commure

# Therapy Progress Notes Cheat Sheet

Language reference for outpatient therapy documentation

## HOW TO USE THIS CHEAT SHEET

This is a language reference for outpatient therapy documentation, not a format explainer. Use it while writing: pull a stem, adapt it to the client and session, individualize the clinical content. Never copy any stem verbatim across clients. For a full breakdown of each format and billing considerations, see the SOAP Notes Guide.

## FORMAT QUICK REFERENCE

*For format explanations, payer considerations, and billing guidance, see the SOAP Notes Guide linked above.*

| Format | Structure | Use when | Payer risk |
|---|---|---|---|
| **SOAP** | Subjective / Objective / Assessment / Plan | Most outpatient therapy. Default in most EHRs. Required by many commercial payers. | Lowest. Explicit S/O split is auditor-readable. |
| **DAP** | Data / Assessment / Plan | Counseling where S/O distinction is thin. When your payer accepts it. | Moderate. Some payers request S/O separation on audit. |
| **BIRP** | Behavior / Intervention / Response / Plan | Community mental health, SUD programs, some Medicaid contracts. | Varies. Confirm with your payer before switching from SOAP. |

## PHRASE BANK 1: PRESENTING CONCERN AND SESSION FOCUS

*Use in: Subjective (SOAP), Data (DAP), Behavior (BIRP).*

**Client-reported presenting concern**

- Client reported [increased anxiety / depressed mood / interpersonal conflict / grief] as the primary focus of today's session.
- Client presented with concerns related to [presenting issue], noting [specific change or trigger] since the last session.
- Client described ongoing difficulty with [symptom or situation], rating distress at [X/10].
- Client reported [improvement / regression / no change] in [specific goal area] since the last session.
- Client initiated discussion of [topic], identifying this as a current priority.

**Session focus**

- Today's session focused on [exploring / processing / reviewing / addressing] [topic].
- Session themes included [theme 1] and [theme 2], with particular attention to [specific aspect].

- Client and clinician examined [pattern / belief / behavior] and its impact on [relationship / functioning / presenting problem].
- Session centered on reviewing progress toward [treatment goal] and identifying barriers to [goal-related behavior].

## PHRASE BANK 2: MENTAL STATUS AND CLINICIAN OBSERVATIONS

*Use in: Objective (SOAP), Data (DAP). Document what you observed, not what you inferred.*

**Appearance and presentation**

- Client appeared [well-groomed / casually dressed / disheveled], appropriate to context.
- Psychomotor activity was [within normal limits / mildly reduced / notably agitated].
- Client arrived [on time / late] and [settled quickly into session / appeared distracted at session onset].

**Speech and affect**

- Speech was [normal in rate and volume / rapid / pressured / slowed / low in volume].
- Mood [anxious / depressed / euthymic / irritable] per client; affect [congruent / restricted / labile / flat / bright].
- Eye contact was [appropriate / limited / avoidant / sustained throughout session].

**Cognition and insight**

- Thought process appeared [linear and goal-directed / tangential / circumstantial].
- Insight into presenting concerns appeared [intact / limited / improving].
- Client demonstrated [good / fair / limited] judgment in discussion of [relevant area].

**Standardized measures**

- [PHQ-9 / GAD-7 / PCL-5] administered; score [X], indicating [interpretation]. Compared to prior score of [X] on [date].
- Columbia Protocol (C-SSRS) administered; risk assessed as [Low / Moderate / High].
- Standardized measure not administered this session due to [reason].

**Discrepancy between self-report and observation**

- Client reported feeling [state], though affect appeared [contrasting observation].
- Stated mood was inconsistent with observed [behavior / affect / presentation]; discrepancy noted and explored in session.

## PHRASE BANK 3: INTERVENTION LANGUAGE

*Use in: Plan (SOAP/DAP), Intervention (BIRP), Assessment. Name the modality, technique, and target.*

**Cognitive-behavioral (CBT)**

- Cognitive restructuring used to identify and challenge [specific distortion or belief].
- Therapist and client completed [ABC model / thought record / behavioral experiment] targeting [belief or behavior].
- Psychoeducation provided on [cognitive distortions / anxiety cycle / behavioral activation / sleep hygiene].
- Exposure hierarchy reviewed; client practiced [step X] with [moderate / minimal] distress.

**DBT**

- DBT skills training focused on [TIPP / DEAR MAN / STOP / ACCEPTS / PLEASE] in the context of [presenting situation].
- Therapist guided client through [distress tolerance / emotion regulation / interpersonal effectiveness] skill practice.

- Mindfulness exercise completed; client [engaged fully / had difficulty sustaining attention].

