Court Report & Progress Update Cheat Sheet

Reviewed by the BastionGPT Clinical Advisory Board · August 2026

A court report or treatment progress update is a limited report a treating clinician sends to a court, probation officer, or attorney: attendance, engagement, goal progress, and treatment recommendations, released only on a valid legal basis (signed authorization, a court order read for its scope, or a qualifying subpoena). It is not a forensic evaluation, and no law mandates the format: the AFCC 2010 court-involved therapy guidelines are the closest convention and are expressly non-mandatory. Most run 1 to 3 pages.

Recipient, legal basis, and reporting period

the scope controls

Do: name the recipient, case identifier, reporting period, and the exact basis: authorization, court order read for scope, or a subpoena meeting 45 CFR 164.512(e); confirm 42 CFR Part 2 before any substance use content.

Pitfall: treating a court order to attend treatment as blanket permission; it authorizes only what sits inside its scope.

Author identity and treatment role

treating clinician, stated

Do: give name, credentials, license, practice contact, treatment start date, and the role statement; note supervised status accurately.

Pitfall: implying appointment as an independent evaluator; overstating the role invites cross-examination the record cannot support.

Attendance and participation

counts and dates, not verdicts

Do: record first and most recent service dates, sessions attended out of sessions scheduled, missed or late when relevant, and current status.

Pitfall: letting attendance stand in for progress or compliance; compliance involves conditions outside the clinician's knowledge.

Goals and interventions

minimum necessary

Do: state goals at the level the recipient needs, plus modality and frequency; include diagnosis only when requested, relevant, and lawful.

Pitfall: the reflexive diagnosis; no general rule requires one in every court update, and privacy law favors the minimum necessary.

Progress, engagement, and risk

label every statement

Do: describe change against the stated goals, each statement labeled documented fact, client report, or clinical opinion; risk information only as the purpose requires.

Pitfall: conclusory labels such as fully compliant or low risk; an unlabeled conclusion collapses under questioning.

Recommendations within the role

treatment needs only

Do: recommend continuation, frequency, level of care, referrals; decline out-of-scope questions in one sentence and name the right instrument.

Pitfall: ultimate-issue opinions; custody, sentencing, and termination of supervision are the court's questions.

Before you sign

- [ ] Legal basis named in the letter; the scope read
- [ ] Role stated: treating clinician, not forensic evaluator
- [ ] Part 2 status checked before any substance use content
- [ ] Attendance reported as counts and dates, never a verdict
- [ ] Every statement labeled: fact, client report, or opinion
- [ ] Out-of-scope questions declined in the letter itself
- [ ] Letter, request, and authorization filed together

Drafting with AI

Give it the request, the authorized scope, and your attendance and session data; it drafts the update with facts, client reports, and opinions labeled, and flags content the authorization does not reach.

"Draft a probation progress update: 11 of 12 sessions attended, two goals, authorization covers attendance and progress only."

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

1 to 3 pages	30 to 60 minutes	Treatment role only	Basis required
400 to 900 words	clinical team estimate	not a forensic evaluation	authorization or court order

Full guide and sample report:
bastiongpt.com/template/court-report

Court Report & Treatment Progress Update Template

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

To (recipient and agency): | Client (initials / court ID): | Date:

Case number: | Reporting period: | Author (name, credentials, license):

Legal basis for disclosure
Signed authorization dated · court order with scope reviewed · other lawful basis · 42 CFR Part 2 status confirmed

Author and treatment role
Treating clinician since [date] · supervised status stated · not an independent forensic evaluator

Attendance and participation
First and most recent session · attended of scheduled · missed or late · current status

Goals and interventions
Goals within the authorized scope · modality and frequency · diagnosis only if requested, relevant, and lawful

Progress and engagement
Label each statement: documented fact · client report · clinical opinion · risk-relevant information only as the purpose requires

Recommendations and scope
Treatment needs only · out-of-scope questions declined in writing · next update schedule

Signature and credentials: | Date signed: