow-up sessionHow to create effective medical progress notes according to the SOAP formatTo help streamline your clinical documentation process, we’ve created a reusable SOAP template:Carepatron’s downloadable SOAP template for medical progress notesPatient progress notes are the component of the patient's record in which you record notes about the interaction you had with them, their reason for visiting, examinations performed on them, medications prescribed on the day, and other relevant details. Patient progress note exampleSubjective: Amy says she is feeling “more relaxed” at work. Amy has scheduled a meeting with her employer to discuss moving departments. Amy reports using calming strategies at work when she starts feeling anxious. Objective: Amy presented as calm and attentive. Amy’s speech was normal. Amy’s mood was normal. Assessment: Amy is responding well to the treatment plan. Her feelings of anxiety at work have decreased. Amy shows improved assertiveness in her professional life. Plan: Amy to have a follow-up session at 10am on 3/09/2022. If symptoms have continued to improve, this will be the final session. Click here to see further examples. This example can be used for:Practitioners who are documenting their patient’s progressIncludes 15 different SOAP note examplesProviders looking to improve their documentation skillsSometimes the best way to guarantee consistency across documentation is to use a template.
Luckily, we’ve got the perfect one for you:Carepatron’s downloadable SOAP template for patient progress notesNursing progress notes are the records kept by nurses during their interactions with each client. These notes help health professionals keep track of the medications and care a patient receives and allow for the patient's medical records to be as up-to-date as possible.Nursing progress note example using the F-DAR method:Focus: Nausea related to anesthesia Data: Patient complained of intense nausea.
Vomited 150 ml of clear fluid at 10:00am.Action: At 10:10am, patient given Compazine 1 mg IV. Response: Patient reported reduced nausea at 10:45am. Patient has stopped vomiting.Click here to see an example. This link includes:Information for nurses who want to use the SOAP note methodA detailed example of a nursing progress note to provide insight for how effective documentation is structured With the right template, streamlining nursing progress notes may be easier than you think:Carepatron’s downloadable SOAP template for nursing progress notesPhysicians record their notes concerning the progress or lack of progress made by the patient between the time of the previous note and the most recent note. In addition to this, doctor's progress notes also describe the patient's condition and the treatment given or planned.Doctor progress note example:Subjective: Sally reports feelings of “extreme anxiety”. Referred to this clinic due to “intense chest pains”. Sally says even the smallest mishap makes her “extremely angry”. Objective: Sally’s speech and thought content was coherent. Sally articulated her emotional states well.

Group Therapy Progress Note

She exhibited anxiety symptoms when asked about her husband and children. Sally applied 5-4-3-2-1 when anxiety symptoms showed. Assessment: Sally is experiencing significant anxiety. She is able to recognize these emotions and use grounding techniques and 5-4-3-2-1 to alleviate the symptoms. Her chest pain is caused by anxiety. Plan: Sally to continue her weekly sessions. The next session is at 09:00am on 05/06/2022. Click here to see another example. This doctor’s progress note example includes:The information that needs to be included when documenting a doctor’s session with a client How to format a doctor progress note, according to the SOAP formatTo help ensure your documentation is consistent, accurate and effective, here is a reusable SOAP note template:Carepatron’s downloadable SOAP template for doctor progress notesGroup therapy notes have two components. The first part of a group therapy note is the group summary. This includes basic information on the group, such as; the group name, main topic(s) covered during the session, interventions implemented, and the schedule. In the second, individualized section, it is important to document how the client engaged within the group. Include information like their level of active engagement, contributions, and reactions.Click here to see an example.Here are some top tips to make sure your notes are up to scratch:Be specific and concise in your progress notes No one has time to write or read novels in the healthcare sector. Progress notes should be able to be easily read by other healthcare providers. You should only include relevant information and use concise language. Sentences that are overly wordy or lengthy are distracting and reduce the effectiveness of documentation. Prioritize your notesLetting progress notes build-up will only make the problem worse.
We understand that staying on top of documentation can be difficult, especially if you see a lot of patients. Nevertheless, if you get into the habit of writing them after every session, the information you include will be much more accurate. Use a template such as SOAP to help you Although everyone likes to have some degree of control over their

work, you shouldn’t underestimate the usefulness of templates.

