SAMPLE CLINICAL DOCUMENTATION

Progress Note - Crisis

Case Snapshot

Client: Adolescent/Young Adult
Presenting Problem / Chief Complaint: Client reports severe depressive symptoms, hopelessness, and suicidal thoughts, stating, “I still feel like there’s no point to keep living.”
Context: Client has a recent history of suicide attempts (most recent 3 months ago), has access to means (insulin), and is experiencing a major life stressor (job loss) that exacerbates suicidal ideation. Symptoms significantly interfere with employment, social relationships, and daily functioning.

Info

Present at Session	*Client*
Service Provided	*Individual Therapy*
Location of Service	*Telehealth*
The client agreed for this visit to occur via telehealth. The client's full name and address of present location has been confirmed at the start of the session:	☑ *Yes – client at home* ☐ *Yes – client in another location, which has been confirmed* ☐ *No*
Is the client presenting any risk factors that indicate further risk assessment is needed?	*Yes*

Measures

Baseline Scores (at intake)	• *PHQ-9: 18 (moderately severe depression)* • *GAD-7: 12 (moderate anxiety)* • *C-SSRS: 4 (suicidal ideation with some intent)*
Current Scores (this session)	• *PHQ-9: 22 (severe depression - significant worsening)* • *GAD-7: 16 (severe anxiety - worsening due to crisis)*

	• *C-SSRS: 5 (active suicidal ideation with intent and plan - crisis level)*
Dropdown / How measures were used in-session:	• *Reviewed scores with the client* • *Drew clinical insights from the data* • *Made treatment adjustments based on measure results* • *Discussed client's perception of progress and scores*
Additional detail on in-session use of measures:	*While ongoing measures were not completed for this session, the C-SSRS (Columbia Suicide Severity Rating Scale) was used to assess suicidal risk in real time. Risk assessment guided immediate intervention including contacting emergency contacts, securing means, and facilitating voluntary hospital evaluation. Clinical decision-making was informed by both current symptom severity and prior history of attempts, ensuring alignment with crisis safety protocols.*

Symptoms

Current Symptoms	*Hopelessness, depression, suicidal ideation. Impaired ability to maintain work, relationships, and basic self-care*
Area(s) of functional impairment	*Social/Relational. Activities of Daily Living. Work.*
How are symptoms specifically impacting clients functioning in this area?	*Conflict and stress within family, reduced engagement with peers. Unable to maintain employment due to depressive symptoms. Inconsistent self-care, lack of basic functioning..*
Focus of session/session summary	*Client presented with severe depressive symptoms and active suicidal ideation following job loss. After leaving a prior session abruptly, therapist initiated outreach and contacted client's mother per safety plan to ensure safety and secure means. Client later re-engaged and endorsed passive suicidality. A C-SSRS risk assessment was conducted, safety plan reviewed, and coordination made for voluntary hospital evaluation. Therapist maintained contact until client confirmed safe arrival at the hospital. Client and mother participated cooperatively in the safety process. Crisis intervention goals were met through de-escalation, stabilization, and linkage to a higher level of care. No immediate safety concerns following hospitalization.*

Treatment

Treatment approaches used for this session (*ie CBT, DBT, EMDR. etc)*	*Crisis intervention*
Specific Interventions	*C-SSRS assessment, review and reinforcement of safety plan, coordination of voluntary hospital evaluation, and collateral communication with hospital intake staff.*
Clients response to interventions	*Client ultimately agreed to voluntary hospitalization. Mother actively participated in securing means and supporting client's engagement in safety plan.*
Plan/homework for next session	*Follow directives of hospital staff and enroll in recommended IOP program. Utilize safety plan if discharged prior to next session. Therapist to follow up post-discharge to coordinate ongoing care.*
Progress towards treatment goals	☐ *No change since last visit* ☐ *Some progress apparent* ☐ *Significant Progress* ☐ *Maintaining/stable* ☑ *Some regression of progress* ☐ *Significant regression of progress*

Diagnosis

Diagnosis	*F33.2 Major Depressive Disorder, recurrent, severe, without psychotic features* *F60.3 Borderline personality disorder*
Date of Service	*06/21/2024*
Session Start Time	*2:05pm*
Session End Time	*3:15pm*
Session Length / CPT	☑ *90839 - Crisis intervention, 30-74 min*

Be sure to review treatment plan if necessary before signing and submitting the note

Signature

Provider Name	*Jane Example*
Date	*6/22/2024*

Time	*8:00am*
License Type	*LCSW*