

# Progress Note Writing Cheat Sheet

Beyond the Mirror Counseling & Wellness

Progress notes are an essential part of ethical, effective clinical care. They help tell the story of the work, support continuity of treatment, and protect both the client and the counselor. A strong progress note reflects not only what was shared, but how the clinician responded skillfully.

Our progress notes include five core components:

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## 1. Subjective

What the client reports

This section reflects the client's internal experience, concerns, and perspective, primarily using their own words.

Includes:

- Client-reported mood, symptoms, or experiences
- Quotes or paraphrased statements
- Changes since the last session (as reported by the client)

Examples:

- Client reports increased anxiety over the past week related to work stress.
  - Client stated, "I feel stuck and overwhelmed, like I can't catch my breath."
  - Client shared feeling more hopeful since the last session.
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## 2. Objective

What the clinician observes

This section includes observable, measurable information noted during the session.

Includes:

- Affect, mood, behavior
- Appearance, engagement, and speech
- Orientation and presentation

Examples:

- Client appeared tearful at times and maintained limited eye contact.
  - Affect congruent with reported mood.
  - Client was alert, oriented, and engaged throughout the session.
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## 3. Therapeutic Techniques / Interventions

What the clinician did

This section documents the clinical skills, interventions, and approaches used during the session.

Includes:

- Modalities or techniques used
- Psychoeducation provided
- Experiential or relational interventions

Examples:

- Therapist provided psychoeducation on nervous system regulation.
  - Used reflective listening and validation to support emotional processing.
  - Guided client through a grounding exercise.
  - Utilized CBT-based reframing to explore cognitive distortions.
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## 4. Assessment

Clinical understanding and progress

This section reflects the clinician's professional assessment of the client's functioning, insight, and progress toward goals.

Includes:

- Progress or barriers related to treatment goals
- Clinical impressions
- Risk assessment (when applicable)

Examples:

- Client demonstrates increased insight into emotional triggers.
- Progress noted toward treatment goals related to emotional regulation.
- Client continues to experience moderate anxiety impacting daily functioning.
- No current safety concerns reported or observed.

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## 5. Plan

What happens next

This section outlines next steps in treatment and ongoing care.

Includes:

- Focus for upcoming sessions
- Homework or between-session practices (if applicable)
- Referrals, coordination, or follow-up plans

Examples:

- Continue weekly therapy focusing on emotional regulation and boundary setting.
- Client will practice grounding techniques between sessions.
- Therapist will follow up on coping strategies discussed.
- Safety plan reviewed and updated as needed.

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## Helpful Reminders

- Notes should be clear, professional, and clinically relevant
- Avoid unnecessary detail; focus on information that supports treatment
- Documentation supports continuity of care and ethical practice
- When unsure, consult with supervision or clinical leadership

# Progress Note Reference Examples

Beyond the Mirror Counseling & Wellness

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## Subjective Information

What the client reports in their own words or perspective

1. Client reports increased anxiety over the past week related to work stress.
  2. Client shared feeling overwhelmed and emotionally exhausted.
  3. Client stated, "I don't feel like myself lately."
  4. Client reports difficulty sleeping and increased rumination at night.
  5. Client described feeling disconnected from others since the last session.
  6. Client reports improved mood following implementation of coping strategies.
  7. Client shared concerns about conflict within a personal relationship.
  8. Client reports decreased appetite and low motivation.
  9. Client stated feeling more hopeful about upcoming changes.
  10. Client reports continued grief related to recent loss.
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## Objective Information

What the clinician observes during the session

1. Client appeared tearful at times during the session.
  2. Affect was congruent with reported mood.
  3. Client maintained limited eye contact throughout the session.
  4. Speech was clear, coherent, and goal-directed.
  5. Client appeared tense, frequently fidgeting in their seat.
  6. Client was alert and oriented to person, place, and time.
  7. Mood appeared anxious with periods of restlessness.
  8. Client was engaged and responsive to therapeutic interventions.
  9. Appearance was appropriate and well-groomed.
  10. Client displayed increased emotional regulation compared to previous sessions.
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## **Therapeutic Techniques / Interventions**

What the clinician did during the session

1. Provided psychoeducation on emotional regulation strategies.
2. Utilized reflective listening to validate client experiences.
3. Guided client through a grounding exercise.
4. Supported identification of cognitive distortions using CBT techniques.
5. Facilitated exploration of relational patterns.
6. Used motivational interviewing to explore ambivalence.
7. Practiced boundary-setting skills through role-play.

8. Integrated mindfulness-based techniques.
  9. Encouraged somatic awareness to support emotional processing.
  10. Provided normalization and validation of client emotions.
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## **Assessment**

Clinical interpretation, progress, and professional judgment

1. Client demonstrates increased insight into emotional triggers.
  2. Progress noted toward treatment goals related to emotional regulation.
  3. Client continues to experience moderate anxiety impacting daily functioning.
  4. Client shows improved ability to identify emotions.
  5. Symptoms remain consistent with previous sessions.
  6. Client appears motivated to engage in treatment.
  7. Ongoing stressors continue to impact mood stability.
  8. No current safety concerns reported or observed.
  9. Client exhibits improved coping skills since beginning treatment.
  10. Client continues to benefit from therapeutic support.
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## **Plan**

Next steps and ongoing treatment direction

1. Continue weekly therapy sessions.
2. Focus next session on emotional regulation skills.
3. Encourage continued practice of grounding techniques between sessions.
4. Review progress toward treatment goals in upcoming sessions.
5. Explore relational dynamics in future sessions.
6. Support development of additional coping strategies.
7. Coordinate care with other providers as needed.
8. Update treatment plan as clinically indicated.
9. Safety plan reviewed and reinforced.
10. Follow up on topics discussed during this session.