SAMPLE
COUNSELING/THERAPY PROGRESS NOTE

Date:_____ Start Time:_____ End Time:_____

Youth’s Name:_____DJJ#:_____DOB:_____

Facility/Program _____

☐ Individual therapy/counseling session

☐ Group therapy/counseling session

☐ Family therapy/counseling session

Focus of the counseling/therapy session:

_____

_____

_____

Youth’s participation in the session:

_____

_____

_____

_____

_____

Youth’s treatment plan goals/objectives addressed in the session:

_____

_____

_____

_____

_____

There are an abundance of resources available that will help you create better documentation, so use this to your advantage! Templates will also ensure that your notes are consistent, making them much easier to read for other providers. Capture and store your progress notes on a secure practice management platformIn addition to using templates like SOAP or DAP, it is a great idea to create and store your documentation on a practice management platform. This will guarantee consistency and accessibility across your practice, leading to better coordination of care and improved clinical outcomes. Practice management systems, like Carepatron, are HIPAA-compliant, meaning the privacy of your patients is protected at all times. Voice transcriptionYes, voice transcription is a thing. Click here to find out how you can use it! This type of software will enable you to save significant amounts of time without compromising on the accuracy of your notes. What’s not to love?Some common mistakes to avoid:Repeating yourselfIn the assessment section, do not rewrite what you stated in the subjective or objective sections. Some practitioners find it difficult to differentiate between the sections of a progress note, but it’s important that you don’t repeat yourself.

Every sentence that you write should be conveying new information, and you should keep this brief and concise. Writing too many notes in the sessionAlthough it can be tempting to write down notes during your session, it is essential that you give your client all of your attention. You want to ensure that your patient feels like their needs are being listened to and it’s your responsibility to deliver this level of professionalism. Feel free to capture some brief notes as you go, but the majority of your documentation should be completed after your session.Judgmental statementsEnsure you use professional language in your notes. All of the information that you write pertaining to the client’s behavior or attitude needs to be supported by evidence.

Remember that progress notes can be used in insurance and legal situations and they are frequently shared between providers - so including any type of biased judgment is an absolute no-go.Avoid acronyms and abbreviationsConsidering the likelihood of your progress notes being shared amongst other providers, insurance teams and even legal staff, it's best to minimize acronyms and abbreviations to prevent misinterpretation. Group therapy is a form of therapy that involves a number of patients (somewhere between 5-15) being treated by a therapist at the same time. These group therapy sessions could be open, meaning new participant are able to join, or closed, where only a core group of clients attend. Group therapy is used for a range of different reasons and can be effective in treating generalized anxiety disorder, eating disorders, post-traumatic stress disorder, and substance abuse disorders. It can also help people learn how to cope with divorce, chronic pain, anger management, grief, and domestic violence.

