

B.I.R.P. Progress Note Checklist

B Behavior Counselor observation, client statements	Check if addressed
1. Subjective data about the client—what are the clients observations, thoughts, direct quotes?	
2. Objective data about the client—what does the counselor observe during the session (affect, mood, appearance)?	
I Intervention Counselor’s methods used to address goals and objectives, observations, client statements	
1. What goals and objectives were addressed this session?	
2. Was homework reviewed?	
R Response Client’s response to the intervention, progress made toward Tx Plan goals and objectives	
1. What is the client’s current response to the clinician’s intervention in the session?	
2. Client’s progress attending to goals and objectives outside of the session?	
P Plan Document what is going to happen next	
1. What in the Tx Plan needs revision?	
2. What is the clinician going to do next?	
3. What is the next session date?	

General Checklist	Check if addressed
1. Does the note connect to the client’s individualized treatment plan?	
2. Are client strengths/limitations in achieving goals noted and considered?	
3. Is the note dated, signed and legible?	
4. Is the client name and/or identifier included on each page?	
5. Has referral and collateral information been documented?	
6. Does the note reflect changes in client status (eg. GAF, measures of functioning)?	
7. Are all abbreviations standardized and consistent?	
8. Did counselor/supervisor sign note?	
9. Would someone not familiar with this case be able to read this note and understand exactly what has occurred in treatment?	
10. Are any non-routine calls, missed sessions, or professional consultations regarding this case documented?	