

Case Note Structure and Types

(Rev 11/10/06)

The Clinical Information System (CIS) is designed to maintain case notes in a consistent and structured fashion, facilitating compliance with bureaucratic expectations while ensuring that data is readily available for clinicians in a predictable format. Several case note types are used to structure notes according to the type of service that is being provided (ie. Individual Case Notes, CSP Note, Initial Assessment, etc.). When dictating case notes, the following information must be dictated, in this order, prior to dictating the “body” of the note:

Client Name

Client ID

Program Enrollment

Date of Service

Start/Stop Time

Length of Service

Location of Service

If there is any ambiguity, the name of the therapist and supervisor.

Case note type

The following outline defines the case note types, the headings that exist in case notes, and the content that should be included under each of these headings. CIS requires that each heading (numbered items) have some data entered under it. Although each of the sub heading items (lettered or Roman numeral items) should be addressed, they are not required by CIS.

Individual Counseling Note

1. Presentation
 - a. Who was present
 - b. Observation of their general presentation (mood, thought process, behavioral functioning, dangerousness to self or others) and any changes from previous presentation
 - c. New events that they are presenting
 - d. New Stressors
2. Goals Addressed
 - a. What specific treatment goals were addressed in this session?
 - b. Note if goals were modified (ie. new ISP developed).
3. Intervention
 - a. What occurred in the session?
 - b. What specific interventions were used (ie. Cognitive restructuring, processing issues, etc.)
4. Response to Intervention
 - a. How did the client respond to the intervention (ie. Accepted feedback, committed to implementing plan, cried throughout session)

5. Plan
 - a. What homework assignments have been given?
 - b. When will the client be seen again?

CSP Note

1. Presentation
 - a. Format—was it a face-to-face or phone call and with whom
 - b. Who was present
 - c. Observation of their general presentation (mood, thought process, behavioral functioning, dangerousness to self or others) and any changes from previous presentation
 - d. New events that they are presenting
 - e. New Stressors
2. Goals Addressed
 - a. What specific treatment goals were addressed in this session?
3. CSP Activity
 - a. What specific CSP activity took place
 - i. Assessment of Needs
 - ii. Monitoring
 - iii. Eliminating Barriers
 - iv. Coordinating/Linkages
 - v. Crisis Management
 - vi. Advocacy
 - vii. Education/Training
 - viii. Empowerment/Skills Building
4. Interventions
 - a. Describe any specific interventions that took place (ie. Processed feelings, taught client about, etc.)
5. Response to Intervention
 - a. How did the client respond to the intervention (ie. Accepted feedback, committed to implementing plan, cried throughout session)
6. Plan
 - a. What homework assignments have been given?
 - b. When will the client be seen again?

Assessment-Adult

1. Reason for Referral
 - a. Why is this client seeking services now?
 - b. Who sent the client for services?
2. Assessment Procedure
 - a. Who was present for the assessment and during which portions
 - b. Statement that client' rights, policy and procedures, and limits of confidentiality were reviewed.
 - c. What techniques were used (gathered psychosocial history, administered House Tree Person, Bender Gestalt, and WRAT, other sources of data, etc.)

3. Family and Social Information
 - a. Marital Status, history of marriage, number and ages of kids—and with whom, quality of marital relationship
 - b. Current living conditions and household composition
 - c. Family of origin—where born, parent’s names, quality of relationship with parents/step-parents in past and currently, are they a current means of support
 - d. Siblings—number, names, ages, quality of relationship with them now and in past, are they a current means of support
 - e. Primary support system—who, how often contact, number of close friends and how they interact
 - f. Community involvement
 - g. Religious/Spiritual identification and involvement
 - h. Ethnicity and its impact on them now and in the past
 - i. History of legal system involvement—now and in the past, name of Probation/Parole Officer, charges, sanctions, etc.
 - j. Interests and hobbies—how do they spend their free time
4. Educational and Occupational History
 - a. Highest level of education, and if graduated from where
 - i. Any involvement in special education, retentions, GPA
 - ii. Behavioral problems in school
 - iii. Extracurricular activities in school
 - b. Current Occupation, length of employment, and income
 - i. Previous employment—location, length, why ended
 - ii. Military history—branch, type of discharge, length of service, job
 - iii. Other sources of income
5. Victimization History
 - a. Childhood
 - i. Physical
 - ii. Sexual
 - iii. Mental
 - iv. Neglect
 - v. Children Services involvement
 - b. Adult
 - i. Victim of crime
 - ii. Domestic violence/abusive relationships
6. History of Potentially Abusive Behavior
 - a. For each substance, when was the onset of usage, current level of usage, highest usage in the past, the last time it was used, and any history of tolerance or withdrawal
 - i. Alcohol
 - ii. Marijuana
 - iii. Cocaine
 - iv. Depressants
 - v. Amphetamines
 - vi. Hallucinogens
 - vii. Opiates

