BIRP Progress Note

Behavior · Intervention · Response · Plan

Session details

Client name or ID

Date of service

Session number

Start time

Stop time

Total minutes

Format: ☐ In person ☐ Telehealth video ☐ Phone Type: ☐ Individual ☐ Couple or family ☐ Group

Treatment plan goal or objective addressed today

B Behavior: what the client reported and what you observed

I Intervention: what you did, and which goal it served

☐ Psychoeducation ☐ Cognitive work ☐ Behavioral activation ☐ Exposure ☐ Skills practice

☐ Mindfulness ☐ Motivational work ☐ Problem solving ☐ Safety planning ☐ Other

R Response: how the client engaged, what changed

Risk check

☐ Not assessed today (say why) ☐ Screened, denies thoughts of harm to self or others ☐ Concern noted: see Plan

P Plan: homework, next session, frequency, referrals

Clinician signature and credentials

Date and time signed

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BIRP Progress Note

Behavior · Intervention · Response · Plan

FILLED EXAMPLE · fictional client, for illustration only

Session details

Client name or ID: M.R. (fictional example)

Date of service: 11/13/2026

Session number: 6

Start time: 10:02 a.m.

Stop time: 10:55 a.m.

Total minutes: 53

Format: ☐ In person ☑ Telehealth video ☐ Phone Type: ☑ Individual ☐ Couple or family ☐ Group

Treatment plan goal or objective addressed today

Problem 1, objective 1.2: reduce avoidance of work meetings (fear ladder, step 3 to 4).

B Behavior: what the client reported and what you observed

Client reported panic symptoms before team meetings on 3 of 5 workdays this week (self log), down from 5 of 5 last week. Attended 2 meetings, left 1 early. Stated: "I went, but I sat by the door the whole time."

GAD-7 today 12 (was 15 on 10/16). On time, alert, engaged; speech normal rate; mood "tense", affect congruent.

Sleep 6 to 7 hours (self report). Client confirmed location (home, private room) at start of telehealth session.

I Intervention: what you did, and which goal it served

Reviewed panic log and ladder. Guided interoceptive exposure: 30 seconds of fast breathing x 3 trials with SUDS ratings. Cognitive restructuring of the prediction "I will faint and everyone will see." Set ladder step 4.

☑ Psychoeducation ☑ Cognitive work ☐ Behavioral activation ☑ Exposure ☐ Skills practice

☐ Mindfulness ☐ Motivational work ☐ Problem solving ☐ Safety planning ☐ Other

R Response: how the client engaged, what changed

SUDS peaked at 70 on trial 1 and fell to 35 by trial 3. Client described the sensations as "uncomfortable, not dangerous." Belief in the fainting prediction 80% at start, 40% at end. Agreed to step 4 and named Thursday's all-staff meeting as the hardest one. Progress toward objective 1.2: partial, moving.

Risk check

☐ Not assessed today (say why) ☑ Screened, denies thoughts of harm to self or others ☐ Concern noted: see Plan

P Plan: homework, next session, frequency, referrals

Homework: daily panic log; ladder step 4 (stay for the full length of 2 meetings, seat of choice, no early exit).

Next session 11/20/2026, telehealth, 53 minutes; weekly frequency continues per plan.

Repeat GAD-7 at session 8 and review objective 1.2 at the 12/14 plan review.

Clinician signature and credentials: A. Rivera, LPC (fictional)

Date and time signed: 11/13/2026 11:20 a.m.

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BIRP Note Checklist

Twelve checks before you sign, and words to swap out

Before you sign

- [ ] 1. Client identifier, date of service, and start and stop times or total minutes are recorded.
- [ ] 2. Format and session type are marked (in person, telehealth, phone; individual, couple, group).
- [ ] 3. The note names the treatment plan goal or objective you worked on today.
- [ ] 4. Behavior uses observations, numbers and the client's own words, not labels.
- [ ] 5. Any measure given today is named, with its score and the last score for comparison.
- [ ] 6. Intervention says what you actually did, not only the name of the model.
- [ ] 7. Response shows how the client engaged and what changed, or did not change.
- [ ] 8. Risk was screened, or the note says why not; any concern links to a step in the Plan.
- [ ] 9. Plan lists homework, the next session date, frequency, and any referral or release.
- [ ] 10. Process thoughts and hypotheses are kept out (they belong in separate psychotherapy notes).
- [ ] 11. Other people are described only as far as the client's care needs.
- [ ] 12. Signed with your credentials and finished within your agency's or payer's timeframe.

Words to watch

Vague	Try instead
Client is doing better.	Panic attacks down from 4 to 1 a week (self log).
Discussed feelings.	Explored grief about the job loss; client named anger and relief.
Client was resistant.	Client declined the exposure task and said, "not this week."
Good session.	Completed 3 exposure trials; SUDS fell from 70 to 35.
Supportive therapy.	Validated, reflected, then problem solved one workday barrier.
Client is manipulative.	Client asked twice to end early; reviewed the session agreement.
Continue treatment.	Weekly CBT per objective 1.2; repeat GAD-7 at session 8.
Seems depressed.	PHQ-9 = 17; flat affect; reports sleeping 11 hours a day.

Progress notes vs psychotherapy notes (HIPAA)

A BIRP note is a progress note: part of the clinical record, and clients generally have a right to see it.

Psychotherapy notes are your separate process notes about session content (45 CFR 164.501). They do not include start and stop times, modalities, test results, or summaries of diagnosis, symptoms, treatment plan or progress.

Write every BIRP note as if the client might read it. Check your state, payer and agency rules too.

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