FREE CLINICAL DOCUMENTATION TEMPLATE PACK

Progress notes templates & examples

Five ready-to-use progress note formats — SOAP, DAP, BIRP, GIRP and PIE — with three filled therapy and nursing examples, a required-element checklist, and step-by-step writing guidance.

SOAP | DAP | BIRP | GIRP | PIE | 3 filled examples | Print or use in your EHR

What is inside

Which format should you pick?

SOAP suits any specialty and is the format payers see most often.

DAP is a shorter behavioral health option.

BIRP fits therapy and counseling, where behavior is the anchor.

GIRP fits goal-driven treatment plans.

PIE fits nursing and allied health.

Who it is for

Therapists, counselors, psychiatrists, nurses, and allied health practitioners who document billable encounters.

How to use these templates

Pick one format for your practice and stay with it. Consistency shortens staff training and makes audits easier to answer.

Printing

Print the format you chose single-sided on Letter or A4 paper. Each blank template is one page, so one sheet covers one encounter.

In your EHR

Copy each section heading and its prompt into a custom form or note template. The prompts become field labels.

This pack is a documentation aid, not legal or clinical advice. Check your payer contracts, state licensing board rules, and internal policy before you adopt a format.

Required-element checklist

Run this checklist before you sign any note. A missing element is the most common reason a payer denies an otherwise valid claim.

- [ ] **Date and time of service** — when the encounter happened.
- [ ] **Duration** — minutes of direct service, matching the code you bill.
- [ ] **Type of service** — individual therapy, group, evaluation, nursing assessment.
- [ ] **Place of service** — in person or telehealth, flagged for the claim.
- [ ] **Presenting concerns** — what the client brought to the session, in their words where you can.
- [ ] **Client status** — mood, affect, cognition, and behavioral observations.
- [ ] **Interventions delivered** — the specific technique or procedure, named.
- [ ] **Client response** — engagement, progress, or barriers you observed.
- [ ] **Risk assessment** — screening result and any safety planning, even when nothing is flagged.
- [ ] **Plan and next steps** — next appointment, homework, referrals, or medication changes.
- [ ] **Signature and credentials** — handwritten or electronic. The note is incomplete without it.

Choosing a format

Format	Structure	Best for
SOAP	Subjective, Objective, Assessment, Plan	Any specialty; the most widely accepted format
DAP	Data, Assessment, Plan	Behavioral health teams who find SOAP verbose
BIRP	Behavior, Intervention, Response, Plan	Therapy and counseling; behavior-focused work
GIRP	Goal, Intervention, Response, Plan	Goal-driven treatment plans and progress tracking
PIE	Problem, Intervention, Evaluation	Nursing and allied health

Writing the note, step by step

Most notes take 8 to 15 minutes once the structure is fixed. Work in this order and the note fills itself.

1. **Open the note straight after the session.** Document within 24 hours, while the detail is fresh. Fill the header first: date, time, duration, service type, and place of service.
2. **Record the presenting concern.** Write what the client came to address today. Quote them where the wording matters.
3. **Describe what you did.** Name the intervention. "Taught box breathing for acute panic" beats "did therapy".
4. **Note the response.** Record observable behavior and reported change, not your assumptions about motive.
5. **Screen for risk.** Document the screening result either way. "No suicidal or homicidal ideation expressed" is a finding.
6. **Set the plan.** Next appointment date, homework, referral, lab order, or medication adjustment.
7. **Sign it.** Add your name, credentials, and the date you wrote the note.

Six mistakes payers look for

Mistake	What it looks like	Write this instead
Vague language	"Client doing better."	"Client reports anxiety down from 8/10 to 5/10 this week."
Copy-paste notes	Last week's note with the date changed.	New observations for this session, in this session's words.
No risk screening	The risk line is left blank.	"No suicidal or homicidal ideation expressed."
Late entries	A note written weeks later, dated as if same-day.	"Late entry: session held 2026-08-24, documented 2026-08-27."
Over-documentation	A paragraph for every section.	Two to four sentences per section, specific and clinical.
Opinion as fact	"Client is manipulative."	"Client gave two different accounts of the same event."

Duration has to match the code

A session billed as 60 minutes of individual therapy needs a note showing 60 minutes of direct service. When the times disagree, the claim is the part that gets reviewed.

SOAP progress note

Subjective, Objective, Assessment, Plan. Use for any specialty.

