B.I.R.P. Progress Note Checklist

B ***Behavior*** ***Counselor observation, client statements.***	***Check if Addressed***
1. Subjective data about the client—what are the client's observations, thoughts, direct quotes?	
2. Objective data about the client—what does the counselor observe during the session (affect, mood, appearance)?	
I ***Intervention*** ***Counselor's methods used to address goals and objectives, observation, client statements.***	
3. What is the counselor's understanding about the problem?	
4. What are the counselors' working hypotheses?	
5. What was the general content and process of the session?	
6. Was homework reviewed (e.g., journal, reading assignments – if any)?	
7. What goals, objectives were addressed this session?	
R ***Response*** ***Client's* response to intervention and progress made toward tx plan goals and objectives**	
8. Client's response to the treatment plan, what needs revision?	
9. What is the client's current response to the treatment plan?	
P ***Plan*** ***Document what is going to happen next***	
10. What in the treatment plan needs revision?	
11. What is the counselor going to do next?	
12. When is the next session date?	
General Checklist	
13. Does this note connect to the client's individualized treatment plan?	
14. Are client strengths/limitations in achieving goals noted and considered?	
15. Is this note dated, signed, and legible?	
16. Is the client name and identifier included on each page?	
17. Has referral information been documented?	
18. Does note reflect changes in client status (e.g., GAF Scale, measures of functioning)?	
19. Are any abbreviations used standardized and consistent?	
20. Would someone not familiar with this case be able to read this note and understand exactly what has occurred in treatment?	
21. Are any non-routine calls, missed sessions, or professional consultations regarding this case documented?	
22. Did counselor/supervisor sign note?	