Thin Notes

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ACA Code: B.6. Records and Documentation

B.6.a. Creating and Maintaining Records and Documentation

Counselors create and maintain records and documentation necessary for rendering professional services.

B.6.b. Confidentiality of Records and Documentation

Counselors ensure that records and documentation kept in any medium are secure and that only authorized persons have access to them.

(ACA, 2014)

Electronic Health Records (EHR)

- Most used today over handwritten
- Must be HIPPA compliant
- Popular/most reliable platforms: Simple Practice and Therapy Notes
- Offer drop down menus to expedite the process
- Help keep notes consistent
- Telehealth platforms (HIPPA compliant)

(SimplePractice, 2023)

Progress Notes: What MUST be included?

- **Demographic information**
  - Client's name and date of birth
  - Date of the session, start and end time of the session
  - Clinician's name, and a handwritten or electronic signature
  - For telehealth sessions, the location of the session
- **Description of client's behavior**
  - Presentation (mood, affect, appearance, and behavior) and Symptoms
  - A diagnosis
  - Safety assessment/plan
  - Any changes to medication
- **Treatment Plan**
  - Treatment modalities used & recommended
  - Interventions used (questions asked/explored, coping skills taught, handouts provided, resources recommended)
  - Client's response to interventions (i.e. the client was open to….)
  - The client's progress toward goals
  - The plan for the client between sessions and in the next session

(SimplePractice, 2023)

Types of Progress Notes

- SOAP
- DAP
- BIRP
- HYBRIDS

SOAP Note Template

SOAP NOTE

JANE DOE, MA
Your Title
100 Main Street
Anywhere, OK 1000
123-456-7890

CLIENT: _____ DATE OF SERVICE: _____ TIME: _____

Appearance
- ☐ WNL
- ☐ Unkempt
- ☐ Dirty
- ☐ Meticulous

Speech
- ☐ WNL
- ☐ Pressured
- ☐ Poverty of
- ☐ Impaired
- ☐ Slow

Mood/Affect
- ☐ WNL
- ☐ Flat
- ☐ Depressed
- ☐ Manic
- ☐ Anxious
- ☐ Fearful
- ☐ Irritable
- ☐ Angry
- ☐ Labile
- ☐ Incongruent

Behavior
- ☐ WNL
- ☐ Guarded
- ☐ Withdrawn
- ☐ Defensive
- ☐ Oppositional
- ☐ Hostile
- ☐ Manipulative
- ☐ Impaired
- ☐ Threatening
- ☐ Impulsive
- ☐ Tearful
- ☐ Tired

Cognitions
- ☐ WNL
- ☐ Loose Assoc.
- ☐ Scattered
- ☐ Blocked
- ☐ Obsessive
- ☐ Paranoid
- ☐ Psychotic

SERVICES RENDERED

Initial Evaluation (90791)
Psychotherapy: 90832/30" 90834 /45" 90837/60"
Family Psychotherapy w/patient (90847)
Family Psychotherapy w/o patient (90846)
Multi-Family Psychotherapy (90849)
Group Psychotherapy (90853)
Crisis Psychotherapy 90839/60" +90840 each addl 30"
Other Other Other

PROGRESS
- ☐ Exceptional
- ☐ Steady
- ☐ Slow
- ☐ Regressing
- ☐ Stable
- ☐ Maintaining
- ☐ Discharge Plan.

CURRENT MEDS
Med:
Dose:
Med:
Dose:
Med:
Dose:

Treatment Goal Addressed: _____

Subjective Data/Clinical Impressions: _____

Objective Data/Behavioral Observations: _____

Assessment: _____

Plan: _____

Danger to Self or Others? : _____

If yes, describe danger and intervention: _____

Rescheduled for: Day:_____ Date:_____ Time:_____ Client will call or email to reschedule

Fee Charged :_____Payment:_____ Check Cash Credit Card Bill Insurance

Therapist Signature: _____ Degree: ____ Title: _____ Date: _____

(TemplateLab, 2021)

SOAP Note Example

Subjective: *Client reported ongoing worry and anticipatory anxiety. They stated "It is hard for me to get excited to go anywhere because I'm always expecting the worst." They also noted extreme restlessness, muscle tension and an average of 3-4 hours of sleep per night.*