CLIENT NAME / ID

DATE OF BIRTH

RECORD NUMBER

DATE OF SERVICE

START / END TIME

DURATION (MINUTES)

SERVICE TYPE

PLACE OF SERVICE

CLINICIAN

S Subjective

What the client reports

Presenting concern, symptoms, changes since last session, quotes where the wording matters.

O Objective

What you observed or measured

Appearance, mood and affect, cognition, engagement, test scores, vitals.

A Assessment

Your clinical interpretation

Working diagnosis, progress toward goals, response to treatment, risk level.

P Plan

What happens next

Next appointment, homework, referrals, medication changes, review point.

RISK SCREENING RESULT

NEXT APPOINTMENT

CLINICIAN SIGNATURE AND CREDENTIALS

DATE SIGNED

DAP progress note

Data, Assessment, Plan. A shorter behavioral health format.

CLIENT NAME / ID

DATE OF BIRTH

RECORD NUMBER

DATE OF SERVICE

START / END TIME

DURATION (MINUTES)

SERVICE TYPE

PLACE OF SERVICE

CLINICIAN

D Data

Reported and observed, together

What the client said, what you saw, and what you delivered in the session.

A Assessment

What the data means

Clinical impression, progress against treatment goals, barriers, risk level.

P Plan

What happens next

Next session focus, homework, referrals, coordination with other providers.

RISK SCREENING RESULT

NEXT APPOINTMENT

CLINICIAN SIGNATURE AND CREDENTIALS

DATE SIGNED

BIRP progress note

Behavior, Intervention, Response, Plan. Common in therapy and counseling.

CLIENT NAME / ID

DATE OF BIRTH

RECORD NUMBER

DATE OF SERVICE

START / END TIME

DURATION (MINUTES)

SERVICE TYPE

PLACE OF SERVICE

CLINICIAN

B Behavior

Reported and observed behavior

Presenting behavior this session, symptom frequency or intensity, direct quotes.

I Intervention

What you did about it

Named technique or modality, and the treatment goal it serves.

R Response

How the client responded

Engagement, skill uptake, resistance, in-session change, homework follow-through.

P Plan

What happens next

Next session focus, between-session practice, referrals, review point.

RISK SCREENING RESULT

NEXT APPOINTMENT

CLINICIAN SIGNATURE AND CREDENTIALS

DATE SIGNED

GIRP progress note

Goal, Intervention, Response, Plan. Built around the treatment plan.

CLIENT NAME / ID

DATE OF BIRTH

RECORD NUMBER

DATE OF SERVICE

START / END TIME

DURATION (MINUTES)

SERVICE TYPE

PLACE OF SERVICE

CLINICIAN

G Goal

The treatment plan objective worked on today

Quote the goal from the treatment plan, with its target and review date.

I Intervention

What you did toward that goal

Named technique, exercise, or coordination activity delivered this session.

R Response

Movement toward the goal

Measured or observed change, client-reported change, remaining barriers.

P Plan

Next step on this goal

Keep, revise, or close the goal, and the next action with a date.

GOAL STATUS

RISK SCREENING RESULT

NEXT APPOINTMENT

CLINICIAN SIGNATURE AND CREDENTIALS

DATE SIGNED

PIE progress note

Problem, Intervention, Evaluation. Standard in nursing and allied health.

PATIENT NAME / ID

DATE OF BIRTH

RECORD NUMBER

DATE OF SERVICE

START / END TIME

DURATION (MINUTES)

SERVICE TYPE

PLACE OF SERVICE

PRACTITIONER

P Problem

The issue being addressed

Number each problem, and note the relevant assessment findings or vitals.

I Intervention

Care delivered for that problem

Assessments, treatments, medications given, education, escalation.

E Evaluation

Outcome of the intervention

Measured response, whether the problem is resolving, and any change to the care plan.

PROBLEM STATUS

ESCALATED TO

NEXT REVIEW

PRACTITIONER SIGNATURE AND CREDENTIALS

DATE SIGNED

Filled example: therapy session, SOAP

Fictional client. Written the way a payer expects to read it.

Client: A. Rivera (ID 40219) • Clinician: J. Okoro, LCSW

Date of service 2026-08-24 • 14:00—14:50 • Duration 50 minutes • Individual therapy • In person

S Subjective

Client reports ongoing anxiety about work presentations. States, "I know it is irrational, but I catastrophize about being judged."

Rates anxiety 6/10 this week, down from 8/10. Sleep improved on the routine agreed last session, now around seven hours a night. Denies suicidal ideation.

O Objective

Alert and oriented. Mood anxious, affect congruent and reactive. Good eye contact, speech normal in rate and volume.

Brought the completed thought-distortion worksheet from last session. Engaged actively in cognitive restructuring for the full session. GAD-7 today 11, down from 15 on 2026-08-03.

A Assessment

Generalized anxiety disorder with a performance trigger. Responding to cognitive behavioral intervention, with the GAD-7 drop supporting the client's own report.

Insight into automatic thoughts is improving. Avoidance of speaking situations remains the main barrier. No safety concerns identified.

P Plan

Continue weekly individual therapy. Client to restructure one work-related thought daily and log the outcome.

Next session begins graded exposure, starting with a two-minute update to her own team. Re-administer the GAD-7 in four weeks. Consider a group exposure referral if avoidance holds.

RISK SCREENING RESULT

No suicidal or homicidal ideation. No self-harm. Safety plan reviewed and unchanged.

NEXT APPOINTMENT

2026-08-31, 14:00, individual therapy, 50 minutes.

Signed J. Okoro, LCSW, 2026-08-24.

Filled example: therapy session, BIRP

The same kind of encounter, structured around behavior instead of report.

Client: M. Bassey (ID 40544) • Clinician: L. Hartley, LPC

Date of service 2026-08-24 • 10:00—10:45 • Duration 45 minutes • Individual therapy • Telehealth, video

B Behavior

Client describes three panic episodes this week, down from five last week. Each lasted under ten minutes.

Reports leaving a grocery store mid-shop on Tuesday. On video the client was visibly restless, shifting position and speaking quickly for the first ten minutes.

I Intervention

Reviewed the panic cycle diagram against Tuesday's episode. Practiced paced breathing at six breaths per minute for four minutes in session.

Built an interoceptive exposure hierarchy targeting the avoidance goal in the treatment plan.

R Response

Client followed the breathing exercise without prompting and reported anxiety falling from 7/10 to 4/10 by the end of it.

Named her own catastrophic prediction before the clinician did, which is new. Agreed to the first two hierarchy steps, and pushed back on step three as too fast.

P Plan

Continue weekly therapy by video. Client to practice paced breathing twice daily and log panic episodes with duration and setting.

Attempt hierarchy steps one and two before the next session. Revisit step three once step two is comfortable.

RISK SCREENING RESULT

No suicidal or homicidal ideation. No substance use reported this week.

NEXT APPOINTMENT

2026-08-31, 10:00, telehealth, 45 minutes.

Telehealth note: client joined from home, consent to video confirmed, connection stable throughout. Signed L. Hartley, LPC, 2026-08-24.

Filled example: nursing visit, PIE

Post-operative review, day two after knee arthroscopy.

Patient: D. Whitfield (ID 88104) • Practitioner: S. Adeyemi, RN

Date of service 2026-08-24 • 09:30—10:00 • Duration 30 minutes • Post-operative assessment • In person

P Problem

Problem 1 — post-operative pain. Patient rates pain 4/10 at rest and 6/10 on movement, day two after right knee arthroscopy.

Problem 2 — wound integrity. Surgical site requires review for signs of infection. Temperature 36.8 °C, pulse 74, blood pressure 122/78.

Problem 3 — reduced range of motion. Right knee flexion measured at 70 degrees, against a 90-degree target for day seven.

I Intervention

Assessed the surgical site. Dressing clean, dry and intact, with no erythema, discharge, or odor. Redressed using aseptic technique.

Reviewed the analgesia schedule and the 20-minute ice protocol with the patient. Elevated the limb on two pillows.

Supervised ankle circles and quadriceps sets, ten repetitions each. Provided written warning signs for infection and deep vein thrombosis.

E Evaluation

Pain fell to 2/10 after elevation and ice. Wound healing as expected, with no infection markers present.

Knee flexion improved to 78 degrees after the exercises, so the day-seven target remains realistic. Patient repeated the warning signs back correctly.

Problems 1 and 2 are resolving and stay open for review. Problem 3 continues under the physical therapy plan.

PROBLEM STATUS

1 and 2 improving, 3 ongoing.

ESCALATED TO

None required this visit.

NEXT REVIEW

2026-08-27, home visit.

Signed S. Adeyemi, RN, 2026-08-24.