**Motivational Interviewing (MI)**

- MI techniques used to explore ambivalence regarding [behavior or change target].
- Change talk elicited around [topic]; client articulated [reason / benefit] for change.
- Discrepancy between [current behavior] and [stated value or goal] was explored collaboratively.

**EMDR**

- EMDR processing continued on Target [#X / theme label]; SUDS [X] at session onset, [X] at close.
- Resourcing phase completed; client installed [calm place / container / resource] for between-session use.
- Positive cognition [describe] installed following processing; VoC [X].

**Supportive and relational**

- Supportive psychotherapy used to process [loss / grief / life transition / relational stress].
- Therapist used reflective listening and validation to support client's expression of [emotion].
- Therapeutic relationship explored; client identified [concern / rupture / appreciation]; addressed in session.

**Safety documentation**

- Safety assessment conducted using [Columbia Protocol / clinical interview]; risk assessed as [Low / Moderate / High, per clinical judgment].
- Safety plan reviewed and [updated / confirmed as operative]. Crisis contacts confirmed: [name], [resource].
- Client verbalized understanding of safety plan and agreed to [contact X / use skill Y] if ideation escalates.
- Client denied suicidal ideation, homicidal ideation, and intent to harm self or others.

## PHRASE BANK 4: CLIENT RESPONSE LANGUAGE

*Use in: Response (BIRP), Plan/Assessment. Document how the client engaged with each intervention.*

**Engagement**

- Client engaged [actively / thoughtfully / with initial resistance / minimally] in today's intervention.
- Client appeared [receptive / hesitant / ambivalent / compliant] when [intervention or topic] was introduced.
- Client verbalized [agreement / uncertainty / discomfort] with the approach used.

**Insight and learning**

- Client demonstrated [increased / emerging / limited] insight into [pattern / belief / behavior].
- Client identified a connection between [past experience] and [current symptom or behavior].
- Client articulated [new perspective / shift in understanding] regarding [topic].

**Emotional response**

- Client became tearful when discussing [topic]; affect [congruent / resolved by end of session / required grounding].
- Client expressed [frustration / relief / sadness / hope] in response to [intervention or discussion].
- Client tolerated discussion of [difficult content] with [minimal / moderate] distress.

**Skill practice**

- Client practiced [skill] in session; demonstrated [adequate / developing / strong] understanding of application.
- Client reported using [skill] between sessions with [partial / full / limited] success.
- Skill gaps identified: [specific area]; to be addressed in [next session / homework].

## PHRASE BANK 5: PLAN AND NEXT STEPS

*Use in: Plan (SOAP/DAP/BIRP). Cover assignments, coordination, treatment plan updates, and follow-up.*

**Between-session assignments**

- Client was assigned [thought record / behavioral activation log / sleep diary / communication log] to complete before next session.
- Client agreed to practice [skill] when [trigger or situation] occurs before the next session.
- Client was encouraged to [specific action]; rationale reviewed and client verbalized understanding.

**Coordination of care**

- Referral to [psychiatry / prescriber / specialist] discussed; client [agreed / declined]; ROI [obtained / not yet obtained].
- Collateral contact made with [relationship] on [date] per signed ROI dated [date]. Information shared: [brief description].
- Coordination with [provider] pending client consent; ROI to be completed at next session.

**Treatment plan updates**

- Session content addressed treatment goal [#X: describe]; progress assessed as [on track / limited / significant].
- Treatment goal [#X] met as of this session. New goal introduced: [describe].
- Treatment goal [#X] modified due to [new stressor / change in presentation]; revised goal: [describe].

**Follow-up and frequency**

- Next session scheduled [date]. Continuing [weekly / biweekly] frequency.
- Session frequency increased to [twice weekly] to support [clinical rationale].
- Discharge planning initiated; client has met [X of Y] treatment goals. Projected transition in [timeframe].

**Telehealth (add when applicable)**

- Session conducted via [audio-video / audio-only] telehealth using [platform]. Client located in [state] at time of service. Session met applicable payer requirements for telehealth reimbursement.

## MEDICAL NECESSITY CHECKLIST

*Confirm before finalizing any therapy progress note. Each item maps to a common payer audit finding.*

- ☐ Diagnosis documented with DSM-5 code (if billing insurance)
- ☐ Presenting symptoms described with functional impact, not just a label
- ☐ Intervention named and linked to diagnosis or treatment goal
- ☐ Client response to intervention documented
- ☐ Safety status addressed explicitly, even if no concerns
- ☐ Progress or change from prior session noted
- ☐ Plan includes next appointment date and session frequency
- ☐ Note content is individualized, not copied from a prior session

*The most common denial pattern in behavioral health is a note that names the session topic but omits the named intervention, the client response, or any link to the treatment plan. A note that passes this checklist is defensible in a payer audit.*