Objective: *Client's speech was rapid and rambling. Their thought processes were tangential. They frequently avoided discussing their anxiety by diverting to unrelated topics of discussion. They were fidgety throughout the session. Their mood was anxious with congruent affect. They denied any SI/HI or psychosis. They were oriented x 4. Writer conducted the GAD-7 assessment with the client and reviewed the severe score result of 18 with them.*

Assessment: *Client continues to experience severe symptoms congruent with their Generalized Anxiety Disorder diagnosis. Their frequent rumination, hypervigilance, physical distress and worry is disruptive to their self care, social life and occupation. Writer will continue to assess for the possibility of Social Anxiety Disorder given client's previous mention of anxiety related relational difficulties.*

Plan: *Client has made minor attempts to implement some of the coping skills discussed with Writer but continues to present with an overall avoidance of deeper intervention for their anxiety. Client has not conducted previously agreed upon homework activities. Writer will continue to build rapport and trust with the client. Writer will provide basic anxiety psychoeducation and teach mindfulness-based relaxation techniques. Writer will introduce the model of CBT to help prepare the client for deeper work on their anxious cognitions, behaviors and emotions.*

(SimplePractice, 2023b)

DAP Note Template

DAP Progress Note Template

Client/ID: **Counselor Initials:**

Session Date:	
Start and Finish Time:	
Data • Focus of session • Descriptions and observations about the client's current state • Interventions used during the session and topics discussed • Client's response to interventions	
Assessment • Client's progress • How the client has responded to treatment • Changes to client's diagnosis (if applicable) • Achievement of treatment goals • Behavior, affect, appearance of client	
Plan • Date, time and location of next session • Goals or homework for client • Referrals • Any changes to current treatment plan	

(Ellison, 2022)

DAP Note Example

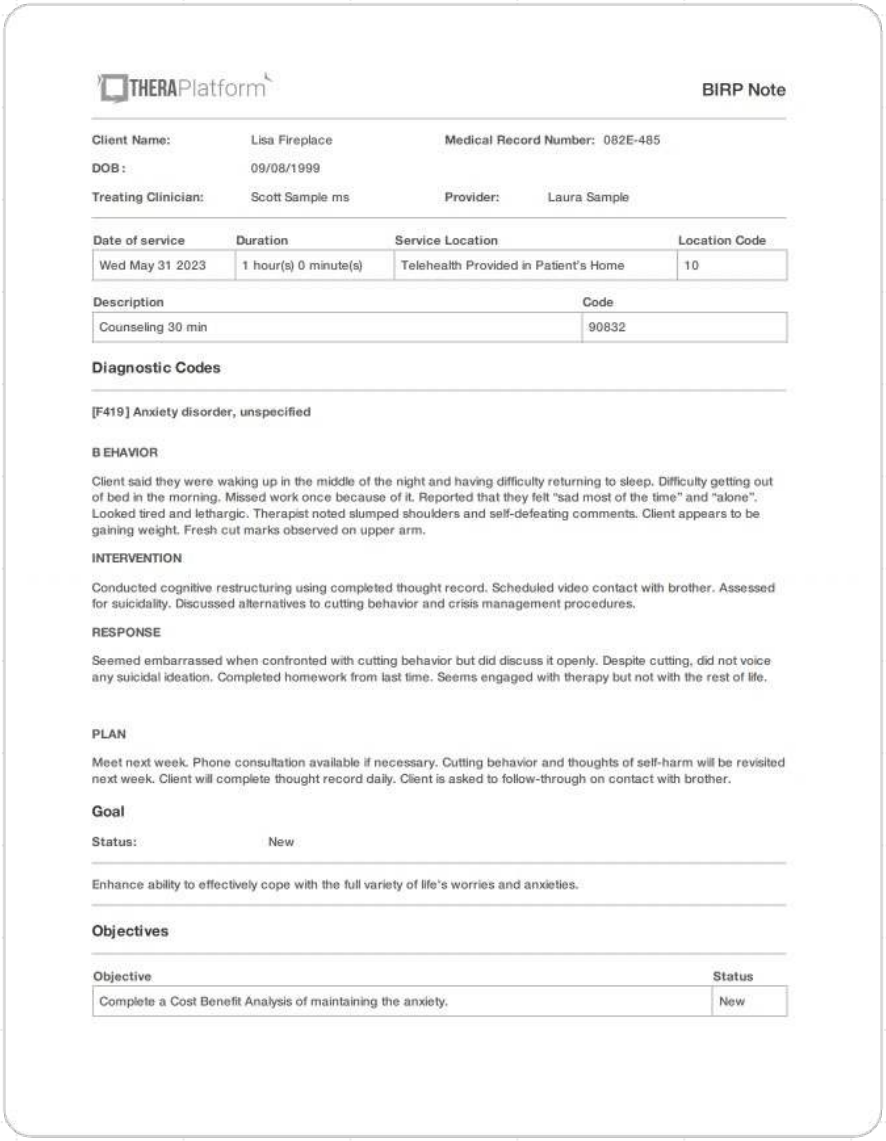
Data: Client expressed deep feelings of grief about the death of her mother. She finds it difficult to “do everyday things like cook and eat”. She is scheduled to return to work next week and she feels “anxious” but is also “excited for normalcy”. Client says she has a good support system and speaks openly to her partner about her grief.

