#### BEHAVIORAL HEALTH OUTPATIENT CLINIC 2121 Main Street Anywhere, USA

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

#### 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:

expressed.

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**

Barbara A. Schell, Glen Gillen, Marjorie Scaffa, Ellen S. Cohn

#### **Therapy Progress Notes Examples:**

The Clinical Documentation Sourcebook Donald E. Wiger, 2010-02-02 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 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 from family business conflicts and inheritance disputes to alcoholabuse physical verbal psychological abuse and religious spiritualconflicts Features over 1 000 prewritten progress notes summarizing patient presentation themes of session and treatmentdelivered Provides an array of treatment approaches that correspond with the 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 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

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#### **Table of Contents Therapy Progress Notes Examples**

- 1. Understanding the eBook Therapy Progress Notes Examples
  - The Rise of Digital Reading Therapy Progress Notes Examples
  - Advantages of eBooks Over Traditional Books
- 2. Identifying Therapy Progress Notes Examples
  - Exploring Different Genres
  - o Considering Fiction vs. Non-Fiction
  - $\circ \ \ Determining \ Your \ Reading \ Goals$
- 3. Choosing the Right eBook Platform
  - $\circ \ \ Popular \ eBook \ Platforms$
  - Features to Look for in an Therapy Progress Notes Examples
  - User-Friendly Interface
- 4. Exploring eBook Recommendations from Therapy Progress Notes Examples
  - Personalized Recommendations

- Therapy Progress Notes Examples User Reviews and Ratings
- Therapy Progress Notes Examples and Bestseller Lists
- 5. Accessing Therapy Progress Notes Examples Free and Paid eBooks
  - Therapy Progress Notes Examples Public Domain eBooks
  - Therapy Progress Notes Examples eBook Subscription Services
  - Therapy Progress Notes Examples Budget-Friendly Options
- 6. Navigating Therapy Progress Notes Examples eBook Formats
  - o ePub, PDF, MOBI, and More
  - Therapy Progress Notes Examples Compatibility with Devices
  - Therapy Progress Notes Examples Enhanced eBook Features
- 7. Enhancing Your Reading Experience
  - $\,\circ\,$  Adjustable Fonts and Text Sizes of Therapy Progress Notes Examples
  - Highlighting and Note-Taking Therapy Progress Notes Examples
  - Interactive Elements Therapy Progress Notes Examples
- 8. Staying Engaged with Therapy Progress Notes Examples
  - o Joining Online Reading Communities
  - Participating in Virtual Book Clubs
  - Following Authors and Publishers Therapy Progress Notes Examples
- 9. Balancing eBooks and Physical Books Therapy Progress Notes Examples
  - Benefits of a Digital Library
  - Creating a Diverse Reading Collection Therapy Progress Notes Examples
- 10. Overcoming Reading Challenges
  - Dealing with Digital Eye Strain
  - Minimizing Distractions
  - Managing Screen Time
- 11. Cultivating a Reading Routine Therapy Progress Notes Examples
  - Setting Reading Goals Therapy Progress Notes Examples
  - Carving Out Dedicated Reading Time
- 12. Sourcing Reliable Information of Therapy Progress Notes Examples
  - Fact-Checking eBook Content of Therapy Progress Notes Examples

- Distinguishing Credible Sources
- 13. Promoting Lifelong Learning
  - Utilizing eBooks for Skill Development
  - Exploring Educational eBooks
- 14. Embracing eBook Trends
  - Integration of Multimedia Elements
  - Interactive and Gamified eBooks

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