SESSION NOTE TEMPLATE

Questions? Visit us at
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1 Patient / Client Information

1 SESSION DETAILS

Name: ____________________ Date of Session: ____________________

DOB: ____________________ Provider: ____________________

Age / Sex: ____________________ Credentials: ____________________

MRN / Client ID: ____________________ Session Type: ____________________

Location / Setting: ____________________ Session Duration: ____________________

R Reason for Session

2 PRIMARY PURPOSE OF THIS SESSION

Document the primary reason for the session — treatment goal, presenting concern, behavioral issue, skill deficit, or follow-up need addressed during the encounter...

S Subjective

3 PATIENT / CLIENT-REPORTED INFORMATION

3a CURRENT SYMPTOMS & CHANGES SINCE PRIOR SESSION

Patient/client-reported symptoms, concerns, stressors, and changes since last session...

3b PROGRESS, BARRIERS & FUNCTIONAL IMPACT

Patient/client perception of progress or barriers, relevant functional impact...

3c PERTINENT NEGATIVES

Explicit denial or acknowledgment of safety concerns — SI/HI, self-harm, substance use, safety planning status...

O Objective

4 OBSERVABLE CLINICAL & BEHAVIORAL INFORMATION

Appearance: ____________________ Participation & Engagement: ____________________

Mood: ____________________ Affect: ____________________

Communication Style: ____________________ Skill Use / Performance: ____________________

Observable Changes from Baseline: ____________________

I Interventions Provided

5 SERVICES DELIVERED DURING SESSION

5a THERAPEUTIC MODALITY & SKILLS

Therapeutic modality or service provided — CBT, DBT, supportive therapy, ABA, skills training, etc. Skills practiced or taught during this session...

5b PSYCHOEDUCATION & BEHAVIORAL STRATEGIES

Psychoeducation content provided, behavioral strategies implemented, caregiver or family involvement (if applicable)...

RE Response to Intervention

6 PATIENT / CLIENT RESPONSE

Engagement Level: ______________ Understanding of Material: ______________

Emotional / Behavioral Response: ______________ Progress / Resistance / Barriers: ______________

Additional narrative on response to intervention if needed...

A Assessment

7 CLINICAL INTERPRETATION

7a CURRENT CLINICAL STATUS & PROGRESS

Current clinical status, progress toward treatment goals, functional impairment or improvement...

7b MEDICAL NECESSITY & RISK / SAFETY

Ongoing medical necessity for services, risk or safety concerns (if present), protective factors...

PL Plan

8 NEXT STEPS

Continue or modify current treatment approach, skills or homework assigned, referrals or coordination of care, safety planning (if applicable)...

F Follow-Up

9 NEXT SESSION

Next session timeframe and what will be reassessed: ______________

TIME DOCUMENTATION & BILLING

Total Time Spent: ______ Counseling / Coordination Time: ______ CPT Code: ______ Basis for Billing: ______

Primary ICD-10 Dx Code: ______________ Secondary ICD-10 Dx Code(s): ______________

PROVIDER NAME ______________ CREDENTIALS ______________ DATE & TIME ______________