Psychotherapy Notes

Your own process notes on the session conversation, kept apart from the record

STORE SEPARATELY from the client record

Not for the chart, portal, claims, letters or general releases. Authorization needed to share.

Session

Client code (not full name)	Date	Session no.	Clinician initials

Hypotheses and themes

Process and the relationship

My reactions (countertransference)

Questions for supervision or consultation

Reminders for next time

Does not belong here: put it in the progress note

- × Medication prescription and monitoring
- × Modality and frequency of treatment
- × Diagnosis, symptoms, functional status
- × Risk assessment and safety actions
- × Session start and stop times
- × Results of clinical tests and measures
- × Treatment plan, prognosis, progress to date
- × Anything needed for billing or coverage

Template to adapt. Not legal advice. Check HIPAA, your state law, board rules and setting policy.

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Progress Note or Psychotherapy Notes?

Sort each item before you write. Filled with a fictional example session.

FILLED EXAMPLE · fictional practice, clinician and client, for illustration only

Progress note: the record

What goes here

- Date, start and stop times, CPT or service type
- Modality, frequency, telehealth platform and location
- Symptoms, mental status and functioning
- Risk asked about, found and done
- Interventions linked to plan goals
- Measures and scores, progress to date
- Diagnosis and medical necessity
- Medication information
- Plan, homework, next session, referrals

Example: session 6, 11/04/2026

Sam R. (fictional), Maple Row Counseling. 2:02 to 2:55 pm, 53 min, 90834, video; client at home in [state].

Worry about work review; sleep about 5 h; missed 2 workdays. PHQ-9 14 (19 at intake), GAD-7 12 (15).

Denied SI, plan, intent and HI; safety plan reviewed. New sertraline from PCP, mild nausea; to discuss with PCP.

Cognitive restructuring for goal 1; partial progress. Dx F43.23. Plan: 2 thought records, wind down routine, measures in 4 weeks, next 11/11.

Psychotherapy notes: separate

What goes here

- Hypotheses about the conversation
- Process, themes, ruptures and repairs
- Your own reactions
- Sensitive detail not needed by others
- Questions for supervision or consultation
- Reminders for next session
- Nothing from the excluded list (left)

Example: session 6, 11/04/2026

S.R., session 6. Spoke of the review only as what the manager "will think"; same words used about father in session 2.

Hypothesis: perfectionism protects against fear of father's criticism. Go slowly; S. shut down when I named father.

Wanted to reassure; held back. Real laughter at the "worst case" script; humor may be a way in.

Consult: when to name the pattern. Phrase: "I am only as good as the last thing I did."

Where does it go? Tick one for each item

Item from the session	Progress note	Psych. notes
Session 2:02 to 2:55 pm, video, 90834	☑	☐
PHQ-9 14, GAD-7 12	☑	☐
Sertraline started, mild nausea	☑	☐
Denied SI and HI; safety plan reviewed	☑	☐
Dx F43.23; partial progress on goal 1	☑	☐
"Manager will think" echoes words about father	☐	☑
I wanted to reassure; held back	☐	☑
Ask consult group when to name the pattern	☐	☑
_____	☐	☐
_____	☐	☐
_____	☐	☐
_____	☐	☐
_____	☐	☐

Quick test before you file

Would a covering clinician need it to treat the client safely? Progress note.

Would a reviewer need it to see why the session happened and what it did? Progress note.

Is it on the excluded list, or about risk? Progress note.

Only your own analysis of the conversation? Psychotherapy notes, kept apart, or nowhere.

Not sure? Progress note, written briefly and factually.

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Before You File: Notes Checklist

Ten checks for each session, plus a log for records requests

Before you file

- [ ] 1. Progress note written first and complete on its own.
- [ ] 2. Times, service code, modality and participants recorded.
- [ ] 3. Symptoms, measures, risk and safety actions in the progress note.
- [ ] 4. Interventions and progress linked to treatment plan goals.
- [ ] 5. Psychotherapy notes, if any, hold no excluded items.
- [ ] 6. Psychotherapy notes stored apart: own folder or EHR section.
- [ ] 7. Not visible in the portal, exports, claims or letters.
- [ ] 8. Both notes brief, respectful, fit to be read by others.
- [ ] 9. Releases: psychotherapy notes only with their own authorization.
- [ ] 10. Policy, Notice of Privacy Practices and consent match practice.

Records request log (what was asked, what was sent)

	Date received	From and purpose	Authority	Sent (record / notes)	Date sent
1.					
2.					
3.					
4.					
5.					

Authority:

client request, general release, psychotherapy notes authorization, court order, subpoena or other law. Call risk management or an attorney before sending notes for any legal request.

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