DAP Note Cheat Sheet

Reviewed by the BastionGPT Clinical Advisory Board · July 2026

A DAP note is a three-part progress note format: Data, Assessment, Plan. It merges SOAP's Subjective and Objective material into a single Data section, which suits the qualitative flow of psychotherapy. A typical therapy DAP note runs 150 to 300 words.

D – Data *everything the session produced*

Do: capture the client's report, your observations, mental-status highlights, scores or logs, the interventions you delivered, and therapy time when the billed code is time-based.
Pitfall: pure narrative with no observable or measurable anchor, or missing therapy time.

A – Assessment *your clinical judgment*

Do: interpret the data: what it means for diagnosis and functioning, progress toward a numbered treatment-plan goal, and current risk status.
Pitfall: restating the Data section instead of interpreting it; that breaks the medical-necessity chain.

P – Plan *what happens next*

Do: list specific, dated next steps: interventions, homework, referrals, next appointment, and any treatment-plan changes.
Pitfall: a bare "continue treatment" with nothing the next note can evaluate.

Before you sign

- ☐ Time recorded for the billed code (start/stop is safest)
- ☐ Data has at least one observable or score
- ☐ Interventions named inside Data
- ☐ Assessment interprets, tied to a numbered plan goal
- ☐ Risk status stated, even when low
- ☐ Signed with credentials, dated promptly

Drafting with AI

Capture 30 seconds of bullets in session: client report, observations, interventions used, scores, risk status, plan changes.

> *"Draft a DAP note from these bullets for a CBT session, panic disorder, session 5 of 12: …"*

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

150–300 words	**10–20 min by hand**	**After each session**	**Care team · payers · auditors**
typical length	clinical team estimate	when it's written	who reads it

Full guide, sample note, and compliance notes:
bastiongpt.com/template/dap-note

DAP Note Template

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

Client (initials): Date: Session #:

Service: ☐ individual ☐ group ☐ telehealth Start/stop or total time:

D – Data

Client report, observations, mental status, scores or logs, interventions delivered, time for billed codes

A – Assessment

Clinical judgment: what the data means, progress toward a numbered treatment-plan goal, risk status

P – Plan

Next steps: interventions, homework, referrals, next appointment, treatment-plan changes

Clinician signature / credentials: Date signed: