

Case Formulation Cheat Sheet

Reviewed by the BastionGPT Clinical Advisory Board · July 2026

A case formulation note (case conceptualization) is the working hypothesis of a case: how predisposing, precipitating, perpetuating, and protective factors fit together to produce the presenting problem, and what that means for treatment. Written at intake and major reviews; most run 1 to 2 pages.

1 – Anchor it in the presenting problem the client's words, plus baselines

Do: state the problem as the client describes it, with baseline measures and functional impact.

Pitfall: a symptom list with no story; the formulation's job is to explain, not restate.

2 – Map the four Ps five, when you lead with Presenting issues

Do: cover predisposing vulnerabilities, precipitating triggers, perpetuating (maintaining) factors, and protective strengths; note any you cannot yet fill.

Pitfall: treating the Ps as a legal requirement; they come from training standards, not statute or payer rules.

3 – Write the working hypothesis one paragraph that explains the case

Do: tie the factors together in your theoretical frame: what drives the problem, and what keeps it going.

Pitfall: repeating the history; a hypothesis makes a claim you can test in treatment.

4 – Draw the treatment implications the bridge to the treatment plan

Do: say what the hypothesis argues you should target first, and with what approach; the plan's goals should trace back here.

Pitfall: a formulation that never changes the plan; auditors look for a coherent thread from assessment to services billed.

5 – Date it, sign it, revisit it a living document, and part of the record

Do: record date, time, and author like any entry, and update the formulation when the case changes.

Pitfall: assuming it is shielded as "psychotherapy notes"; a formulation containing diagnosis or plan content is part of the regular, auditable record (45 CFR 164.501).

Before you sign

- ☐ Presenting problem in the client's own words
- ☐ All four Ps addressed, or the gap noted
- ☐ Hypothesis explains, not just restates, the history
- ☐ Treatment implications stated and reflected in the plan
- ☐ Date, time, and author identifiable
- ☐ Stored in the regular record, not mislabeled

Drafting with AI

Give it your intake or biopsychosocial bullets: history, triggers, maintaining factors, strengths, and your theoretical frame.

"Draft a 5P case formulation from this intake summary: social anxiety, onset after promotion to a client-facing role, avoids meetings, strong partner support, CBT frame: ..."

Never paste client-identifying information into consumer AI tools. BastionGPT is HIPAA-compliant with a signed BAA on every plan.

1–2 pages
typical length

20–40 min by hand
clinical team estimate

At intake & major reviews
when it's written

You · supervisors · auditors
who reads it

Case Formulation Note Template

Copy or print for your practice · Adapt fields to your organization's, payer's and jurisdiction's documentation requirements.

Client (initials):

Date:

Diagnosis (ICD-10), if established:

Presenting problem & context

In the client's own words where possible; baseline measures and functional impact

Predisposing factors

Longstanding vulnerabilities: developmental, biological, relational, cultural

Precipitating factors

Recent events or triggers linked to onset of the current episode

Perpetuating factors

What maintains the problem now: avoidance, reinforcement, context, relationships

Protective factors

Strengths, supports, coping skills, values, and what has helped before

Working hypothesis

How the factors fit together in your theoretical frame to produce and maintain the problem

Treatment implications

What to target first and with what approach; carries into the treatment plan's goals

Formulation discussed with client: ☐

Review / update date:

Clinician signature / credentials:

Date signed: