

THERAPY FOLLOW-UP SESSION NOTE

Client: _____ Date: _____

Session #: _____ Duration: _____ Type: Individual Family Group

Therapist: _____ Next Appointment: _____

SESSION OVERVIEW

Client's Presentation Today: Improved Same Worse Mixed Crisis

Mood/Affect: Euthymic Depressed Anxious Irritable Elevated Labile

Overall Functioning (1-10): _____ **Change from last session:** Better Same Worse

PROGRESS SINCE LAST SESSION

Homework/Between-Session Tasks: Completed Partially completed Not completed N/A

Details: _____

Symptom Changes: Significant improvement Some improvement No change
 Some worsening Significant worsening

Specific Changes: _____

Medication Changes: None Dose adjustment New medication Discontinued
medication **Details:** _____

Life Events/Stressors: None Work/school Relationships Family Health Financial Legal Details: _____

TODAY'S SESSION CONTENT

Primary Focus: Crisis intervention Symptom management Skill building Processing emotions Relationship issues Trauma processing Behavioral changes Medication review Other: _____

Topics Discussed: _____

Interventions Used: Cognitive restructuring Behavioral activation Mindfulness Exposure EMDR Psychoeducation Problem-solving Communication skills Relaxation techniques Grounding exercises Other: _____

Client Response to Interventions: Very engaged Engaged Somewhat engaged Resistant Overwhelmed

CURRENT SYMPTOMS ASSESSMENT

Depression Symptoms: None Mild Moderate Severe **Specific symptoms:** _____

Anxiety Symptoms: None Mild Moderate Severe **Specific symptoms:** _____

Sleep: Normal Difficulty falling asleep Frequent waking Early waking Oversleeping

Appetite: Normal Decreased Increased Significant changes

Energy Level: Normal Low Very low High Fluctuating

Concentration: Normal Mild difficulty Moderate difficulty Severe difficulty

SAFETY ASSESSMENT

Suicidal Ideation: None Passive Active without plan Active with plan Intent

Self-Harm Behaviors: None Thoughts Urges Recent behavior

Risk to Others: None Thoughts Threats Concerning behavior

Substance Use: None As prescribed Occasional use Regular use Concerning use

Overall Risk Level: Low Moderate High Imminent danger

Safety Plan: Reviewed Updated Created Not needed

THERAPEUTIC RELATIONSHIP

Rapport: Excellent Good Fair Strained Poor

Client Engagement: Highly engaged Engaged Moderately engaged Minimally engaged Disengaged

Therapeutic Alliance: Strong Good Developing Weak Ruptured

Resistance/Barriers: None Ambivalence Fear Shame External pressures Cognitive limitations **Details:** _____

GOAL PROGRESS

Goal 1: _____ **Progress:** Achieved Significant progress Some progress No progress Regression

Goal 2: _____ **Progress:** Achieved Significant progress Some progress No progress Regression

Goal 3: _____ **Progress:** Achieved Significant progress Some progress No progress Regression

New Goals Identified:

HOMEWORK/BETWEEN-SESSION TASKS

Assigned Tasks: 1. _____ 2. _____ 3. _____

Skills to Practice: Mindfulness Deep breathing Thought challenging Behavioral activation Communication skills Grounding techniques Journaling Exercise Other: _____

Resources Provided: Handouts Apps Books Websites Referrals Other: _____

CLINICAL OBSERVATIONS

Mental Status: Appearance: Appropriate Disheveled Unusual **Behavior:** Cooperative Agitated Withdrawn Hyperactive **Speech:** Normal Rapid Slow Pressured Quiet **Thought Process:** Linear Tangential Circumstantial Disorganized **Insight:** Good Fair Poor Absent **Judgment:** Good Fair Poor Impaired

Notable Observations:

TREATMENT PLANNING

Current Treatment Approach: CBT DBT EMDR Psychodynamic Humanistic Solution-focused Family systems Trauma-focused Other: _____

Treatment Modifications Needed: None Frequency change Approach change Additional services **Details:** _____

Referrals/Consultations: None needed Psychiatry Medical Specialist Case management Other: _____

Session Frequency: Weekly Bi-weekly Monthly As needed Increase frequency Decrease frequency

NEXT SESSION PLAN

Primary Focus for Next Session:

Specific Interventions Planned:

Topics to Address:

Materials Needed: Assessment tools Handouts Worksheets Art supplies
Other: _____

PROGRESS SUMMARY

Overall Progress Rating (1-10): _____

Strengths Demonstrated:

Areas for Continued Work:

Prognosis: Excellent Good Fair Guarded Poor

Estimated Sessions Remaining: _____

THERAPIST NOTES

Clinical Impressions:

Countertransference/Personal Reactions:

Supervision/Consultation Needs: None Case discussion Specific intervention
 Ethical concern Safety concern Other: _____

Documentation/Administrative: Treatment plan update needed Insurance authorization
 Coordination with other providers Other: _____

Therapist Signature: _____ **Date:** _____

License #: _____ **Credentials:** _____

Confidential treatment record protected by HIPAA regulations.