Case Note Structure and Types

(Rev 05/10/2010)

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.).

Case notes can be generated in one of three ways: CIS Self-Write, CIS Dictate, and e-Scribe. With CIS Self-Write, you will enter all of the information directly into CIS, either by typing the data directly in CSI or using Dragon Naturally Speaking. With CIS Dictate, you will enter some core information into CIS, and then will use CIS to dictate the note using the structure outlined below. At this time, CIS Dictate is to only be used with intake notes unless you have received express permission otherwise. In rare cases (when you have been pre approved to do so), you may use either e-Dictate or a tape to dictate a note. In all cases, the following information will be needed prior to initiating the note and will either be entered in this order or dictated in this order before dictating the "body" of the note:

Client Name
Client ID
Program Enrollment
Date of Service
Type of Service
Location of Service
Start/Stop Time
Length of Service
Primary Therapist
Secondary Therapist
Type of Case Note (it must be one of the types listed below)

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) and/or need to be modified.
3. Intervention
    a. What occurred in the session?
    b. What specific interventions were used (ie. Cognitive restructuring, processing issues, etc.)
4. Response to Intervention/Progress
    a. How did the client respond to the intervention (ie. Accepted feedback, committed to implementing plan, cried throughout session)
    b. What progress has been made since the initiation of treatment and/or since the last 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/Progress
    a. How did the client respond to the intervention (ie. Accepted feedback, committed to implementing plan, cried throughout session)
    b. What progress has been made since the initiation of treatment and/or since the last 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

Diagnostic Assessment Extension (only to be used within 30 days/4 sessions of intake)

1. Purpose
   a. Why was the assessment extended?
   b. What was done during this session?
2. Presentation
   a. Appearance
   b. Ability to engage in the assessment activity
   c. Who was present for what part of the assessment
3. Assessment Activities (up to 2 sections)
   a. What assessment activities were done and were they done according to standard protocol (or deviated from standard procedure).
   b. What were the results
4. Plan
   a. What will happen next?

Evaluation

1. Reason for Referral
   a. Who referred the person for the evaluation
   b. What conditions led to the referral
   c. What are the questions to be addressed in the evaluation?
2. Evaluation Procedure
   a. Note Client Rights and Policy and Procedures were reviewed
   b. What specifically occurred during the evaluation
   c. Who was present for what sections of the evaluation
3. 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
4. Plan
   a. What additional techniques will be done
   b. What will happen next

MFCA

1. Reason for Referral
   a. Why is this client seeking services now?
   b. Who sent the client for services?
2. Assessment Procedure
   d. Who was present for the assessment and during which portions
   e. Statement that client' rights, policy and procedures, and limits of confidentiality were reviewed.
   f. 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 History
   a. Highest level of education, and if graduated from where
   b. Any involvement in special education, retentions, GPA
   c. Behavioral problems in school
   d. Extracurricular activities in school
5. Occupational History
   a. Current Occupation, length of employment, and income
   b. Previous employment—location, length, why ended
   c. Military history—branch, type of discharge, length of service, job
   d. Other sources of income
6. 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

7. 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
8. 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
9. 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
10. 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
11. Daily Functioning
   a. What activities does the person do from the beginning of the day to the end of the day for a typical day
   b. What supports do they use to engage in these activities
   c. Where do these activities occur
   d. In what ways are these daily activities like work activities.
12. Test Results
   a. Intelligence testing
   b. Achievement testing
   c. Projective testing
   d. Objective testing
   e. Adaptive measures
13. Clinical Formulation
   a. Synthesis of clinical data (not a summary)—do not present new data in this section
   b. Provisional diagnosis
14. Conclusion/Recommendations
   a. Statement as to whether the individual is capable of obtaining/maintaining employment
   b. Statement as to whether the person, if they are unable to work, when they will likely be able to work
   c. What is the tentative treatment plan—what services are recommended to maximize their ability to work?

Psychiatric Intake

1. Reason for Referral
   a. Brief description of client (ie. 35 year old Caucasian male)
   b. Who referred?
   c. Why referred?
   d. Other noteworthy information about referral (ie. noted history of substance abuse, previous client of agency, etc.)
2. Presenting Psychiatric Problem
   Chief Complaint—Why is the client seeking services at this time in their words.

3. History of Present Illness
   a. Age/nature of onset of symptoms
   b. Developmental Issues
   c. History of Hospitalization
   d. History of Outpatient Treatment
   e. History of substance abuse
   f. History of mental illness in extended family
   g. History of medications and efficacy/side effects of the medications
   h. Current Medications
4. Health History
   a. Allergies, including reactions
   b. History of medical hospitalizations
   c. History of surgeries
   d. History of brain injury
   e. Current physical presentation
   f. Vitals (if taken)
5. Mental Status Examination
   a. General observations (Appearance, Build, Demeanor, Eye Contact, Activity, Speech)
   b. Thought Content (Delusions, Self Abuse, Aggressiveness)
   c. Perception (Hallucinations, Illusions)
   d. Thought Process
   e. Mood
   f. Affect
   g. Behavior
   h. Cognition
   i. Other
6. Diagnosis (should match ISP)
   All 5 Axis
7. Medications Prescribed
   a. Name
   b. Dosage/Route/Frequency
   c. Amount/Refills
   d. Rationale for giving medication

8. Explanation Given to Client
    a. "The rational for medication choices was provided to the client and a discussion about the possible risks, benefits, and alternative treatments occurred with the client/guardian"
    b Describe how the client/guardian responded to the above education such as:
        i. Understood Information
        ii. Does not understand
        iii. Agrees with Medication
        iv. Refuses Medication
    c. Other
9. Laboratory Tests Ordered
    a. Name of test
    b. Where it will be done
10. Follow Up Plan
    a. Referrals
    b. Future Labs
    c. Medical Strategies/Recommendations
    d. Next Visit

Psychiatric Progress Note

1. Interim History
    a. Review client's condition/ Overall functioning since last seen
    b. Review of medications taken, including pertaining to physical health
    c. Effectiveness/side effects of current medications
    d. Substance Abuse
    e. Change in health (include pregnancy/lactation status)
    f. Client's assessment of progress related to symptoms
    g. Vitals (if taken)

2. Mental Status
    a. Appearance/Demeanor/Activity/Speech
    b. Thought Process
    c. Thought Content
    d. Perception
    e. Mood/Affect
    f. Suicidal/Homicidal Ideation (assess lethality if thoughts)
    g. Behavior
    h. Cognition
    i. Insight/Judgment
    j. Other

3. Side Effects/Symptoms
    List all or note if none present/reported from current medications

4. Intervention
    a. What interventions were provided
    b. Client's response to the intervention
    c. Progress towards goals/objectives

5. Medications Prescribed
    a. Name
    b. Dosage/Route/Frequency
    c. Amount/Refills
    d. Rationale for giving medication

6. Explanation Given to Client
    a. "The rational for medication choices was provided to the client and a discussion about the possible risks, benefits, and alternative treatments occurred with the client/guardian"
    b. Describe how the client/guardian responded to the above education such as:
        Understood Information
        Does not understand
        Agrees with Medication
        Refuses Medication
    c. Other

7. Laboratory Tests Ordered
    a. Name of test
    b. Where it will be done

8. Follow Up Plan
    a. Referrals
    b. Future Labs
    c. Medical Strategies/Recommendations
    d. Next Visit

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 where 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.

Other Note—Long

This is like the "Other Note" but is to be used when you anticipate needing more than 8,000 characters (approximately 2 ½ pages).