Just like with any other type of therapy, group therapy requires the therapist to write clinical documentation, including case notes. These case notes provide information regarding what was covered in a particular session and how involved the participants were. Keeping accurate and effective case notes helps therapists plan future group therapy sessions and ensures they are informed about how their patients are progressing. To help therapists write these case notes in a more efficient manner, we have designed a PDF case note template that can be downloaded and either edited online or printed out into physical copies. This group note template will help ensure you are writing the best possible case notes, allowing you to devise informed treatment plans and achieve good clinical outcomes.Download TemplateDownload Example PDFWe understand that therapists don’t have an abundance of time to spend learning how to navigate new tools which is why we’ve made sure that using our group case notes is very easy. To implement this resource into your practice, simply follow these steps. We’ve also created a group note example using our template so you can see what it looks like in action.Step One: Access the PDFNaturally, the first thing you need to do is access the PDF template. We’ve included a link to the document a little further down on this page and by clicking on this you should be taken to a PDF reader. From here, you can either edit the document directly or print it out if you would prefer to write using a physical copy.Step Two: Complete the case notesAfter you have had a group therapy session, it’s time to complete the case notes. We recommend completing one case note per participant so you can effectively keep track of each patient’s progress. It is up to you when you complete your case notes, but we recommend writing them immediately after the group therapy session so the information is still fresh in your mind. Step Three: Store the note securelyWhen the case notes have been finished, it’s time to store them securely. Case notes contain confidential information regarding patient identity, meaning you are legally required to store them with safeguards in place. There are a couple of options in this regard: you can either store notes online using an EHR platform, or you can store the physical copies using a filing cabinet.To help you visualize what our template looks like in action, we’ve created an example case note. The actual case notes will evidently differ depending on what type of therapy you specialize in and the type of patients that you treat, but this example should give you an insight into how they can be used. Download this Group Therapy Case Notes Example (Sample) here:As I’m sure you are aware, there is a range of different specializations that incorporate group therapy into their treatment. We’ve tried to ensure that our group therapy case notes template is applicable to as many of these different fields as possible, including the following:Cognitive behavioral groupsInterpersonal groupsEducational groupsSupport groupsAdditionally, this template can be used for groups whose members regularly attend therapy sessions as well as those who attend sporadically. The dynamic treatment methods used during group therapy sessions differ slightly from individual therapy practice, and we’ve designed this case notes template to reflect these differences. As such, any therapist who is involved with treating patients in a group setting will be able to utilize the template.This case notes template has a range of day-to-day uses for therapists. Some of these include:Increased organization: Implementing this template into your therapy practice will improve the organization of your documentation. Staying on top of writing notes and keeping them stored in an organized way can be time-consuming, particularly when you have a very busy schedule. With this template, you can streamline organization by leaving formatting up to us. Accuracy: Our template includes all of the aspects of a group therapy session that need to be recorded. By having different sections for each of these components, you can feel confident that you have detailed everything necessary to gain a comprehensive insight into how each of your patients are progressing. Saves time: This template has also been designed to save you time. You no longer have to structure or format your case notes, and can instead simply access the document and make the relevant changes. With the time that you save, you can instead focus on caring for your patients.As I’m sure you are aware, writing clinical documentation is a legal requirement and an integral aspect of working as a therapist. In addition to being a necessity, writing accurate case notes will also contribute to a range of different benefits:Track patient progressCase notes are primarily used by therapists to track the progress of their patients. They can access these notes and determine how their patient has improved, and also potentially identify areas that require more therapeutic work.

By writing accurate and detailed notes, you can more easily assess how each of your patients are progressing. Develop an accurate treatment planIn addition to allowing therapists to track the progress of their patients, case notes are also integral to informing an accurate treatment plan. The information that you record in these notes will allow you to develop each section of your treatment plan and devise interventions to utilize in your group therapy sessions.Insurance purposesIf any of your patients are having these sessions covered by their insurance provider, the insurance company may request to see clinical documents, including case notes. To help make this process as smooth as possible and ensure you get reimbursed quickly, it’s a good idea to stay on top of writing your case notes. Using our template will also assist this by ensuring consistency and standardization across your documents. CommunicationA patient who is attending your group therapy sessions may be being treated by various other care providers. In order to guarantee an optimized coordination of care and ensure that all of the patient’s needs are being met, these primary care providers need to establish good communication – which can be facilitated by writing effective case notes. Meaningful patient relationships One of the most important aspects of working as a therapist is establishing meaningful and positive relationships with clients. This helps encourage honesty and transparency while also ensuring clients feel safe in your care. Writing accurate notes leads to better treatment plans and greater transparency, which are pivotal components of developing meaningful relationships.How do you write a SOAP note for group therapy?How long should a group therapy case note be?When should I write my case notes?Writing clinical documentation is a demanding aspect of working as a therapist. While documentation is extremely essential, it can be helpful to utilize tools that simplify the workload. Carepatron is an all-in-one practice management software that has been designed to streamline clinical and administrative processes. If you choose to invest in Carepatron, you will have access to a robust set of case note templates, as well as a sophisticated voice-to-text transcription software. The platform also has in-built storage capabilities that allow you to store your documents in an accessible and HIPAA-compliant manner.

We understand how important privacy and safety are, which is why there is a range of physical and electronic safeguards in place that protect patient data at all times.

Further, if you ever run into any obstacles, you just have to reach out to Carepatron’s round-the-clock support team who will help you resolve the issue immediately. If you are looking for software that has more to offer than documentation tools, then don’t worry, Carepatron can manage that as well. With additional features targeting medical billing, scheduling, patient engagement, and mobile health, this system truly has something for everyone.How do you write a SOAP note for group therapy?How do you write a SOAP note for group therapy?