Individual Therapy Session Note Cheat Sheet

Reviewed by the BastionGPT Clinical Advisory Board · July 2026

An individual therapy session note is the clinical record of one one-on-one psychotherapy session: what was addressed, the interventions used, the client's response, current risk, and the plan. Any structure works: SOAP, DAP, BIRP, or narrative. Most run 150 to 350 words.

1 – Header and identifiers the claim match auditors check first
Do: client identifier, date of service, service and CPT code, session number, setting.
Pitfall: a date of service that does not match the claim.

2 – Time 16–37 min → 90832 · 38–52 → 90834 · 53+ → 90837
Do: start and stop times or total time for every time-based code.
Pitfall: missing time, the top deficiency in OIG's national audit: 60 of 216 sampled days.

3 – Presentation and symptoms the client's report
Do: current symptoms, stressors, functioning, and change since last session.
Pitfall: mood adjectives with no anchor a reviewer can picture.

4 – Mental status observations brief and session-relevant
Do: appearance, engagement, speech, affect; what you saw today.
Pitfall: boilerplate exam text pasted into every session.

5 – Interventions the medical-necessity link
Do: name the technique and cite the treatment-plan goal it served.
Pitfall: "provided supportive therapy" with nothing specific behind it.

6 – Response and progress did anything change?
Do: in-session response and status against the goal, with scores where used.
Pitfall: a note that never says whether anything changed.

7 – Risk status show monitoring, not absence
Do: a statement either way, even when risk is low.
Pitfall: silence on risk across an entire episode of care.

8 – Plan and signature close the loop, same day
Do: next steps, homework, next appointment; sign with credentials and date.
Pitfall: "continue treatment" plus batch signing; 31 of 216 OIG days lacked signatures.

Before you sign

- ☐ Time recorded: start/stop or total
- ☐ Intervention named, plan goal cited
- ☐ Progress measurable: score or evidence
- ☐ Risk documented either way
- ☐ Note matches the claim: date, code, units
- ☐ Signed with credentials, same day

Drafting with AI

Give it your session bullets or a transcript: time, what you worked on, the client's response, risk, and the plan.

> *"Draft a 90834 session note in DAP format from these bullets: exposure homework done, anxiety 6 to 3 during tasks, GAD-7 8, no SI, next hierarchy step planned: …"*

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

150–350 words	**10–20 min by hand**	**After every session**	**Care team · payers · auditors**
typical length	clinical team estimate	when it's written	who reads it

Full guide, sample, and compliance notes: **bastiongpt.com/template/therapy-session-note** **BastionGPT** drafts session notes for you. Free 7-day trial.

Individual Therapy Session Note Template

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

Client (initials): Date of service: Session #:

Service / CPT code: Setting (office / telehealth):

Start time: Stop time: Total time:

Presentation and symptoms
Client's report: current symptoms, stressors, functioning, change since last session

Mental status observations
Appearance, engagement, speech, affect; session-relevant, not boilerplate

Interventions (technique + plan goal #)
Name the technique and the treatment-plan goal it served

Response and progress
In-session response, movement toward the goal, scores where used

Risk status
A statement either way, even when risk is low

Plan / next steps
Homework, coordination, referrals, what the next session evaluates

Next appointment: Outcome score, if used (e.g., PHQ-9, GAD-7):

Clinician signature / credentials: Date signed:

Supervisor signature, where required: Date: