

PIE Note Cheat Sheet

Reviewed by the BastionGPT Clinical Advisory Board · July 2026

A PIE note is a three-part progress note format: Problem, Intervention, Evaluation. Each entry hangs off a numbered problem from the client's problem list; there is no separate assessment or plan section, so interpretation and next steps live inside the entry. A typical PIE note runs 100 to 250 words.

P – Problem the problem worked this session

Do: state the problem concretely, keyed to the numbered problem list or treatment plan; include current status: client report, observations, scores. Client quotes go here (PIE has no Subjective section).

Pitfall: a vague problem ("client struggling") or an unnumbered problem that tracks to nothing on the treatment plan; that breaks the medical-necessity chain.

I – Intervention what you did about it

Do: record the specific therapeutic work delivered against that problem: the technique used, the skill taught, the material reviewed.

Pitfall: naming only the modality ("provided CBT"); auditors read this for the actual intervention, not the brand of therapy.

E – Evaluation how the client responded

Do: record response and progress, measurable where possible; PIE has no plan section, so next steps, homework, and plan changes live here, with dates.

Pitfall: grading attendance ("client engaged well") instead of response, and leaving next steps nowhere in the record.

Before you sign

- ☐ Time recorded for the billed code (start/stop is safest)
- ☐ Problem numbered and matched to the treatment plan
- ☐ Intervention is the specific maneuver, not the modality label
- ☐ Evaluation records measurable response, not attendance
- ☐ Next steps dated in Evaluation (PIE has no Plan box)
- ☐ Risk status stated, even when low
- ☐ Signed with credentials, dated promptly

Drafting with AI

Capture 30 seconds of bullets in session: problem worked, client status, interventions used, response, scores, next steps.

"Draft a PIE note from these bullets for a behavioral activation session, major depressive disorder, session 8 of 16: ..."

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

100–250 words
typical length

10–15 min by hand
clinical team estimate

Per problem, per session
when it's written

**Care team · payers ·
auditors**
who reads it

PIE 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: _____

Problem # (from treatment plan): _____

P – Problem

The problem worked this session, keyed to the problem list; current status, client report, scores

I – Intervention

The specific interventions delivered against this problem: technique used, skill taught, material reviewed

E – Evaluation

Response and progress, measurable where possible; next steps and plan changes; risk status

Clinician signature / credentials: _____ Date signed: _____