Assessment: Client shows slight improvement. She was attentive during the session and able to discuss her emotions. She is continuing to work on grief coping mechanisms. No suicide risk.

Plan: Client scheduled for a session next week on 4/10/2022. Will reassess suitability of returning to work and discuss reducing her hours.

(Ellison, 2022)

BIRP Note Template



THERAPlatform

BIRP Note

Client Name: Lisa Fireplace **Medical Record Number:** 082E-485

DOB: 09/08/1999

Treating Clinician: Scott Sample ms **Provider:** Laura Sample

Date of service	Duration	Service Location	Location Code
Wed May 31 2023	1 hour(s) 0 minute(s)	Telehealth Provided in Patient's Home	10

Description	Code
Counseling 30 min	90832

Diagnostic Codes

[F419] Anxiety disorder, unspecified

B EHAVIOR

Client said they were waking up in the middle of the night and having difficulty returning to sleep. Difficulty getting out of bed in the morning. Missed work once because of it. Reported that they felt "sad most of the time" and "alone". Looked tired and lethargic. Therapist noted slumped shoulders and self-defeating comments. Client appears to be gaining weight. Fresh cut marks observed on upper arm.

INTERVENTION

Conducted cognitive restructuring using completed thought record. Scheduled video contact with brother. Assessed for suicidality. Discussed alternatives to cutting behavior and crisis management procedures.

RESPONSE

Seemed embarrassed when confronted with cutting behavior but did discuss it openly. Despite cutting, did not voice any suicidal ideation. Completed homework from last time. Seems engaged with therapy but not with the rest of life.

PLAN

Meet next week. Phone consultation available if necessary. Cutting behavior and thoughts of self-harm will be revisited next week. Client will complete thought record daily. Client is asked to follow-through on contact with brother.

Goal

Status: New

Enhance ability to effectively cope with the full variety of life's worries and anxieties.

Objectives

Objective	Status
Complete a Cost Benefit Analysis of maintaining the anxiety.	New

(TheraPlatform, 2023)

BIRP Note Example

Behavior: Client reported sleeping only 3-4 hours a night due to worries. Avoiding social interactions because of fear of judgments. Client said, “I would rather stay home than be scorned by other people”. Looked agitated, tired, shaking leg. Appears to be ruminating about lack of friends but afraid to do anything about it.

Intervention: Taught relaxation techniques, including deep abdominal breathing. Went over the concept of “worry time” with client to aid in sleep. Discussed scheduling a prosocial activity for this week. Asked client “what is the worst that can happen?” if they go outside their comfort zone.

Response: Expressed desire to try something new but noted some reluctance. Does not seem motivated to follow through. Didn’t complete homework from last time.

Plan: Meet next week. Client will practice relaxation daily. Will practice “worry time”every night before bedtime. Client will perform scheduled social activity. Next week client will be taught progressive muscle relaxation and review anxious thinking regarding social situations.

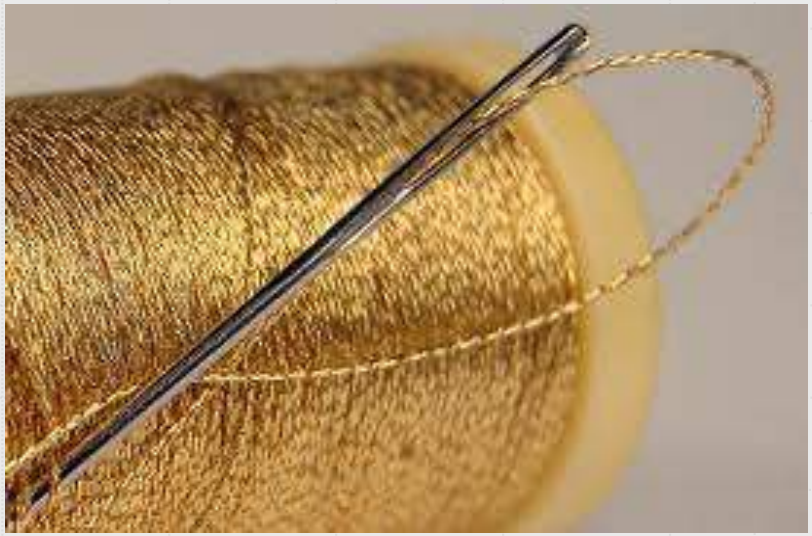
(TheraPlatform, 2023)

The Golden Rule

If it is not documented,
it did not happen.

The Golden Thread

The common thread that runs through your documentation. It is the tie that binds together your clinical observation, assessment, intervention, and plan.



Process > Content

Process focuses on the client's symptoms/problem, the counselor's assessment/interventions, the client's response to interventions, and the plan. Client's are better served/protected when progress notes focus on the process.

Content gets bogged down in the details, may overly use quotes, easy to loose focus of process when lost in content. Content should be vague when possible for progress notes.

(TheraPlatform, 2023)

What makes a thin note?

- LESS!
- Thin, lean, or minimal notation includes information about the process of what occurred without dipping into the details (unless you believe some details are necessary to support your diagnosis/treatment).
- You want enough detail to withstand third-party scrutiny but no more.
  - Support your diagnosis and treatment using process language as much as possible
- Avoid quotes!
- Use bullet points whenever possible

Examples

Client and Session Content	Clinical Note Documentation
Client shares they drank heavily after three months of sobriety. You help them explore what happened in that moment.	Client reports relapse after three months due to recent stressors. Engaged client in identifying triggers and safety planning to support ongoing sobriety.
Client refuses to participate in therapy, stating it's a waste of time. You try to better understand where they are coming from.	Client reports resistance to ongoing therapy. Engaged client in identifying needs for therapy and revised treatment goals to support attendance and progress towards goals.
Client appears depressed in session with observable behaviors of slouching, limited facial expression, and monotone speech. You want to capture how they present in the room.	Client was observed to be depressed in session, as evidenced by slouched speech, flat affect, and restricted animation and speech.
Client and mom are fighting in the session, yelling at one another and reacting defensively. You facilitate processing to regulate their emotions and support connection.	Client and MOC were observed to engage in conflict in response to miscommunication. Engaged client and MOC in healthy communication skills including reflection and active listening to support emotion regulation and to strengthen relationship.
Client discloses they were bothered by something you'd said last session. You ask them to share more to better understand.	Client demonstrated self-advocacy in session by requesting to revisit a former topic of discussion. Highlighted client strengths in communicating needs and explored structure to encourage supportive processing in future sessions.
Client reports struggling with a new relationship due to trauma flashbacks and feeling unsafe. You engage the client in exploring needs for safety and provide psychoeducation of trauma.	Client processed implications of trauma on current relationships including safety needs. Engaged client in exploring characteristics of healthy relationships including psychoeducation on self-sabotage, attachment, and fight/flight/freeze reactions in response to trauma.

(TheraPlatform, 2023)

(Powers, 2023)

Process/Psychotherapy notes

- Better handwritten – no digital footprint
- Leave out any identifying info
- Code client names, date record
- Keep these very slim (i.e. words to jog memory, short sentences designed to prompt memory)
- These can help jog your memory for completing progress notes after sessions

References

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