

Group Psychotherapy Progress Note

The Group Psychotherapy Progress Note is used for billable outpatient psychotherapy groups. Use the Intensive Services Progress Note form to document other groups offered as part of programs such as Partial Hospitalization (PHP), Community Based Adolescent Treatment (CBAT) and Transitional Support Services (TSS).

Data Field	Identifying Information Instructions
Person's Name	Record the first name, last name, and middle initial of the person being served. Order of name is at agency discretion.
Record Number	Record your agency's established identification number for the person.
Person's DOB	Record the person's date of birth to serve as another identifier.
Organization Name:	Record the organization for whom you are delivering the service.
Group Name	Give the name of the specific group. Example: Anger Management.
Number of Attendees	Enter the number of persons attending the group on this date.
Person Served Did Not Attend	Indicate the reason the person served did not attend the group session.
Data Field	Documentation of Person's Served Participation and Response to Group Treatment
Behavior in Group	Check box(es) to document the person's observed behavior during the group session.
Person's Served Mood	Check box(es) to document the person's observed or reported mood during the group session.
Stressors/Extraordinary Events/New Issues Presented Today	There are four options available for staff using this section of the progress note: 1. If person does not report/present any new issues, mark "None Reported" and proceed to planned intervention/goals. 2. If person reports a new issue that was resolved during the session check the "New Issue resolved, no CA Update required" box. Briefly document the new issue, identify the interventions used in the Therapeutic Interventions section and indicate the resolution in the Response section of the progress note. If services are provided during the session that have not been previously ordered in the Individualized Action plan, then an explanation of the rationale for those services should be provided. 3. If person presents an issue that has been previously assessed and for which Goals/Objectives and services have been ordered, then the information may be briefly documented as an indicator of the progress or lack of progress achieved. 4. If person presents any new issue(s) that represent a therapeutic need that is not already being addressed in the IAP, check box indicating a "CA Update Required" and record notation that new issue has been recorded on a Comprehensive Assessment Update of the same Date and write detailed narrative on the appropriate CA Update as instructed in this manual. Also, the newly assessed therapeutic information may require a new goal, objective, therapeutic intervention or service that will require further use of the IAP Review/Revision form. Example: Person became uncharacteristically angry with another group member during the group session and the two began arguing loudly. Group therapist intervened and assisted person with identifying what had triggered excessive anger today. Person was able to recognize that the other group member reminded her of her abusive uncle and apologized to the other member. Example of New Issue needing CA Update: The person reported new symptoms of nightmares, intrusive memories, and

Group Therapy Notes Examples

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Table of Contents Group Therapy Notes Examples

1. Understanding the eBook Group Therapy Notes Examples
 - The Rise of Digital Reading Group Therapy Notes Examples
 - Advantages of eBooks Over Traditional Books
2. Identifying Group Therapy Notes Examples
 - Exploring Different Genres
 - Considering Fiction vs. Non-Fiction
 - Determining Your Reading Goals
3. Choosing the Right eBook Platform
 - Popular eBook Platforms
 - Features to Look for in an eBook Platform
 - User-Friendly Interface
4. Exploring eBook Recommendations from Group Therapy Notes Examples
 - Personalized Recommendations
 - Group Therapy Notes Examples User Reviews and Ratings
 - Group Therapy Notes Examples and Bestseller Lists

5. Accessing Group Therapy Notes Examples Free and Paid eBooks
 - Group Therapy Notes Examples Public Domain eBooks
 - Group Therapy Notes Examples eBook Subscription Services
 - Group Therapy Notes Examples Budget-Friendly Options
6. Navigating Group Therapy Notes Examples eBook Formats
 - ePub, PDF, MOBI, and More
 - Group Therapy Notes Examples Compatibility with Devices
 - Group Therapy Notes Examples Enhanced eBook Features
7. Enhancing Your Reading Experience
 - Adjustable Fonts and Text Sizes of Group Therapy Notes Examples
 - Highlighting and Note-Taking Group Therapy Notes Examples
 - Interactive Elements Group Therapy Notes Examples
8. Staying Engaged with Group Therapy Notes Examples
 - Joining Online Reading Communities
 - Participating in Virtual Book Clubs
 - Following Authors and Publishers Group Therapy Notes Examples
9. Balancing eBooks and Physical Books Group Therapy Notes Examples
 - Benefits of a Digital Library
 - Creating a Diverse Reading Collection Group Therapy Notes Examples
10. Overcoming Reading Challenges
 - Dealing with Digital Eye Strain
 - Minimizing Distractions
 - Managing Screen Time
11. Cultivating a Reading Routine Group Therapy Notes Examples
 - Setting Reading Goals Group Therapy Notes Examples
 - Carving Out Dedicated Reading Time
12. Sourcing Reliable Information of Group Therapy Notes Examples
 - Fact-Checking eBook Content of Group Therapy Notes Examples
 - Distinguishing Credible Sources
13. Promoting Lifelong Learning

- Utilizing eBooks for Skill Development
- Exploring Educational eBooks

14. Embracing eBook Trends

- Integration of Multimedia Elements
- Interactive and Gamified eBooks

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