

Narrative Progress Note Cheat Sheet

Reviewed by the BastionGPT Clinical Advisory Board · August 2026

A narrative progress note is a free-text progress note: it documents a therapy session in flowing prose instead of the labeled sections of SOAP or DAP. Use it when chronology and clinical reasoning matter more than a template; it is fully compliant as long as the required content is present. Most narrative notes run 150 to 500 words.

No format is mandated; every enforceable rule attaches to content. Frame the prose with the header facts (date · service and code · start/stop times for time-based codes · diagnosis · signature with credentials), write in any order, and hit all five anchors before you sign.

1 • Presentation what the client brought

Do: state symptoms, functioning, and change since last session, with scores (PHQ-9, GAD-7) and your observations.

Pitfall: opening with logistics ("arrived on time, reviewed homework") and never stating symptom status; how the client is doing belongs in the first third of the note.

2 • Intervention what you did, by name

Do: name the technique: cognitive restructuring, behavioral activation, exposure planning, grief work. A named technique makes the note evidence of a psychotherapy service.

Pitfall: letting "discussed" and "explored" carry the whole note; unnamed interventions are the classic narrative omission because no field asks for them.

3 • Response the golden thread to the plan

Do: record how the client responded and where that leaves progress toward a specific treatment-plan goal; one sentence ties the session to medical necessity.

Pitfall: a vivid account of the session with no sentence connecting it to a goal; in prose, the medical-necessity chain breaks silently.

4 • Risk findable in seconds

Do: state current risk status either way when clinically indicated; a short labeled line starting "Risk:" stays findable without breaking the narrative voice.

Pitfall: burying a risk denial mid-paragraph or omitting it; a risk statement nobody can locate does the same work as one never written.

5 • Plan end with dated next steps

Do: close with homework, changes in approach, coordination, and the next appointment date, specific enough to check the next session against.

Pitfall: trailing off with "will continue to work on goals"; end the story with dated, specific next steps.

Before you sign

- ☐ All five anchors findable in the prose
- ☐ Start/stop time in the header for the billed code
- ☐ Intervention named, not "discussed" or "explored"
- ☐ Progress tied to a numbered treatment-plan goal
- ☐ Risk stated either way, in a labeled sentence
- ☐ Fresh prose, dated plan, signed with credentials

Drafting with AI

Capture 30 seconds of bullets in session: presentation, named interventions, response, scores, risk status, plan changes.

"Draft a narrative progress note in flowing prose from these bullets, MDD, CBT with behavioral activation, session 8 of 16: ..."

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

150 to 500 words
typical length

10 to 25 min by hand
clinical team estimate

After any session
when it's written

Therapist · auditors
who reads it

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

Start/stop time:

Clinician signature / credentials: _____ Date signed: _____