- viii. Inhalants
 - ix. Other (X, etc.)
 - x. Tobacco
 - xi. Caffeine
 - b. Sexual History
 - i. Number of partners
 - ii. One-night-stands
 - iii. Prostitution
 - c. Pathological gambling
 - d. Abusive eating behavior
 - e. Co-dependency issues
 - f. Substance abuse in the family/significant others
7. Mental Health and Substance Use Treatment History
- a. Previous counseling—name of therapist, location, time frame, issues that were addressed, diagnosis, medications
 - b. Previous hospitalizations—location, time frame, why hospitalized, compliance with follow-up care
 - c. History of bizarre ideation
 - d. History of Suicidal/Homicidal ideation
 - e. Current substance abuse treatment--Number of Outpatient, Residential, and Rehab episodes
 - f. Family mental health history
8. Medical Status
- a. Primary care physician
 - b. Current medical problems
 - c. Current medications
 - d. Activities of daily living (ADL) limitations
 - e. Eating patterns--# meals/day, changes in appetite, weight gain/loss
 - f. Sleeping pattern—difficulties getting to sleep or staying asleep, average # of hours of sleep per 24 hour period of time
 - g. Medical hospitalizations—why, when, how long in
 - h. History of brain trauma—impact
 - i. Developmental problems (language, mobility, social)
 - j. Significant medical problems in the past
 - k. Significant potentially contributing medical difficulties in the extended family system
9. Mental Status Examination
- a. Physical description (height, weight, hair, clothing)
 - b. Presentation (speech pattern, vocabulary, eye contact, approach to assessment, general behavior)
 - c. Thought Content (preoccupations, grandiosity, hostility/aggressiveness, suicidal/homicidal)
 - d. Thought Process (logical, tangential, loose, incoherent, etc.)
 - e. Perceptual issues (delusions, hallucinations)
 - f. Affect including range
 - g. Cognition (estimate of IQ, orientation, remote and recent recall)

- h. Insight and Judgment
- 10. Clinical Formulation
 - a. Synthesis of clinical data (not a summary)—do not present new data in this section
 - b. Provisional diagnosis
- 11. Plan/Recommendations
 - a. What is the tentative treatment plan?
 - b. What data will be sought (ROI's, other testing, etc.)?
 - c. What referrals will be made?
 - d. When will they be seen again?
 - e. Client's response to recommendations/plan

Assessment-Youth

- 1. Reason for Referral
 - a. Why is this client seeking services now?
 - b. Who sent the client for services?
 - c. Current guardian and why if not parents
 - d. Description of problem according to parent/guardian/youth/referral source
- 2. Assessment Procedure
 - a. Who was present for the assessment and during which portions
 - b. Statement that client' rights, policy and procedures, and limits of confidentiality were reviewed.
 - c. What techniques were used (gathered psychosocial history, administered House Tree Person, Bender Gestalt, and WRAT, other sources of data, etc.)
- 3. Family and Social Information
 - a. Family of origin—where born, parent's names, quality of relationship with parents/step-parents in past and currently, are they a current means of support, what do the parents do for a living
 - b. Placement history—where has the youth lived, with whom, and why did each placement change
 - c. Current living arrangements—who is in the home, how do they get along, does the youth like the current living arrangements
 - d. Siblings—number, names, ages, quality of relationship with them now and in past, are they a current means of support
 - e. Primary support system—who, how often contact, number of close friends and how they interact
 - f. Community involvement
 - g. Religious/Spiritual identification and involvement
 - h. Ethnicity and its impact on them now and in the past
 - i. History of legal system involvement—now and in the past, name of Probation/Parole Officer, charges, sanctions, etc.
 - j. Interests and hobbies—how do they spend their free time
- 4. Educational and Occupational History
 - a. Highest level of education, and if graduated from where
 - i. Any involvement in special education, retentions, GPA, proficiency testing

- ii. Behavioral problems in school
 - iii. Extracurricular activities in school
 - b. Current Occupation, length of employment, and income
 - i. Previous employment—location, length, why ended
 - ii. Other sources of income
- 5. Victimization History
 - i. Physical
 - ii. Sexual
 - iii. Mental
 - iv. Neglect
 - v. Children Services involvement
- 6. History of Potentially Abusive Behavior
 - a. For each substance, when was the onset of usage, current level of usage, highest usage in the past, the last time it was used, and any history of tolerance or withdrawal
 - i. Alcohol
 - ii. Marijuana
 - iii. Cocaine
 - iv. Depressants
 - v. Amphetamines
 - vi. Hallucinogens
 - vii. Opiates
 - viii. Inhalants
 - ix. Other (X, etc.)
 - x. Tobacco
 - xi. Caffeine
 - b. Sexual History
 - i. Number of partners with age differences
 - ii. One-night-stands
 - iii. Prostitution
 - c. Pathological gambling
 - d. Abusive eating behavior
 - e. Co-dependency issues
 - f. Substance abuse in the family/significant others
- 7. Mental Health and Substance Use Treatment History
 - a. Previous counseling—name of therapist, location, time frame, issues that were addressed, diagnosis, medications
 - b. Previous hospitalizations—location, time frame, why hospitalized, compliance with follow-up care
 - c. History of bizarre ideation
 - d. History of Suicidal/Homicidal ideation
 - e. Current substance abuse treatment--Number of Outpatient, Residential, and Rehab episodes
 - f. Family mental health history
- 8. Medical Status
 - a. Primary care physician

