Psychotherapy Progress Note Cheat Sheet

Reviewed by the BastionGPT Clinical Advisory Board · July 2026

A psychotherapy progress note is the session-by-session record of psychotherapy in the standard clinical chart: presentation, interventions, response, and plan. It is legally distinct from HIPAA's separately kept "psychotherapy notes." Most run 100 to 350 words.

1 – Frame the encounter *who, when, what service*

Do: record client, date, session number, service type and length, and start/stop or total time for the billed code.
Pitfall: missing psychotherapy time; a named cause of improper payment in OIG's national audit.

2 – Presentation & status *what you saw and measured*

Do: capture symptoms, mental-status highlights, scores (PHQ-9, GAD-7), and changes since last session.
Pitfall: vague global statements ("doing better") with nothing observable behind them.

3 – Interventions *name what you actually did*

Do: name the techniques: cognitive restructuring, behavioral activation, exposure, EMDR resourcing.
Pitfall: "provided supportive therapy" alone; auditors flag unspecified therapeutic maneuvers.

4 – Response & progress *what the service accomplished*

Do: record the client's response, movement toward a numbered treatment-plan goal, and risk status.
Pitfall: no treatment-plan linkage, which breaks the medical-necessity chain payers look for.

5 – Plan, sign, date *next steps, then authenticate*

Do: list specific next steps, homework, and the next appointment; sign with credentials promptly.
Pitfall: unsigned or undated notes, or pasted signature images; both appear in federal audit findings.

Before you sign

- [ ] Time recorded to support the billed code
- [ ] Interventions named specifically, not "provided therapy"
- [ ] Response recorded separately from intervention
- [ ] Progress tied to a numbered treatment-plan goal
- [ ] Risk status stated, even when low
- [ ] Signed with credentials, dated promptly

Drafting with AI

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

> *"Draft a psychotherapy progress note from these bullets for a behavioral activation session, MDD, session 8 of 16: …"*

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

100–350 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/psychotherapy-progress-note

Psychotherapy Progress 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:

Presentation & status

Symptoms, mental status highlights, scores (PHQ-9, GAD-7), changes since last session

Interventions provided

Named techniques: what you actually did, specific enough for a reviewer to tell what the service was

Response & progress toward goal

Client response in session, movement toward a numbered treatment-plan goal

Risk status

Statement either way; silence reads as absence, not monitoring

Plan / next steps

Interventions for coming sessions, homework, referrals, next appointment

Clinician signature / credentials: Date signed: