Individual Counseling/Psychotherapy Progress Note

This form to be used by OMH Mental Health Clinics, CDT, OASAS outpatient, OASAS Adolescent, Methadone programs, ACT Teams, PROS
Use this note to document individual, family or couples psychotherapy sessions. (PROS progress notes are required monthly or more frequently where clinically appropriate including, but not limited to, crisis or relapse situations and significant changes in individual's status).

Data Field	Identifying Information Instruction
Organization Name	Enter organization name.
Program Name	Enter your program name.
Individual's Name	Record the first name, middle initial, and last name of the Individual served. Order of name is at agency discretion.
Record #	Record your agency's established record number for the Individual served.
DOB	Record the Individual's date of birth. **Example : mm/dd/yyyy**
Modality	Check appropriate box to indicate the type of session: individual, family, couple, or phone.
Individuals Present	Check the box that applies for the contact type. List location if offsite. Check appropriate box: "Individual Present"- If Individual served is present "Others Present" – If others are present. Identify name(s) and relationship (s) to the Individual served. "No Show" – If Individual served did not show. Follow-up as indicated by agency policy/ procedures "Individual Canceled" – If Individual served canceled. "Provider Canceled" – If provider canceled. Document explanation(s) as relevant. Manual and Agency Policy should indicate need to address missed appointments (No Show and Cancellation) in subsequent progress notes.
Individual's Report of Progress Toward Goals/Objectives Since Last Session	Document Individual's self-report of progress toward goals/ objectives since last session including other sources of information, such as family, case manager, etc.
Individual's Condition: **Mental Status**	This is a Mini-Mental Status Exam. Check appropriate box to indicate Individual's condition as "No Change" or "Notable". If "Notable" is checked, describe the changes. **Note**: Notable is defined as behavior or symptoms different from the individual's baseline status. These changes may be signs the individual is experiencing increased problems or distress or may indicate an improvement in functioning/symptoms/behavior. **Example: Thought process/orientation is marked *Notable* and the comments are: "John is distracted and responding to voices he is hearing today." However, if John's baseline is that he always hears some voices and responds, a *Notable* comment would not be needed unless the intensity or impact of the voices on John is significantly different than his baseline.**

Risk Assessment/ Danger To	Check appropriate box(s) to indicate area(s) and type(s) of risk or check *None*. Describe types of risk behavior such as cutting, mutilation, unsafe sex, etc. under Additional Comments. If any box except *None* is marked, be sure to document in the *Response to Interventions* section how this was addressed and resolved.
Data Field	**New Issues/Stressors/Extraordinary Events Instructions**
New Issues/ Stressors/ Extraordinary Events Presented Today	There are three options available for staff using this section of the progress note (new issues refers to all **new** issues/stressors/extraordinary events). 1. If individual reports a new issue that was resolved during the contact, check the "New Issue Resolved, No Update Required" box. Briefly document the new issue in this section and then identify the interventions used in the Interventions/Methods section and indicate the resolution in the Response section of the progress note. If services are provided during the contact that have not been previously ordered in the Individualized Action Plan, then an explanation of the rationale for those services should be provided. **Example of a New Issue not needing a CA/IAP update: During the counseling session John became angry and loud, counselor was able to have John explore his anger and John admitted to needing to use his calming techniques. Within 5 minutes, John was able to calm himself down and resume discussions with the counselor. NO CA/IAP update needed.** 2. If individual presents any new issue(s) that represent a need that is not already being addressed in the IAP, check box indicating "New Issue/ CA/IAP Update Required" and record notation that new issue has been recorded on a Comprehensive Assessment Update of the same date and write detailed narrative on the appropriate CA Update as instructed in this manual. Also, the newly assessed issue(s) may require a new goal, objective, intervention or service that will require use of the IAP Review/Revision form. **Example of New Issue needing CA/IAP Update:** **Joan reported new symptoms of nightmares, intrusive memories, and feeling unsafe, triggered by an event that reminded her of an incident when she was a victim of abuse at age 12. This has not been previously reported. Both parties agreed that a CA and IAP update was needed, and was recorded on the CA and IAP Updates on this date.** **3.** If no new issues presented mark "None Reported" and proceed to planned intervention/goals. .

Data Field	Goal(s) Addressed as Per Individualized Action Plan
Goal(s) Addressed as Per Individualized Action Plan	Identify the specific goal(s) and objective(s) in the Individualized Action Plan being addressed during this intervention. All interventions must be documented in a progress note and must be targeted toward specific goal(s)/objective(s) in the Individualized Action Plan except as noted above under new issues.
Data Field	**Interventions, Progress, and Response to Interventions Instructions**
Intervention(s) / Methods Provided	Describe the specific therapeutic interventions used in the psychotherapy session to assist the Individual in realizing the goals and objectives addressed as the focus of this particular session. **Individual Example: Helped Larry to develop a list of those situations at work which most often result in him becoming angry and acting out. Demonstrated and role-played de-escalation technique of leaving area and self-calming, using relaxation techniques.** **Family Example: Family members were asked to take turns saying something positive about each other and then to express how difficult that is. Then they were asked to talk about what impact doing that has upon the individual's depressed mood.** **Couples Example: Provider asked the Larry and his partner to listen to each other for five minutes and then to tell the other individual what they heard.**

Response to Intervention/ Progress Toward Goals and Objectives	This section should address **BOTH**: • *The Individual's response to the intervention* - Include evidence the Individual participated in the session and how, and information about how the Individual, family, and /or collaterals were able to benefit from the intervention e.g. through active participation, better understanding of issues, understanding or demonstration of new skills. • *Progress toward goals and objectives* - Include an assessment of how the session has moved the Individual closer, further away, or had no discernable impact on meeting the Individual's identified goal(s) and objective(s). **Individual Example: John actively participated by listing triggers. Agreed to practice de-escalation and calming techniques during the next two weeks, particularly on the job. He is very anxious about this. John agrees identifying those situations in which his anger is a problem is a big step forward for him. Agrees he must continue to work on this or possibly lose his job.** **Family Example: Amy was able to tell her parents that their criticisms of her schoolwork made her feel bad and she needed more positive feedback and support from them. Her parents could not recognize that their comments were critical and insisted she was misunderstanding them. Although Amy did not receive the support she requested, she showed good progress as she was able to continue discussing the issue with her parents without escalating.** **Couples Example: As Allen described a recent argument with his partner, he was able to recognize how their communication style exacerbates his anxiety. Allen reported becoming increasingly anxious in the session each time his partner interrupted him. Once identified, Allen was better able to assert himself while his partner was able to decrease the number of interruptions.**
Plan / Additional Information	The clinician should document future steps or actions planned with the Individual such as homework, plans for the next session, etc. *Plan to overcome lack of progress* - If no progress is made over time, this section should also include how the counselor intends to change his/her strategy to help the Individual work toward improvement. Document additional pertinent information that is not appropriate to document elsewhere. **Example: John will keep a mood journal to identify triggers to explosive episodes and bring to next session to review and discuss alternative responses.**

Data Field	Signature Instructions
Print Staff Name/ Credentials/Title	Print staff name, credentials (degree/license), and title.
Staff Signature	Legible signature
Date	Record the date of signature, including the month, day, and year. **Example : mm/dd/yyyy**
Supervisor Name/Credentials/Title (if needed)	Print the supervisor's name, credential (degree/license), and title of supervisor, if needed.
Supervisor Signature	Legible signature
Date	Record the date of signature, including the month, day and year. **Example : mm/dd/yyyy**
Individual's Signature (optional)	Legible signature. This is encouraged, especially if the note was written collaboratively.
Guardian's Signature (optional)	Signature. This is encouraged, especially if the note was written collaboratively.
Data Field	**Medicare "Incident To" Instructions**
Medicare "Incident to" Services Only (if applicable)	Check the box when service is to be billed using the "incident to" billing rules.
Name and Credentials of Medicare Authorized Supervising Professional on Site:	Enter the name of the appropriate supervising professional who provided the on-site supervision of the "incident to" service. **Note:** The presence of an appropriate licensed supervising professional is one of the key requirements for an "*incident to"* service. In some cases, the service is billed under the number of the supervising professional. In others, the attending professional's number should be used.