Progress Note Exercise:

Objectives:

1. Participants will be able to understand how to document the link between the Medical Necessity Primary Diagnosis, the Client Plan Objectives, and Interventions in a progress note.

2. Participants will be able to successfully write a progress note which meets Medi-Cal documentation standards linking the Medical Necessity/Primary Diagnosis, Client Plan Objectives, and Interventions.

- 30 minutes
    - Break out in to smaller groups
    - Each group will collectively identify 2 mental health objectives based upon the clients goal and write a progress note for a psychotherapy session based upon the BIRP model
    - Review and revise notes with group

Vignette 1

You have been seeing John for 4 months and have developed a solid working rapport. He attends sessions as scheduled. He is a 22 year old, single, African-American, identified gay male, who lives with roommates in Berkeley, employed as a waiter, and is a Landscape Architecture major attending UC Berkeley. He began therapy to address feeling sad, lonely, and depressed for the past year, but maybe longer. His primary diagnosis is Dysthymic disorder. He has reported a decrease in his marijuana use during the past 6 months and is improving in his academics. His main goal is to be able to be in a steady relationship, complete school in the next 9 months, and then secure a position.

Today he presents with sad affect and discussed feeling disappointed with himself because he drank a lot the other night, overslept, and missed one of his classes. He also stated that he feels uncertain that he will ever meet guys that are “easy going and have a good head on their shoulders.”

Vignette 2

You have just met with Donovan for the 3 initial assessment sessions. He is a 42 year old Mexican-American, Bilingual, and is employed as an electrician in his cousin's company. He is originally from Oaxaca, Mexico, has been in the US off and on since he was 14 years old, is an undocumented person, living in San Leandro with his wife and their 3 children. He reported occasional use of alcohol and denied all drug use or experimentation. He denied a history of mental health issues/treatment. He was directed by his PCP to seek out counseling for intense panic attacks. He is not clear what counseling is about, but is willing to give it a try. He reported that he does not want to take medications and would rather find another way to stop what is happening. He reported his sleep is "rocky", has intermittent nightmares that he cannot remember, and wakes up in a pool of sweat. You were able to identify with him that his main concerns are to stop the sudden panic attacks.

Vignette 3

Yolanda is a 15 year old, African American female. She has been in counseling with you for approximately 2 months. She was brought in for counseling by her parents who were concerned about her abrupt change in mood after a break-up with her boyfriend. For the past 3 months, she has been feeling predominantly sad, anxious, her sleep has been disrupted, and she reports having difficulty concentrating. She denies any self-harm behaviors or thoughts, has no history of mental health issues/treatment, and denies all substance use. In general, she is bright, has a long-history enjoying school, and has several close friends. She described her relationship to her family as very good. Her main goals are to stop feeling sad and be able to feel good about herself. Her primary diagnosis is Adjustment Disorder with mixed Anxiety and Depressed Mood. Today she is reporting she has not spent time with her friends in a long time, feeling lonely, her affect is sad and she discussed feeling anxious about the upcoming summer break. She discussed feelings of rejection and unworthiness since her boyfriend broke up with her. She reported she is mostly listening to music and studying on her own after school and in the past week has become suddenly angry with her younger sister when she came into her room.

Objective Formulation Exercise:

Axis I Diagnosis: _____

Client's Stated Goal:

_____
_____
_____

Objective 1 (Observable & Measureable, With Baseline & Timeframes):

_____
_____
_____

Objective 2 (Observable & Measureable, With Baseline & Timeframes):

_____
_____
_____

Progress Note

Client Name: _____ MRN/SS: _____

Service Date: _____ Service Code: _____ Service Location: _____

Diagnosis: _____

Objective #:_____

B (Today's Behavioral Observation/Assessment):

_____
_____
_____
_____

I: (Clinician's Intervention)

_____
_____
_____
_____

R: (Client's Response)

_____
_____
_____
_____

P: (Today's Plan: Follow up, Homework, Focus of Next Session, etc.)

_____
_____
_____
_____

Clinician Name: _____

Clinician Signature: _____ **Date:** _____