- b. Current medical problems
 - c. Current medications
 - d. Activities of daily living (ADL) limitations
 - e. Eating patterns--# meals/day, changes in appetite, weight gain/loss
 - f. Sleeping pattern—difficulties getting to sleep or staying asleep, average # of hours of sleep per 24 hour period of time, nightmares/terrors, sleep walking
 - g. Medical hospitalizations—why, when, how long in
 - h. History of brain trauma—impact
 - i. Developmental problems (language, mobility, social)
 - j. Significant medical problems in the past
 - k. Significant potentially contributing medical difficulties in the extended family system
9. Mental Status Examination
- a. Physical description (height, weight, hair, clothing)
 - b. Presentation (speech pattern, vocabulary, eye contact, approach to assessment, general behavior)
 - c. Thought Content (preoccupations, grandiosity, hostility/aggressiveness, suicidal/homicidal)
 - d. Thought Process (logical, tangential, loose, incoherent, etc.)
 - e. Perceptual issues (delusions, hallucinations)
 - f. Affect including range
 - g. Cognition (estimate of IQ, orientation, remote and recent recall)
 - h. Insight and Judgment
10. Clinical Formulation
- a. Synthesis of clinical data (not a summary)—do not present new data in this section
 - b. Provisional diagnosis
11. Plan/Recommendations
- a. What is the tentative treatment plan?
 - b. What data will be sought (ROI's, other testing, etc.)?
 - c. What referrals will be made?
 - d. When will they be seen again?
 - e. Client's response to recommendations/plan

Psychiatric Intake

- 1. Chief Complaint
 - a. Why referred
 - b. Primary concerns presented
- 2. Mania evaluation
- 3. Depression Evaluation
- 4. History of Present Illness
- 5. Social History
- 6. Past Psychiatric History
- 7. Family Psychiatric History

8. Drugs and Alcohol
 - a. Past
 - b. Present
9. Medical History
 - a. Current medications
10. Allergies
11. Victimization History
12. Mental Status Examination
 - a. Appearance
 - b. Speech/Communication
 - c. Mood/Affect
 - d. Perception
 - e. Ideation
 - f. Motor Activity
 - g. Attitude
 - h. Orientation
 - i. Memory
 - j. Proverbs
 - k. Intellect
 - l. Judgment
 - m. Insight
13. Diagnosis (all 5 Axis)
14. Plan
 - a. Medications prescribed
 - b. Lab tests ordered
 - c. Explained rationale for medications choices and discussed possible risks, benefits, and alternative treatment with the client
 - d. Follow-up plan
15. Client/Guardian response to plan

Psychiatric Note

1. Presentation
 - a. Appearance/Demeanor/Activity/Speech
 - b. Thought Process
 - c. Thought Content
 - d. Perception
 - e. Mood/Affect
 - f. Suicidal/homicidal Ideation
 - g. Behavior
 - h. Cognition
 - i. Insight/Judgment
 - j. Other

2. Interim History
 - a. Lab test reviews
 - b. Side effects noted
 - c. Response to medications
 - d. Impact of intervention on symptoms
 - e. Changes in diagnosis and why
3. Plan
 - a. Changes in medication
 - b. Lab tests ordered
 - c. Explained rationale for medications choices and discussed possible risks, benefits, and alternative treatment with the client
 - d. Clients response to plan
 - e. Follow-up plan

Group Note

1. Group Name
2. General Description of Group Activities
 - a. How many present
 - b. What occurred during the session
3. Presentation
 - a. What was this person's presentation
 - b. Any new concerns raised
 - c. Progress on homework
4. Individual Goals Addressed
 - a. What were the goals that this client addressed in this group?
5. Specific Interventions with Client
 - a. What specific interventions were used with this particular client (ie. Confrontation, processing, reviewing homework, etc.)
6. Response to Intervention
7. Plan

Other Note

This note is a “free form” note that does not have any structure. This should be used for non-billable activities or cancelled/no-show appointments that need to be documented in the client's record. This note type can also be used when the only activity that occurred was testing (for example, when someone administers IQ testing for another clinician's client)—however, when used for testing, the client's presentation, response to testing, and a summary of the outcome of the testing should be included in the note.